TRAINING & ORIENTATION

Personal Preference Program

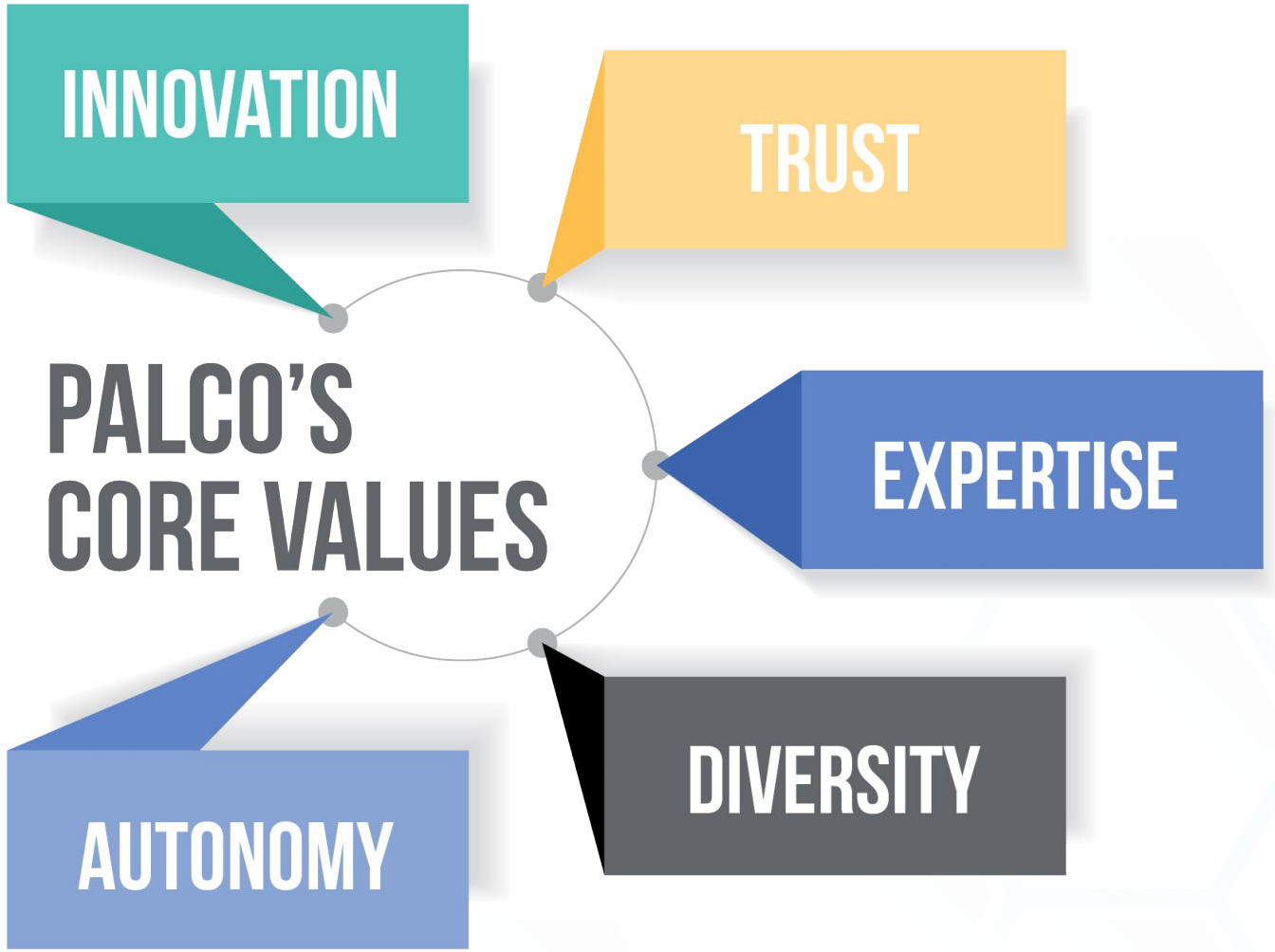
TRAINING TOPICS

- Company Overview
- Participant Enrollment Forms
- Employee/Worker Enrollment Forms
- Program Reminders
- Resources


PALCO
COMPANY
OVERVIEW

MISSION & CORE VALUES

Empowering Independence. Sharpened by experience and amplified by modern technology, Palco advocates for people to live independent lives.



COMPANY HIGHLIGHTS

OVER 25 years of FMS experience

1ST VF/EA in the country

Nationally-recognized thought leaders in self-direction

100% Certified Public Accountant (CPA) and privately owned

Women owned and operated

Programs Served

13 YEARS of Support Broker Experience

$580M In total payroll and vendor payments administered


PALCO
Participant Enrollment Packet

Participant Packet

PALCO
Empowering Independence

PO Box 13260
Maumelle, AR 72113
Toll Free 866.710.0456
Online: PalcoFirst.com

Personal Preference Program
Participant Enrollment Packet

Thank you for choosing Palco to direct your care. This packet contains all the forms you need to enroll as a Participant/Authorized Representative in self-direction and begin paying your worker. Please make sure to follow all directions in this packet.

You must complete and return:

- ☐ Participant Referral & Intake
- ☐ Participant Statement of Responsibilities & Attestation
- ☐ Personal Preference Program Consent Form
- ☐ Duplication of Services
- ☐ Participant Authorized Representative Designation Form
- ☐ Participant Authorized Representative Removal Form
- ☐ M-5008-R Appointment of Taxpayer Rep
- ☐ IRS Form SS4
- ☐ IRS Form 2678
- ☐ IRS Form 8821
- ☐ Criminal Background Check Selection

Failure to return these forms will delay enrollment. We encourage you to use the checklist above as a final review before you return the forms to Palco. 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: 732-351-4804
Email: enrollment@palcofirst.com
Palco, Inc.
Attn: Enrollment
P.O. Box 13260
Maumelle, AR 72113

Visit our website to download an intake form OR contact customer support to get connected to an enrollment specialist. You must complete a consent form before receiving an email with your login instructions. Follow the instructions in that email to complete your enrollment.

Participant Referral & Intake

Intake Form

- Form must be completed in entirety.
- All information on form is needed for enrollment.
- Palco's online enrollment process is quick and easy.

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PO Box 13260
Maumelle, AR 72113

Personal Preference Program

Participant Referral & Intake

Complete this form entirely to begin the enrollment process with Palco. All information on this form is required to enroll. Services should not begin until you receive a notification from Palco that enrollment is approved.

PARTICIPANT/CLIENT INFORMATION			
First Name	Middle Name	Last Name	County
Social Security Number	Date of Birth (mm/dd/yyy)		
Mailing Address (Street Address, including Apt #)			
City	State	Zip	County
Email	Phone	Preferred Method of Communication ☐ Email ☐ Mail ☐ Phone/Voicemail	

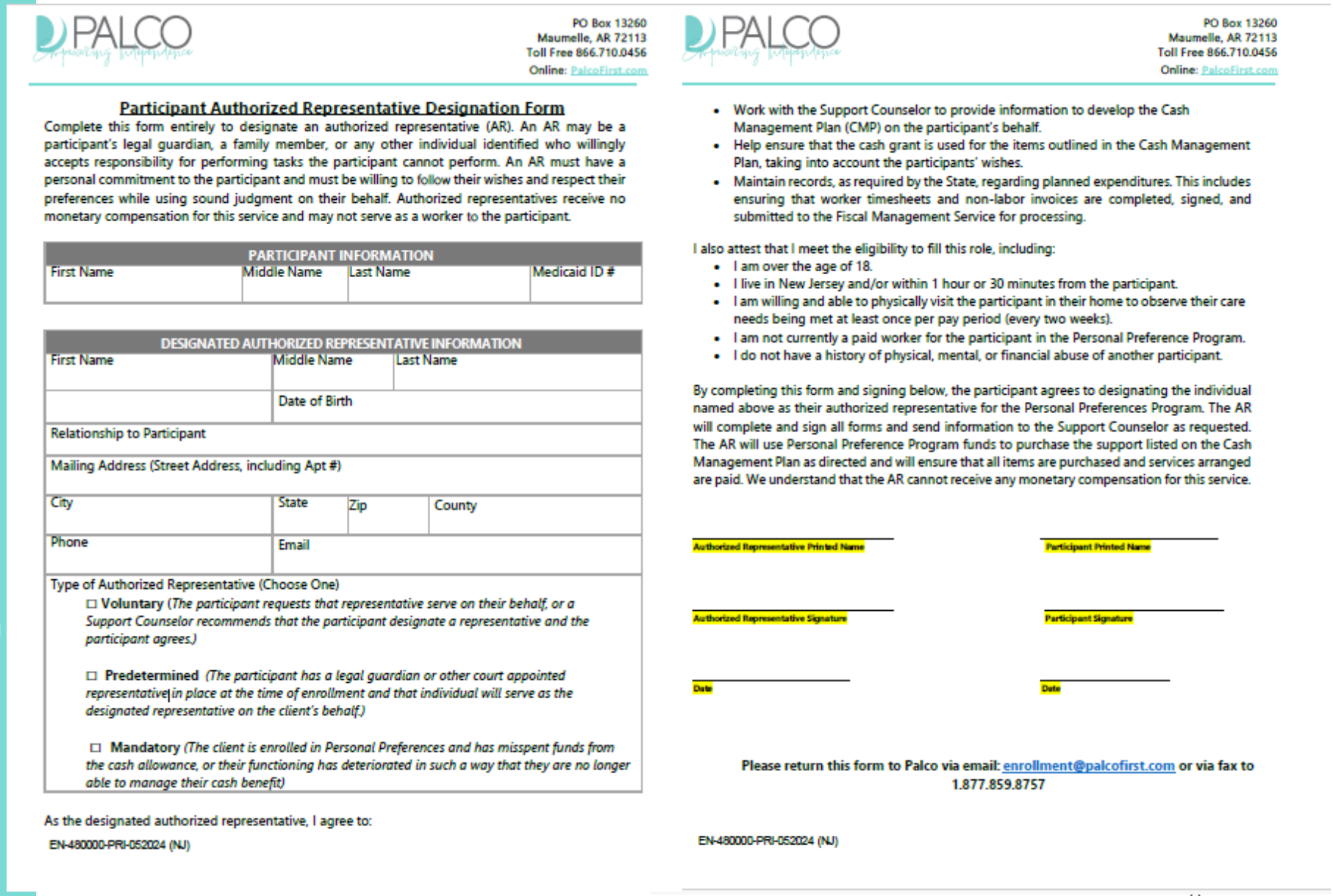
By participating in the Personal Preference Program, the participant/authorized representative will manage and direct these services and funds provided under the budget. This responsibility is known as the employer of record.

Palco has a fully online enrollment process that is quick and easy. The Employer of Record will receive login instructions from Palco via email within 3-5 business days. Once you receive the email, complete your enrollment right away to avoid any delays.

Participant Authorized Representative Designation Form (Optional)

3 Types of Authorized Representative:

- **Voluntary**- Participant may choose to appoint an AR for various reasons.
- **Predetermined**- Participant has a predetermined representative such as legal guardian or court appointed in place.
- **Mandatory** – Participant has misused the budget or is unable to manage the program. Minor children as well.



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PO Box 13260
Maumelle, AR 72113
Toll Free 866.710.0456
Online: PalcoFirst.com

Participant Authorized Representative Designation Form

Complete this form entirely to designate an authorized representative (AR). An AR may be a participant's legal guardian, a family member, or any other individual identified who willingly accepts responsibility for performing tasks the participant cannot perform. An AR must have a personal commitment to the participant and must be willing to follow their wishes and respect their preferences while using sound judgment on their behalf. Authorized representatives receive no monetary compensation for this service and may not serve as a worker to the participant.

PARTICIPANT INFORMATION			
First Name	Middle Name	Last Name	Medicaid ID #

DESIGNATED AUTHORIZED REPRESENTATIVE INFORMATION			
First Name	Middle Name	Last Name	
	Date of Birth		
Relationship to Participant			
Mailing Address (Street Address, including Apt #)			
City	State	Zip	County
Phone	Email		

Type of Authorized Representative (Choose One)

☐ **Voluntary** *(The participant requests that representative serve on their behalf, or a Support Counselor recommends that the participant designate a representative and the participant agrees.)*

☐ **Predetermined** *(The participant has a legal guardian or other court appointed representative in place at the time of enrollment and that individual will serve as the designated representative on the client's behalf.)*

☐ **Mandatory** *(The client is enrolled in Personal Preferences and has misspent funds from the cash allowance, or their functioning has deteriorated in such a way that they are no longer able to manage their cash benefit)*

As the designated authorized representative, I agree to:

EN-480000-PRI-052024 (NJ)

PALCO
Empowering Independence

PO Box 13260
Maumelle, AR 72113
Toll Free 866.710.0456
Online: PalcoFirst.com

- Work with the Support Counselor to provide information to develop the Cash Management Plan (CMP) on the participant's behalf.
- Help ensure that the cash grant is used for the items outlined in the Cash Management Plan, taking into account the participants' wishes.
- Maintain records, as required by the State, regarding planned expenditures. This includes ensuring that worker timesheets and non-labor invoices are completed, signed, and submitted to the Fiscal Management Service for processing.

I also attest that I meet the eligibility to fill this role, including:

- I am over the age of 18.
- I live in New Jersey and/or within 1 hour or 30 minutes from the participant.
- I am willing and able to physically visit the participant in their home to observe their care needs being met at least once per pay period (every two weeks).
- I am not currently a paid worker for the participant in the Personal Preference Program.
- I do not have a history of physical, mental, or financial abuse of another participant.

By completing this form and signing below, the participant agrees to designating the individual named above as their authorized representative for the Personal Preferences Program. The AR will complete and sign all forms and send information to the Support Counselor as requested. The AR will use Personal Preference Program funds to purchase the support listed on the Cash Management Plan as directed and will ensure that all items are purchased and services arranged are paid. We understand that the AR cannot receive any monetary compensation for this service.

Authorized Representative Printed Name

Participant Printed Name

Authorized Representative Signature

Participant Signature

Date

Date

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

EN-480000-PRI-052024 (NJ)

Employer Authority Agreement

Employer Authorization Agreement

As the employer of record, I understand that I have certain responsibilities, such as filing and paying employment taxes for my workers and other employment-related responsibilities falling under Internal Revenue Service (IRS) guidance, Department of Labor (DOL), and agency/programmatic guidelines and regulations. Palco, Inc. will act as my agent in a limited scope and on my behalf for only the tasks related to this program and as listed below, notwithstanding approval by the IRS or other state agencies.

- To perform all duties as the Fiscal/Employer Agent as required by contract, policy regulation, federal and state statues, and other applicable rules and regulations.
- To obtain a Federal Employer Identification Number (FEIN), file IRS Form 2678 to represent me for program-related and employer-related tax purposes, file tax reports, and correspond with the IRS regarding FEINs or employer tax information.
- To establish and register me as an employer in the state in which business is conducted.
- To be my agent for the limited purposes of state and/or local income tax withholding and state unemployment tax purposes, including applying for state and/or local income tax withholding and state unemployment identification number(s), establishing online account(s) to file and pay taxes on my behalf, and receiving correspondence related to my program-related state and/or local income tax withholding and state unemployment tax account(s).

Consent Form

Personal Preference Program Consent Form

I hereby apply for participation in the Personal Preference Program (PPP). I agree to the following terms and conditions in applying for the program, and by signing my signature, indicate that I understand and accept the responsibilities involved in my participation in PPP, as detailed below:

- I understand that I cannot start the Personal Preference Program until I receive approval from Horizon NJ Health (HNJH). The SPO does not authorize when I will begin PPP, only my Managed Care Organization (MCO) can give this authorization.
- I understand that PPP is a Medicaid funded program and that if I lose eligibility for Medicaid, I am no longer eligible for the program. I understand that my workers cannot continue to work for me and will not be paid if I lose Medicaid eligibility. I understand that Medicaid does not notify the program & if I should become ineligible for Medicaid, I am responsible for making sure that my workers do not continue to work.
- I understand that my participation in the program is in place of receiving the traditional Medicaid Personal Care Assistant (PCA) Program from a home care agency and that my agency services will end prior to receiving a cash grant from Personal Preference. Once I start the program, if I continue to accept traditional Medicaid PCA delivered services from an agency, I will be responsible for paying for these services.
- I understand that if I switch my MCO, I am responsible for telling the new MCO that I am enrolled in Personal Preference to avoid duplication of homecare services.
- I understand that I will be set up as a business in the State of New Jersey and I will become a common law participant.
- I understand that I will become the Employer of Record (EOR) for the workers I hire and that I am legally required to pay participant-related business taxes for the workers I hire. My monthly budget will be used, in part, to pay for participant-related taxes. I will use the Fiscal Management Service Organization to assist me with these responsibilities. I understand that the program is a consumer directed program and that I must be able to self-direct my care. If I cannot, I must have an authorized representative act on my behalf. The authorized representative cannot also be a paid worker within the Cash Management Plan (CMP).
- I understand that I will receive a cash allowance, in place of traditional agency model PCA services, to hire people, buy services and make other purchases related to my personal care needs. I understand that I will choose what services and purchases will best meet my needs, subject to approval by my Horizon NJ Health.

New Jersey Department of Human Services Division of
Medical Assistance and Health Services

- I understand that I will choose who provides my services and, as the participant of record, all workers I choose to hire must be legally able to be employed. I understand that my workers will be required to complete Federal documents including a W4 Form and 19 Form. I understand that all wages paid to my workers will be taxable and reportable.
- I understand that time sheets are legal documents. I understand if I submit time sheets with false information, I will be disenrolled from the program and my case will be referred to Medicaid Fraud and Abuse for an investigation and possible criminal charges.
- I understand that I can only use my monthly budget for what has been approved in my CMP by my Support Counselor. I understand that if I submit timesheets or invoices for goods and services that are not included in my approved CMP, they will not be paid.
- I understand that I must not overspend my monthly cash allowance. I understand that if I do overspend my cash allowance, I am responsible for restitution, including responsibility for the payment of workers and purchases. I may borrow from my future allowance to cover overspending with permission from my Support Counselor.
- I will be able to get help from my PPP Support Counselor in making sure the budget is being used correctly. I understand that if I misuse my budget, I may be involuntarily transferred back to the traditional Medicaid Personal Care Assistant program and my case may be referred to the Medicaid Fraud and Abuse Unit for investigation.
- I understand that if my MCO completes a reassessment of PCA hours, I cannot use the new hours until I have completed a revised CMP and it has been approved by my Support Counselor. Even if the MCO issues a letter of benefits, describing a change in PCA hours, the use of those hours cannot be used until I revise my CMP, and it is reviewed and approved by my Support Counselor.
- I understand that I am responsible for managing my CMP and making appropriate changes to my CMP, not my Support Counselor. I am responsible to see that the services that I receive are those listed in my CMP and that all timesheets and invoices match what has been approved in my CMP. If I need assistance with my CMP, my Support Counselor will provide me with guidance.
- I understand that the cash grant I receive from Personal Preference is not counted as personal income for the participant. I understand that any worker I hire through Personal Preference will receive income that is counted as personal income. Therefore, if I live with my worker and we receive household benefits such as SSI, Food Stamps, housing benefits, etc., that are determined by both of our incomes, household benefits could be affected.
- Both your SSI & Food Stamp benefits will not change because of your decision to participate in the Personal Preference Program. I understand that my Personal Preference cash allowance will not be counted as income or as a resource for SSI or Food Stamp eligibility during my participation in this program.

Consent Form Continued

New Jersey Department of Human Services Division of Medical Assistance and Health Services

PALCO

- If I live in a subsidizing housing complex or receive rental assistance, I understand that my participation in the program will not affect my housing eligibility.
- I understand that participation in the program will not affect my eligibility for other services from the following agencies: NJ Division of Deaf & Hard of Hearing, NJ Division of Developmental Disabilities and NJ Department of Labor, Division of Vocational Rehabilitation Services, including vocational rehabilitation services and independent living services programs.
- I understand that services I receive from the NJ Commission for the Blind and Visually Impaired may be affected by a Personal Preference cash allowance. I understand that it's my responsibility to check with my local office to see if my services will be affected by my participation in the Personal Preference.
- I understand that my Personal Preference cash allowance may be counted as income or an asset for post-secondary education loan program eligibility during my participation in Personal Preference. These loan programs include: the Federal Perkins Loan Program, Federal Work-Study Program, Federal Supplemental Education Opportunity Grant Program, the FFEL Program, and the Federal Pell Grant Program. I understand that it is my responsibility to consult with my loan officer to see if my eligibility for post-secondary education loans will be affected by my participation in the Personal Preference Program.
- I understand that I can ask my Support Counselor or other program staff any questions I have about the program and my rights as a consumer. If I decide the program is not right for me, I may return to the traditional Medicaid PCA Program to receive services without penalty or loss of benefits to which I am otherwise entitled. I must notify my Support Counselor upon disenrollment.
- I agree to abide by the guidelines, directives and procedures issued by the Personal Preference Program and to provide such information and reports as are requested by my Support Counselor and/or the State Program Office.

Participant/Authorized Representative Printed Name

_____

Participant/Authorized Representative Signature

_____

Date

Duplication of Service

New Jersey Department of Human Services Division
of Medical Assistance and Health Services

PALCO

Personal Preference Program
Duplication of Service Statement of Understanding

Participation in the Personal Preference Program (PPP) is an alternate for receiving the traditional NJ FamilyCare/Medicaid Personal Care Assistant (PCA) services from a home care agency. NJ FamilyCare/Medicaid recipients cannot be enrolled in PPP and also receive PCA services from a home care agency at the same time. NJ FamilyCare/Medicaid will only pay for ONE.

Once the Personal Preference Program begins, traditional NJ FamilyCare/Medicaid PCA services delivered from an agency must end. The MCO provider that covers your NJ FamilyCare/Medicaid services will notify you current home care agency; to tell them you are going to begin PPP. Your MCO is responsible for stopping your agency delivered PCA services, before you begin PPP, so there is no duplication of service. **Once PPP begins, receiving service from an agency is Medicaid Fraud.**

If the home care agency continues to send a home health aide to your home once you begin PPP, you must turn the aide away. You must also call your MCO provider and notify them that the home care agency is still trying to send a home health aide.

If you accept the services of the home care agency while on PPP, it is considered a duplication of service, as well as Medicaid Fraud. If the PPP discovers that you are receiving agency delivered PCA services while also receiving a monthly grant from PPP, your case will be referred to the Medicaid Fraud and Abuse Unit for investigation. You will also be disenrolled from PPP.

Participant Printed Name _____

Authorized Representative Printed Name (If applicable) _____

Participant Signature _____

Authorized Representative Signature (If applicable) _____

Date _____

Date _____

Page 1 of 1

Criminal Background Check Selection

PALCO
Empowering Independence

PO Box 13260
Maumelle, AR 72113

Criminal Background Check Selection

Criminal Background Checks are optional for workers in the Personal Preference Program. Participants are allowed to request that Palco conduct criminal background checks for their workers. Participants must indicate in the below box, if they are waiving or requesting the option of completing a criminal background check.

PARTICIPANT INFORMATION		
Full Name (First, Middle, Last):	Palco ID:	Program: ppp

WORKER INFORMATION			
First Name	Middle Name	Last Name	
Social Security Number:	Email:	Date of Birth (mm/dd/yyyy):	Gender: ☐ Male ☐ Female
Full Address (Street, City, State, Zip Code):			

I, as the participant, choose to (Please check one):

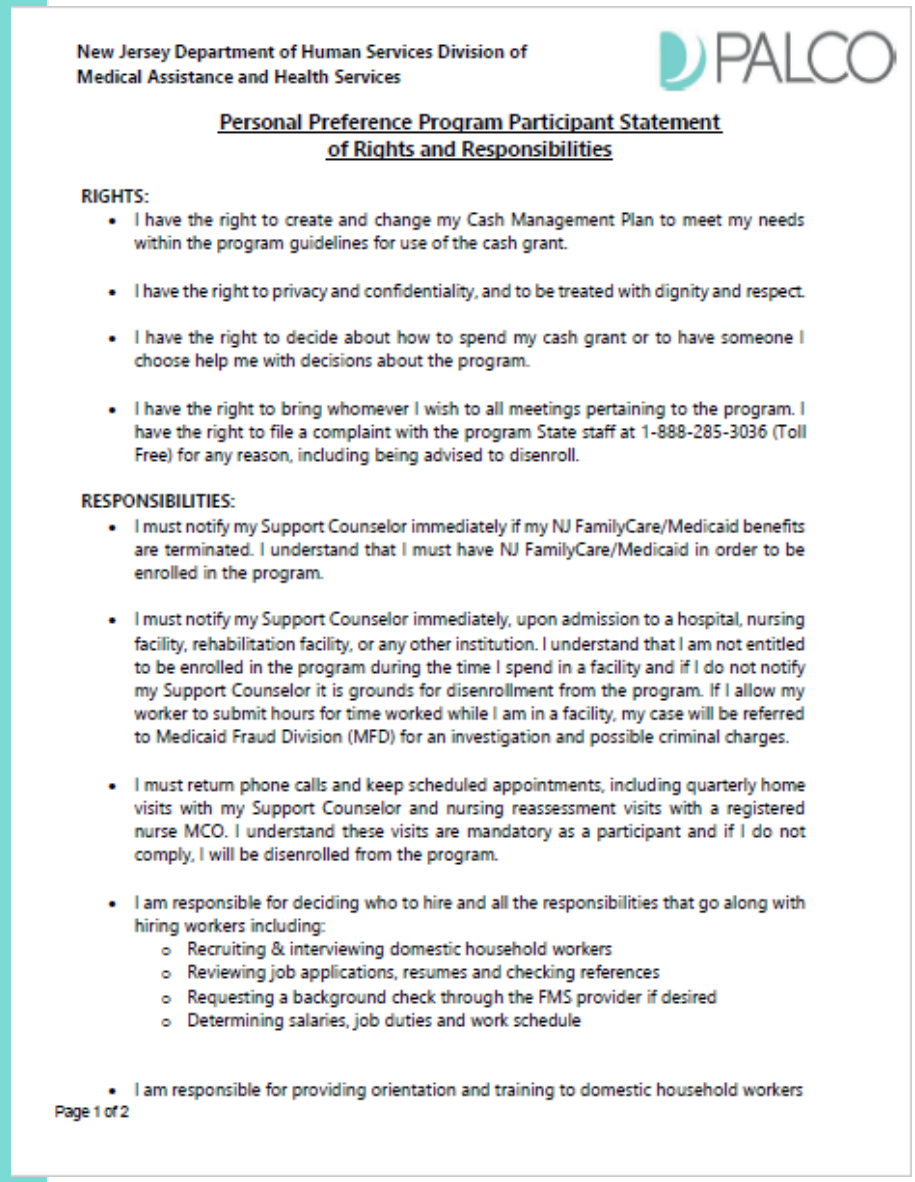
☐ **Conduct the State-Wide Criminal Background Check**
- A fee of $20.00 must be approved and available in the participant's budget allocation
- Criminal Background Checks my delay the enrollment process

☐ **I have decided to waive the State-Wide Criminal Background Check for this worker**
- I understand that this means I may be hiring someone with prior convictions, and I accept full responsibility for this decision

_____
Participant/Authorized Representative Printed Name

_____ _____
Participant/Authorized Representative Signature **Date**

Rights & Responsibilities



New Jersey Department of Human Services Division of Medical Assistance and Health Services

PALCO

Personal Preference Program Participant Statement of Rights and Responsibilities

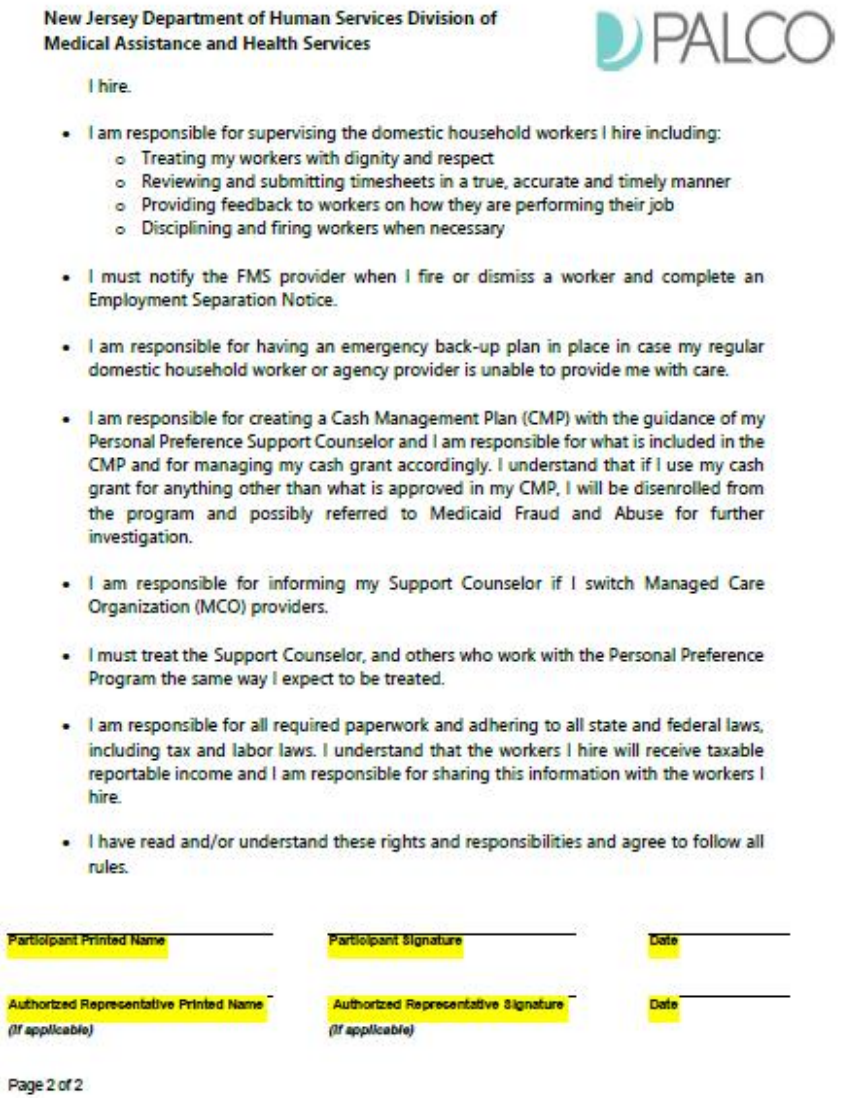
RIGHTS:

- I have the right to create and change my Cash Management Plan to meet my needs within the program guidelines for use of the cash grant.
- I have the right to privacy and confidentiality, and to be treated with dignity and respect.
- I have the right to decide about how to spend my cash grant or to have someone I choose help me with decisions about the program.
- I have the right to bring whomever I wish to all meetings pertaining to the program. I have the right to file a complaint with the program State staff at 1-888-285-3036 (Toll Free) for any reason, including being advised to disenroll.

RESPONSIBILITIES:

- I must notify my Support Counselor immediately if my NJ FamilyCare/Medicaid benefits are terminated. I understand that I must have NJ FamilyCare/Medicaid in order to be enrolled in the program.
- I must notify my Support Counselor immediately, upon admission to a hospital, nursing facility, rehabilitation facility, or any other institution. I understand that I am not entitled to be enrolled in the program during the time I spend in a facility and if I do not notify my Support Counselor it is grounds for disenrollment from the program. If I allow my worker to submit hours for time worked while I am in a facility, my case will be referred to Medicaid Fraud Division (MFD) for an investigation and possible criminal charges.
- I must return phone calls and keep scheduled appointments, including quarterly home visits with my Support Counselor and nursing reassessment visits with a registered nurse MCO. I understand these visits are mandatory as a participant and if I do not comply, I will be disenrolled from the program.
- I am responsible for deciding who to hire and all the responsibilities that go along with hiring workers including:
  - Recruiting & interviewing domestic household workers
  - Reviewing job applications, resumes and checking references
  - Requesting a background check through the FMS provider if desired
  - Determining salaries, job duties and work schedule
- I am responsible for providing orientation and training to domestic household workers

Page 1 of 2



New Jersey Department of Human Services Division of Medical Assistance and Health Services

PALCO

I hire.

- I am responsible for supervising the domestic household workers I hire including:
  - Treating my workers with dignity and respect
  - Reviewing and submitting timesheets in a true, accurate and timely manner
  - Providing feedback to workers on how they are performing their job
  - Disciplining and firing workers when necessary
- I must notify the FMS provider when I fire or dismiss a worker and complete an Employment Separation Notice.
- I am responsible for having an emergency back-up plan in place in case my regular domestic household worker or agency provider is unable to provide me with care.
- I am responsible for creating a Cash Management Plan (CMP) with the guidance of my Personal Preference Support Counselor and I am responsible for what is included in the CMP and for managing my cash grant accordingly. I understand that if I use my cash grant for anything other than what is approved in my CMP, I will be disenrolled from the program and possibly referred to Medicaid Fraud and Abuse for further investigation.
- I am responsible for informing my Support Counselor if I switch Managed Care Organization (MCO) providers.
- I must treat the Support Counselor, and others who work with the Personal Preference Program the same way I expect to be treated.
- I am responsible for all required paperwork and adhering to all state and federal laws, including tax and labor laws. I understand that the workers I hire will receive taxable reportable income and I am responsible for sharing this information with the workers I hire.
- I have read and/or understand these rights and responsibilities and agree to follow all rules.

Participant Printed Name _____ Participant Signature _____ Date _____

Authorized Representative Printed Name _____ Authorized Representative Signature _____ Date _____
(If applicable) *(If applicable)*

Page 2 of 2

TAX DOCUMENTS

M-5008-R
Appointment of Taxpayer Representative

M-5008-R (5/24)

New Jersey Division of Taxation

Appointment of Taxpayer Representative

1. Taxpayer Information

Use this form to designate a representative(s) and grant the representative(s) the authority to obligate, bind, and/or appear on your behalf before the New Jersey Division of Taxation. Section 3 of the form allows you to list which tax matters your representative is authorized to handle on your behalf.

Taxpayer Is:

☐ Individual ☐ Corporation ☐ Sole Proprietorship ☐ Limited Liability Company
☐ Estate ☐ Partnership ☐ Trust (other than a business trust)
☒ Other Specify HOUSEHOLD CARE SERVICE RECIPIENT (HCSR)

Taxpayer's Name (Unitary Group Name if combined group)	SS Number/NJ Taxpayer ID Number/Unitary ID Number	
Spouse's/CU Partner's Name	Social Security Number	
Mailing Address PO BOX 13260		Country (If not US)
City Maumelle	State AR	ZIP Code 72113
Email Address		Phone Number
Managerial Member's Name (if combined group)	Managerial Member's FEIN	
Name of Trustee or Executor		
Address of Trustee or Executor		Country (If not US)
City	State	ZIP Code
Email Address		Phone Number

2. Representative Information

The named representative(s) must sign and date where indicated in Section 8 on page 2 or this appointment will be rejected. If the representative is a tax practitioner, the representative must enter his/her Preparer Tax Identification Number (PTIN) as the Representative ID. Representatives who do not have a PTIN must enter their Social Security number.

The taxpayer(s) named in Section 1 above appoints the person(s) named below as his/her/their taxpayer representative to represent them in connection with the tax matter(s) listed in Section 3.

Name PALCO, INC	Representative ID	
Address PO BOX 242930, LITTLE ROCK, AR 72223		
Email Address tax@palcofirst.com	Phone Number 501.604.9936	Fax Number
Name	Representative ID	
Address		
Email Address	Phone Number	Fax Number

3. Tax Matters

I/We appoint the representative(s) named in Section 2 above to represent me/us for:

☐ All tax matters ☒ Specific tax matters listed below

Type of Tax (New Jersey Gross Income, Sales and Use, Corporation, Partnership, Employment, Inheritance, etc.)	Years(s) and Period(s)

4. Acts Authorized

The representative(s) is/are authorized to receive and inspect confidential tax records and is/are granted full power to act with respect to the tax matters described in Section 3 above, and to do and perform all such acts as I/we could do or perform. The authority granted by this appointment does not include the power to endorse a refund check.

☐ If you want the representative(s) to have limited power, provide an explanation on the lines below and check this box. You may attach additional information as well.

5. Notices and Communications

We will send original notices and other written communications to you and a copy (other than automated computer notices) to the first representative listed in Section 2 unless you check one or more of the boxes below.

☐ I/We do not want the Division to send any notices or communications to my representative(s).

☐ I/We want the Division to send a copy of notices and/or communications (other than automated computer notices) to both representatives listed in Section 2.

6. Retention/Revocation of Prior Appointment(s) or Power(s)

The filing of this form automatically revokes all earlier Appointment(s) of Taxpayer Representative and/or Power(s) of Attorney on file with the Division of Taxation for the tax matters and years or periods listed in Section 3 unless you check the box below.

☐ I/We do not want to revoke any prior Appointment(s) of Taxpayer Representative and/or Power(s) of Attorney. If you check this box, you must attach copies of the previous Appointment(s) and/or Power(s) that you do not want to revoke.

7. Signature of Taxpayer(s)

If the tax matters covered by this appointment concern a joint Gross Income Tax return and the representative(s) is/are being appointed to represent both spouses/CU partners, both must sign below.

If a corporate officer, partner, guardian, tax matter partner, executor, administrator, or trustee signs the appointment on behalf of the taxpayer, the signature below certifies that they have the authority to execute this form on behalf of the taxpayer(s).
Note: If the taxpayer is a combined group, the managerial member is responsible for acting on behalf of the group for Corporation Business Tax purposes. The corporate officer of the managerial member who signs the appointment on behalf of the combined group certifies that they have the authority to execute this form on behalf of the combined group.

This Appointment of Taxpayer Representative Is Void if not Signed and Dated

Taxpayer Signature	Date
Print Name	Title (if applicable)
Taxpayer Signature	Date
Print Name	Title (if applicable)

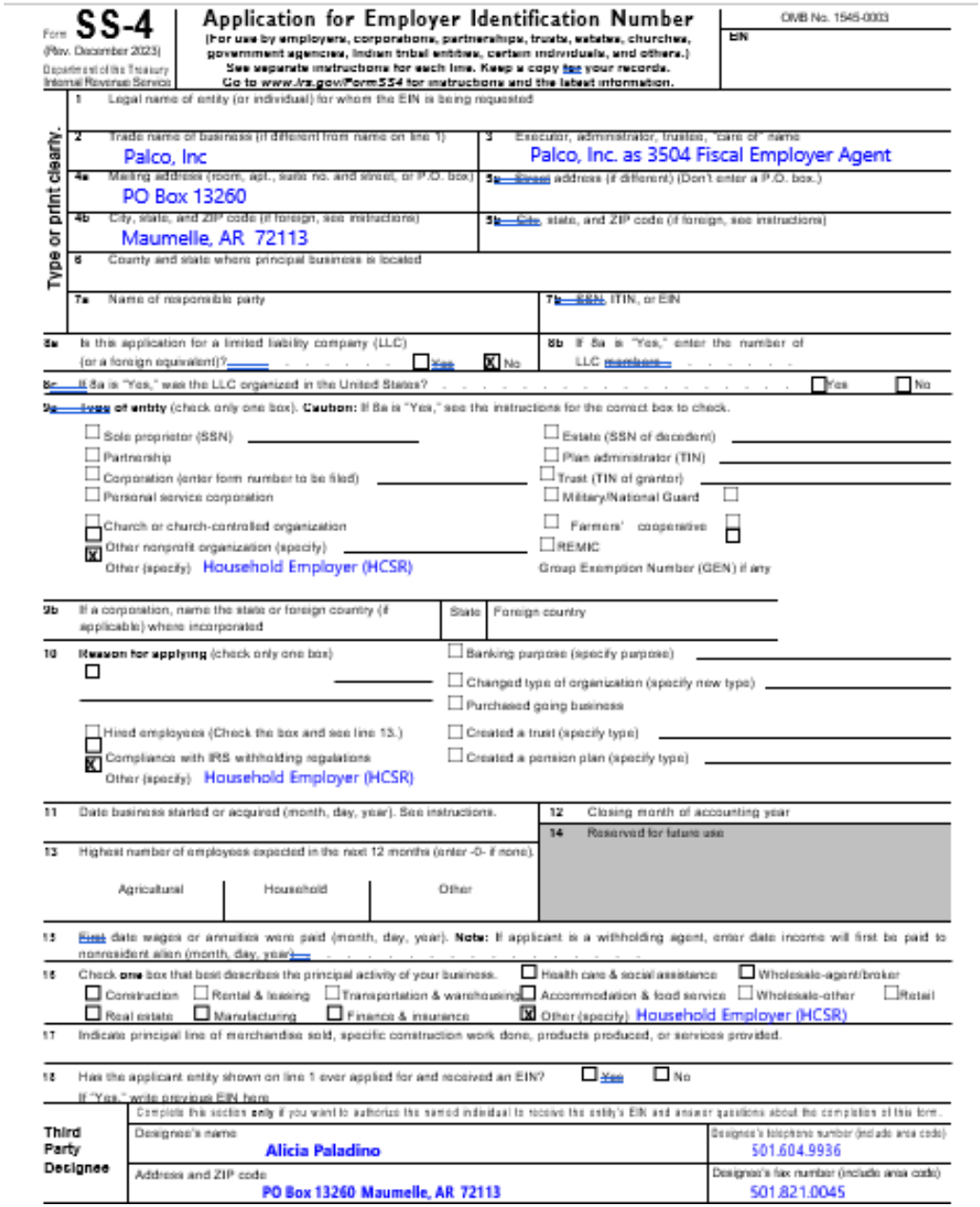
8. Acceptance of Representation and Signature

I/We accept the appointment as representative(s) for the taxpayer(s) who has/have executed this Appointment of Taxpayer Representative.

Representative Signature	Date
Print Name ALICIA PALADINO	Title (if applicable) CHIEF EXECUTIVE OFFICER
Representative Signature	Date
Print Name	Title (if applicable)

TAX DOCUMENTS

SS4
Application for Employer Identification Number



Form **SS-4** (Rev. December 2023)
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.
Go to www.irs.gov/Form SS4 for instructions and the latest information.

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): Palco, Inc

3 Executor, administrator, trustee, "care of" name: Palco, Inc. as 3504 Fiscal Employer Agent

4a Mailing address (room, apt., suite no. and street, or P.O. box): PO Box 13260

5a Street address (if different) (Don't enter a P.O. box.)

4b City, state, and ZIP code (if foreign, see instructions): Maumelle, AR 72113

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

6 County and state where principal business is located

7a Name of responsible party

7b SSN, ITIN, or EIN

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

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

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

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

- ☐ Sole proprietor (SSN)
- ☐ Partnership
- ☐ Corporation (enter form number to be filed)
- ☐ Personal service corporation
- ☐ Church or church-controlled organization
- ☒ Other nonprofit organization (specify)
- Other (specify): Household Employer (HCSR)
- ☐ Estate (SSN of decedent)
- ☐ Plan administrator (TIN)
- ☐ Trust (TIN of grantor)
- ☐ Military/National Guard
- ☐ Farmers' cooperative
- ☐ REMIC
- 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)

- ☐ Banking purpose (specify purpose)
- ☐ Changed type of organization (specify new type)
- ☐ Purchased going business
- ☐ Hired employees (Check the box and see line 13.)
- ☒ Compliance with IRS withholding regulations
- Other (specify): Household Employer (HCSR)
- ☐ 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).

Agricultural	Household	Other

14 Reserved for future use

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

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

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

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

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

If "Yes," write previous EIN here

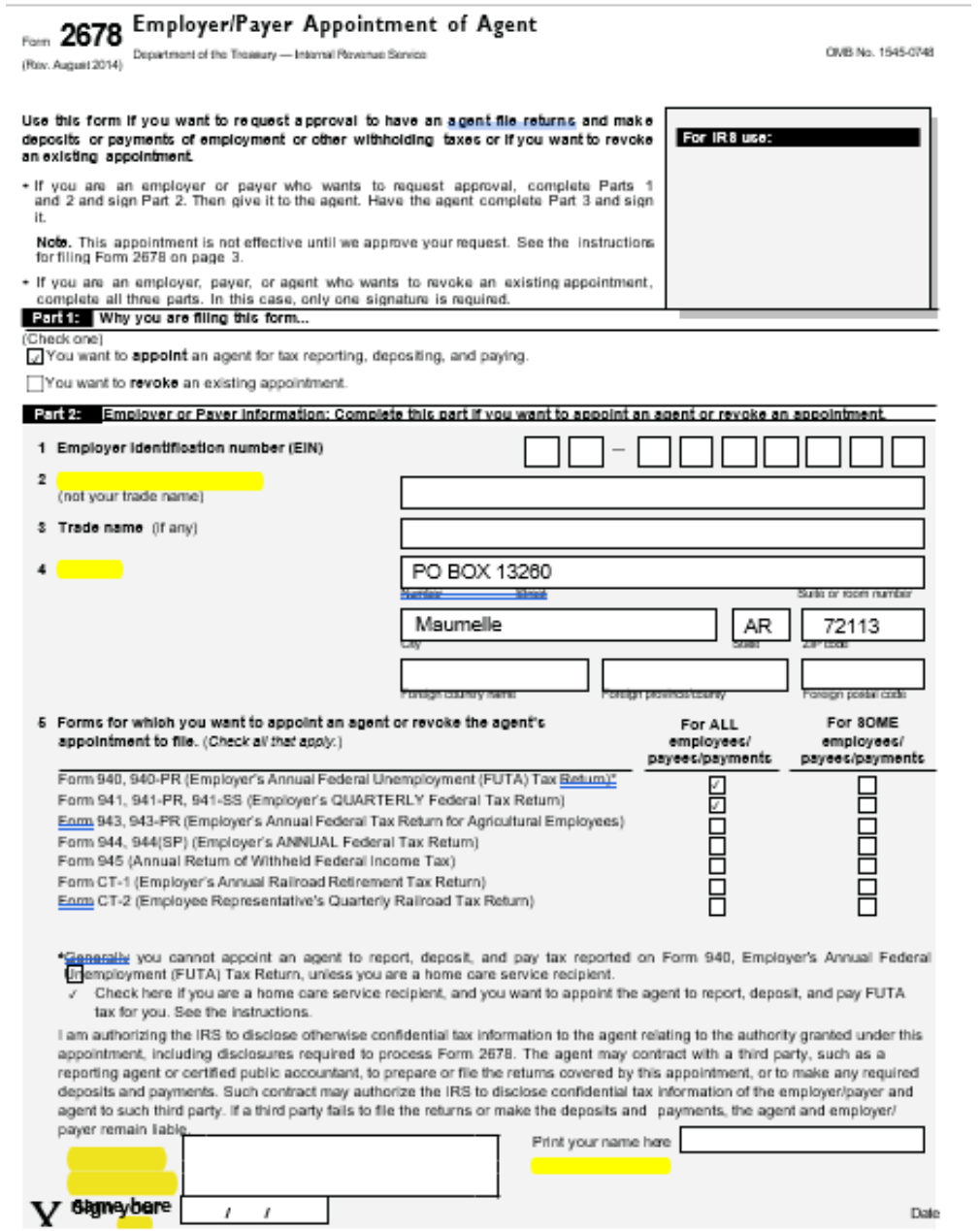
Third Party Designee

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

Designee's name	Designee's telephone number (include area code)
Alicia Paladino	501.604.9936
Address and ZIP code	**Designee's fax number (include area code)**
PO Box 13260 Maumelle, AR 72113	501.821.0045

TAX DOCUMENTS

2678
Employer/Payer Appointment of Agent



Form **2678** (Rev. August 2014)

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 (not your trade name)

3 **Trade name** (if any)

4 PO BOX 13260

Number Street — Suite or room number

Maumelle — AR — 72113

City — State — ZIP code

Foreign country name — Foreign province/county — Foreign postal code

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

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

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

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

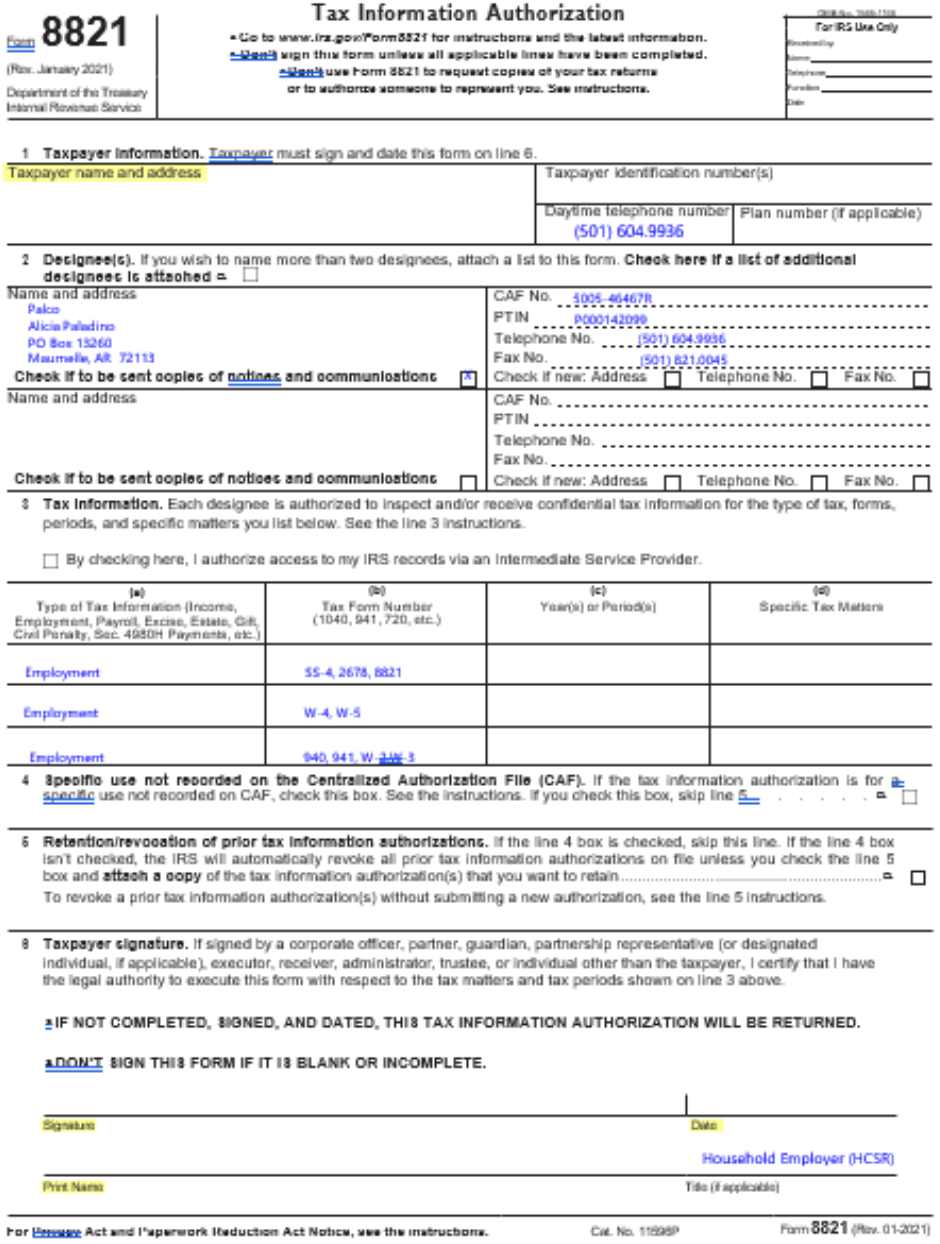
I am authorizing the IRS to disclose otherwise confidential tax information to the agent relating to the authority granted under this appointment, including disclosures required to process Form 2678. The agent may contract with a third party, such as a reporting agent or certified public accountant,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

Print your name here

Signature — Date

TAX DOCUMENTS

8821
Tax Information Authorization



Form **8821**
(Rev. January 2021)
Department of the Treasury
Internal Revenue Service

Tax Information Authorization

▪ Go to www.irs.gov/Form8821 for instructions and the latest information.
▪ Don't sign this form unless all applicable lines have been completed.
▪ Don't use Form 8821 to request copies of your tax returns or to authorize someone to represent you. See instructions.

For IRS Use Only
Received by
Name
Telephone
Function
Date

1 **Taxpayer information.** Taxpayer must sign and date this form on line 6.

Taxpayer name and address	Taxpayer identification number(s)	
	Daytime telephone number: (501) 604.9936	Plan number (if applicable)

2 **Designee(s).** If you wish to name more than two designees, attach a list to this form. **Check here if a list of additional designees is attached** ▫ ☐

Name and address	
Palco Alicia Paladino PO Box 13260 Maumelle, AR 72113	CAF No. 1005-464678 PTIN P00142099 Telephone No. (501) 604.9936 Fax No. (501) 821.0045
Check if to be sent copies of notices and communications ☒	Check if new: Address ☐ Telephone No. ☐ Fax No. ☐
Name and address	CAF No. PTIN Telephone No. Fax No.
Check if to be sent copies of notices and communications ☐	Check if new: Address ☐ Telephone No. ☐ Fax No. ☐

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

☐ By checking here, I authorize access to my IRS records via an Intermediate Service Provider.

(a) Type of Tax Information (Income, Employment, Payroll, Excise, Estate, Gift, Civil Penalty, Sec. 4980H Payments, etc.)	(b) Tax Form Number (1040, 941, 720, etc.)	(c) Year(s) or Period(s)	(d) Specific Tax Matters
Employment	SS-4, 2678, 8821		
Employment	W-4, W-5		
Employment	940, 941, W-2/W-3		

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

5 **Retention/revocation of prior tax information authorizations.** If the line 4 box is checked, skip this line. If the line 4 box isn't checked, the IRS will automatically revoke all prior tax information authorizations on file unless you check the line 5 box and **attach a copy** of the tax information authorization(s) that you want to retain . . . . . ▫ ☐
To revoke a prior tax information authorization(s) without submitting a new authorization, see the line 5 instructions.

6 **Taxpayer signature.** If signed by a corporate officer, partner, guardian, partnership representative (or designated individual, if applicable), executor, receiver, administrator, trustee, or individual other than the taxpayer, I certify that I have the legal authority to execute this form with respect to the tax matters and tax periods shown on line 3 above.

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

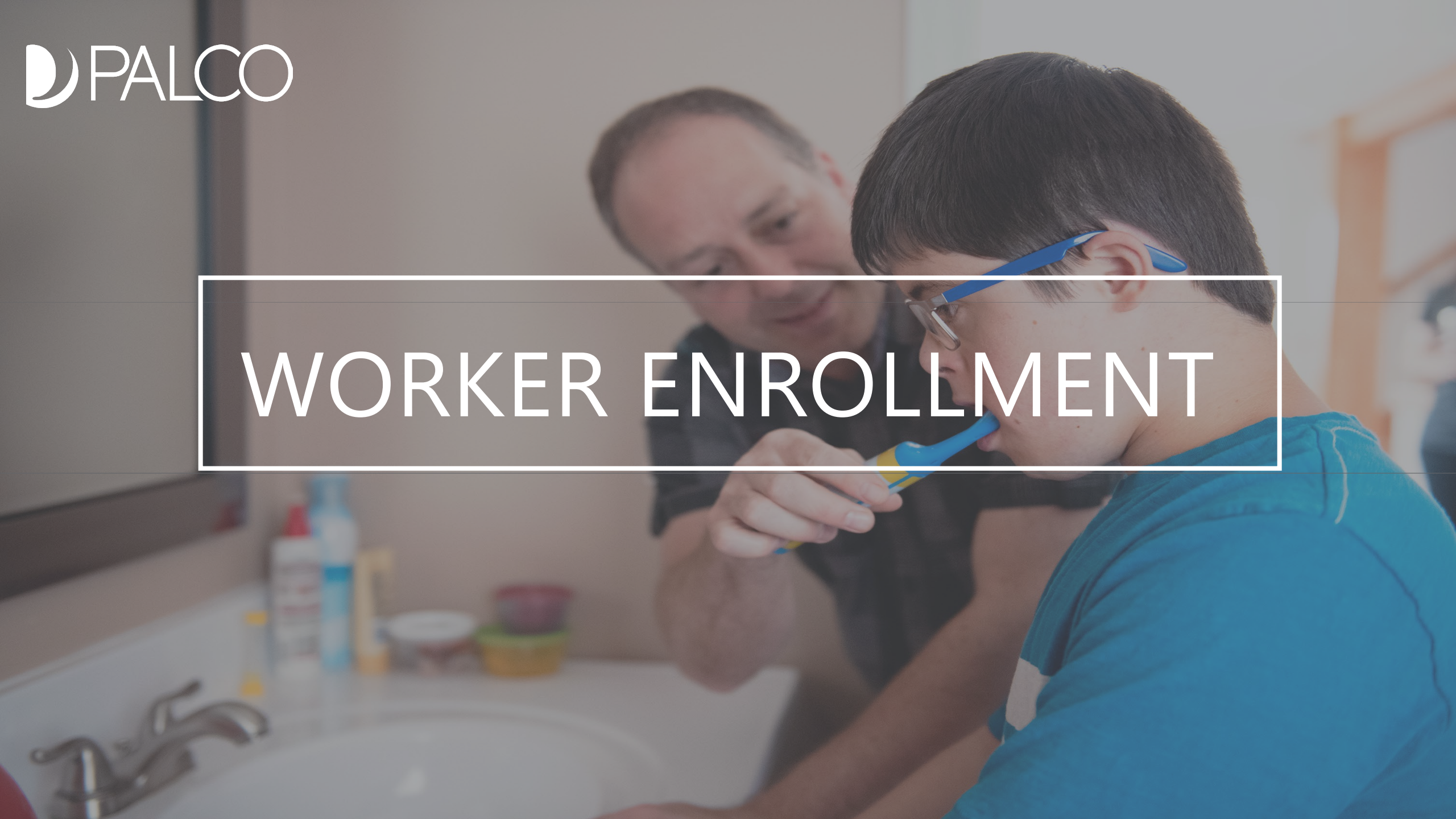
▪ **DON'T SIGN THIS FORM IF IT IS BLANK OR INCOMPLETE.**

Signature | Date

Household Employer (HCSR)

Print Name | Title (if applicable)

For Privacy Act and Paperwork Reduction Act Notice, see the instructions. Cat. No. 11980P Form **8821** (Rev. 01-2021)



WORKER ENROLLMENT

Worker Employment Packet

Personal Preference Program
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 Form
- ☐ Worker Information & Qualification Form
- ☐ US CIS Form I-9
- ☐ New Jersey Worker Pay Rate Information
- ☐ NJ W-4 State Withholding Form
- ☐ IRS Form W-4
- ☐ EVV Consent Form OR EVV Live-in Exemption

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: 877-859-8757
Toll Free: 1-877-710-0457
Email: enrollNJ@palcofirst.com
Palco, Inc.
Attn: Enrollment
P.O. 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 732.351.4804 or Support_NJ@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

EN-480000-WTC-052024

WORKER INTAKE

Worker/Applicant Intake

Complete this form entirely to begin the enrollment process as a worker in the Personal Preference Program. Completion of this form does not constitute hiring by the employer.

PARTICIPANT INFORMATION		
Full Name	SSN	Program

WORKER INFORMATION			
First Name	Middle Name	Last Name	
Social Security Number	Email	Date of Birth (mm/dd/yyyy)	Gender Male Female
Is the worker related to the participant/client by blood or marriage? ☐No ☐Yes. I am the participant/client's _____ (specify relationship)			
Do you share a residence with the participant/client? ☐No ☐ Yes. Please specify who owns or rents the residence: _____ Is the worker at least 18 years of age? ☐No ☐Yes			
Physical Address (Street Address, Including Apt. #)			
City	State	Zip	County
Mailing Address (Street Address, Including Apt. #) – *if different than the physical address*			
City	State	Zip	County
Phone1	Phone2	Preferred Method of Communication ☐ Email ☐ Mail ☐ Phone / Voicemail	

How would you like to continue the enrollment process?

☐ **Complete enrollment online.** By checking this option, the worker has provided an email address that belongs to him or her and understands that Palco is not responsible for providing information to an incorrect email address supplied by him or her. The worker agrees to receive information, notifications, and other correspondence electronically. Such correspondence may contain Personal Health Information, as defined at 45 CFR 160.103, and other personally identifiable information. The worker accepts all risks associated with the transmission of such information via those channels. The worker understands that his or her consent is in effect until Palco is notified in writing that the worker withdraws such consent.

☐ **Receive a packet via email.**

☐ **Receive a paper packet via mail.**

Worker Printed Name _____ Participant/Authorized Representative Printed Name _____

Worker Signature _____ Date _____ Participant/Authorized Representative Signature _____ Date _____

WORKER INFORMATION & QUALIFICATION

PALCO

Worker Information & Qualification

This form is required for all workers in self-direction. Please complete this form entirely.

WORKER (APPLICANT) INFORMATION	
Full Name	ID/Last 4 of SSN

As a worker in self-direction, you must agree to the following terms of employment:

- You understand that the participant is your employer. Neither Palco, nor program/state administrators, is your employer.
- This position is paid as an employee and not as an independent contractor.
- This document does not create an anticipation, nor a contract, of employment.
- To adhere to all federal, state, local, and program laws, regulations, policies, and requirements throughout your employment. This includes staying current on information provided to you about the program throughout your employment.
- To accurately complete all enrollment documentation to ensure that you meet the program's eligibility requirements for providing services and are not prohibited in any manner from providing services.
- That your employment is contingent upon many factors, including successful completion and/or passing of required background checks, training, and/or credentialing.
- To report any changes in your ability to deliver services, including changes in your background history or qualifications required to perform services under this program.
- Being paid for services through the program is contingent upon the participant's eligibility for the program. Once eligibility terminates, you may no longer be paid through this program.
- Your participant is responsible for payment of services for activities not authorized in or exceeding the limitations established by the budget.
- Funds to pay for services are from public sources, and financial accountability and liability applies to the use of the funds. You understand that submitting false or fraudulent timesheets or submitting timesheets for tasks other than those approved on the authorized budget will be reported to the appropriate authorities for investigation and possible prosecution as fraud.
- That medical and personal information and data about the participant and the worker is confidential. You have read and agree to Palco's Privacy Practices.
- That neither Palco nor program/state administrators are responsible or liable for any negligent acts, work-related injuries, or omissions by me, the participant, participant, other workers or service providers, or authorized representatives.
- To report all critical incidents relating to the participant's health, safety, and welfare, including suspicion of fraud, abuse, or neglect.

PALCO

You certify that you are at least 18 years of age or, if younger, of eligible age to obtain legal working papers under NJ law (typically 16–17 years old with valid working papers). You give your permission for Palco to run federal and state Office of Inspector General Medicaid exclusion checks and to share the results with my participant, state and program administrators, and others who may be involved in the participant's care through this program. You understand that your employment is based on the outcome of these checks and that you cannot provide services, nor receive payment, until Palco has notified you that you have been cleared to do so. You hereby release your participant, Palco, and his/her agents from any and all liability, claims and/or demands, of whatever kind, related to the compilation or preparation of the checks hereby authorized.

- ☒ Criminal Background Check (per participant)
- ☒ Office of Inspector General (OIG) Medicaid exclusion check / List of Excluded Individuals and Entities (LEIE)
- ☒ U.S.CIS E-Verify system.

By signing below, you acknowledge that you have read this agreement and accept responsibility as a worker in self-direction, understand the responsibilities and duties associated with that role, and will comply with program policies and requirements. The information provided herein is true and accurate to the best of your knowledge. You further understand and agree that violation of this agreement will result in termination.

Worker Printed Name _____ Worker Signature _____ Date _____

I-9 EMPLOYMENT ELIGIBILITY VERFICATION

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.)

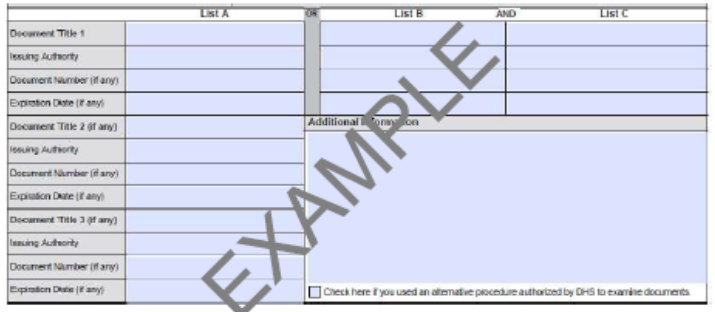
- ☐ Select the following box that applies to you.
  - If you select box 3, supply your alien registration or USCIS number,
  - If you select box 4, supply your work expiration date and complete any one of the three fields that follow.

- ☐ 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,



- ☐ 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,

- ☐ 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.

I-9 EMPLOYMENT ELIGIBILITY VERFICATION Continued

Employment Eligibility Verification

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

USCIS Form 1-9
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 1-9. 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 1-9 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.):

D 1. A citizen of the United States
D 2. A noncitizen national of the United States (See Instructions.)
D 3. A lawful permanent resident (Enter USCIS or A-Number.)
D 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)			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)					

D 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

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 OHS 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.

	OR		
• 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.		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 1-9 Central for more information.

I-9 EMPLOYMENT ELIGIBILITY VERFICATION Continued

Preparer and/or Translator Certification for Section 1

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

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

Reverification and Rehire (formerly Section 3)

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

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

everification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show ontinued 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

everification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show ontinued 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.

PAYROLL INFORMATION

PALCO

PALCO PAYMENT SCHEDULE - 2025

New Jersey Horizon

Service Period		Timesheets Due to Palco by 12 PM EST	Electronic Timesheets Due by 12 pm	Payments Made by Palco by 5pm
MONDAY	SUNDAY	MONDAY	TUESDAY	WEDNESDAY
Start Date	End Date	Deadline	Deadline	Paid On
December 30, 2024	January 12, 2025	January 13, 2025	January 14, 2025	January 22, 2025
January 13, 2025	January 26, 2025	January 27, 2025	January 28, 2025	February 5, 2025
January 27, 2025	February 9, 2025	February 10, 2025	February 11, 2025	February 19, 2025
February 10, 2025	February 23, 2025	February 24, 2025	February 25, 2025	March 5, 2025
February 24, 2025	March 9, 2025	March 10, 2025	March 11, 2025	March 19, 2025
March 10, 2025	March 23, 2025	March 24, 2025	March 25, 2025	April 2, 2025
March 24, 2025	April 6, 2025	April 7, 2025	April 8, 2025	April 16, 2025
April 7, 2025	April 20, 2025	April 21, 2025	April 22, 2025	April 30, 2025
April 21, 2025	May 4, 2025	May 5, 2025	May 6, 2025	May 14, 2025
May 5, 2025	May 18, 2025	May 19, 2025	May 20, 2025	May 28, 2025
May 19, 2025	June 1, 2025	June 2, 2025	June 3, 2025	June 11, 2025
June 2, 2025	June 15, 2025	June 16, 2025	June 17, 2025	June 25, 2025
June 16, 2025	June 29, 2025	June 30, 2025	July 1, 2025	July 9, 2025
June 30, 2025	July 13, 2025	July 14, 2025	July 15, 2025	July 23, 2025
July 14, 2025	July 27, 2025	July 28, 2025	July 29, 2025	August 6, 2025
July 28, 2025	August 10, 2025	August 11, 2025	August 12, 2025	August 20, 2025
August 11, 2025	August 24, 2025	August 25, 2025	August 26, 2025	September 3, 2025
August 25, 2025	September 7, 2025	September 8, 2025	September 9, 2025	September 17, 2025
September 8, 2025	September 21, 2025	September 22, 2025	September 23, 2025	October 1, 2025
September 22, 2025	October 5, 2025	October 6, 2025	October 7, 2025	October 15, 2025
October 6, 2025	October 19, 2025	October 20, 2025	October 21, 2025	October 29, 2025
October 20, 2025	November 2, 2025	November 3, 2025	November 4, 2025	November 12, 2025
November 3, 2025	November 16, 2025	November 17, 2025	November 18, 2025	November 26, 2025
November 17, 2025	November 30, 2025	December 1, 2025	December 2, 2025	December 10, 2025
December 1, 2025	December 14, 2025	December 15, 2025	December 16, 2025	December 24, 2025
December 15, 2025	December 28, 2025	December 29, 2025	December 30, 2025	January 7, 2026
December 29, 2025	January 11, 2026	January 12, 2026	January 13, 2026	January 21, 2026

Late time submissions and mistakes may result in late payment

2025 Bank and/or Palco Office Closures

New Year's Day – Wednesday, January 1*
Martin Luther King, Jr Day – Monday, January 20
President's Day – Monday, February 17
Memorial Day - Monday, May 26*
Juneteenth Day – Thursday, June 19
Independence Day - Friday, July 4*
Labor Day - Monday, September 1*
Columbus Day – Monday, October 13
Veterans Day - Tuesday, November 11
Thanksgiving - Thursday-Friday, November 27-28*
Christmas - Wednesday-Thursday, December 24-25*

* Palco Office Closures

EN-330000-BWS-1.0

IRS FORM W4

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

City or town, state, and ZIP code

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*.

(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.

CAUTION ***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.

New Jersey W4 State Withholding

Form **NJ-W4**
(1-21)

State of New Jersey – Division of Taxation
Employee's Withholding Allowance Certificate

1. SS#	2. Filing Status: (Check only one box) 1. ☐ Single 2. ☐ Married/Civil Union Couple Joint 3. ☐ Married/Civil Union Partner Separate 4. ☐ Head of Household 5. ☐ Qualifying Widow(er)/Surviving Civil Union Partner
Name	
Address	
City / State / Zip	

3. If you have chosen to use the chart from instruction A, enter the appropriate letter here	3.
4. Total number of allowances you are claiming (see instructions)	4.
5. Additional amount you want deducted from each pay	5. $
6. I claim exemption from withholding of NJ Gross Income Tax and I certify that I have met the conditions in the instructions of the NJ-W4. If you have met the conditions, enter "EXEMPT" here	6.

7. Under penalties of perjury, I certify that I am entitled to the number of withholding allowances claimed on this certificate or entitled to claim exempt status.

Employee's Signature | Date

Employer's Name and Address | Employer Identification Number

BASIC INSTRUCTIONS

Line 1 Enter your name, address, and Social Security number in the spaces provided.

Line 2 Check the box that indicates your filing status. If you checked Box 1 (Single) or Box 3 (Married/Civil Union Partner Separate) you will be withheld at Rate A.
Note: If you have checked Box 2 (Married/Civil Union Couple Joint), Box 4 (Head of Household) or Box 5 (Qualifying Widow(er) Surviving Civil Union Partner) and either your spouse/civil union partner works or you have more than one job or more than one source of income and the combined total of all wages is greater than $50,000, see instruction A below. If you do not complete Line 3, you will be withheld at Rate B.

Line 3 If you have chosen to use the wage chart below, enter the appropriate letter.

Line 4 Enter the number of allowances you are claiming. Entering a number on this line will decrease the amount of withholding and could result in an underpayment on your return.

Line 5 Enter the amount of additional withholdings you want deducted from each pay.

Line 6 Enter "EXEMPT" to indicate that you are exempt from New Jersey Gross Income Tax Withholdings, if you meet one of the following conditions:

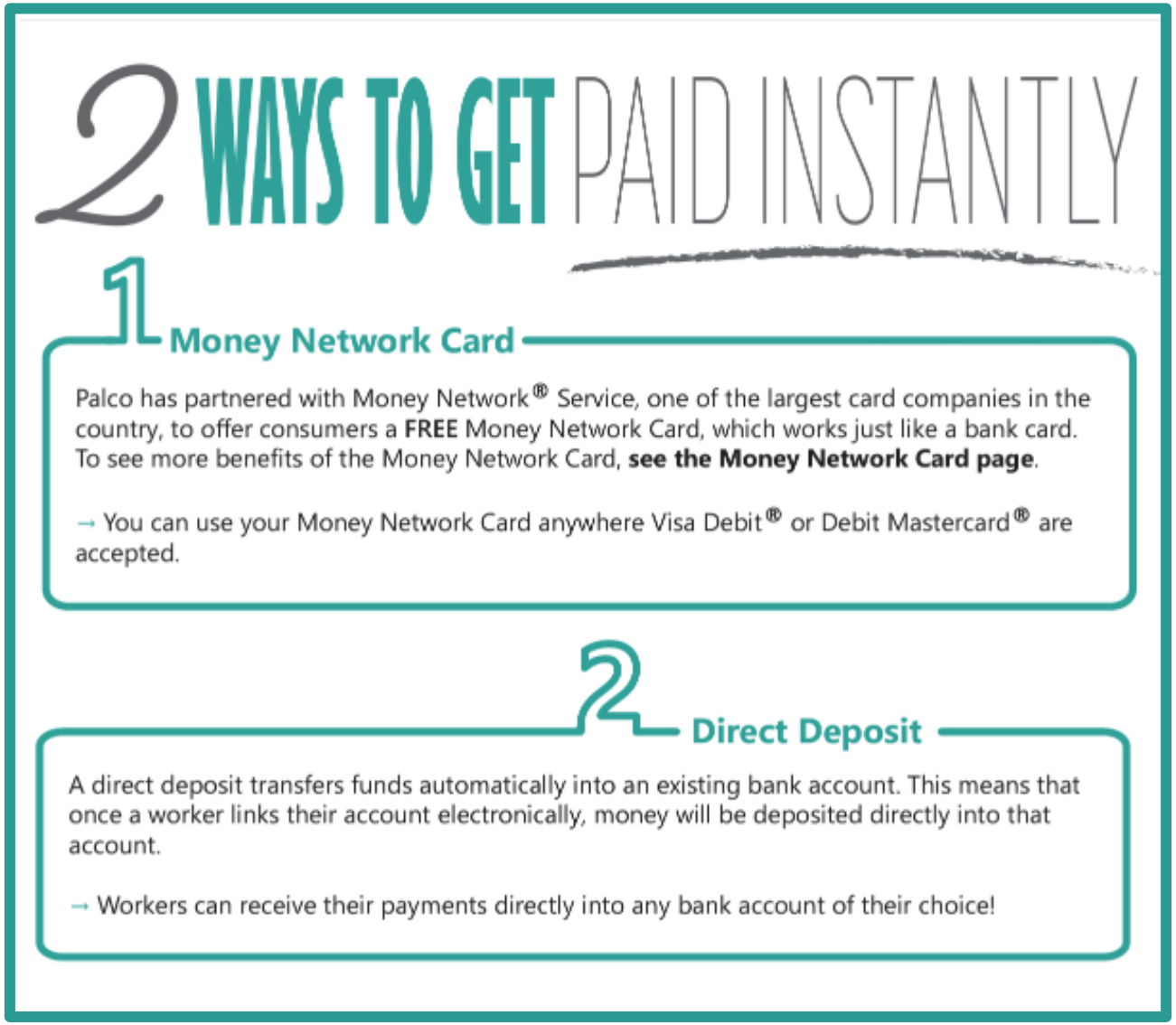
- Your filing status is **SINGLE** or **MARRIED/CIVIL UNION PARTNER SEPARATE** and your wages plus your taxable nonwage income will be $10,000 or less for the current year.
- Your filing status is **MARRIED/CIVIL UNION COUPLE JOINT**, and your wages combined with your spouse's/civil union partner's wages plus your taxable nonwage income will be $20,000 or less for the current year.
- Your filing status is **HEAD OF HOUSEHOLD** or **QUALIFYING WIDOW(ER)/SURVIVING CIVIL UNION PARTNER** and your wages plus your taxable nonwage income will be $20,000 or less for the current year.

Your exemption is good for ONE year only. You must complete and submit a form each year certifying you have no New Jersey Gross Income Tax liability and claim exemption from withholding. If you have questions about eligibility, filing status, withholding rates, etc. when completing this form, call the Division of Taxation's Customer Service Center at (609) 292-6400.

Instruction A - Wage Chart

This chart is designed to increase withholdings on your wages, if these wages will be taxed at a higher rate due to inclusion of other wages or income on your NJ-1040 return. **It is not intended to provide withholding for other income or wages.** If you need additional withholdings for other income or wages, use Line 5 on the NJ-W4. This Wage Chart applies to taxpayers who are married/civil union couple filing jointly, heads of households, or qualifying widow(er)/surviving civil union partner. **Single individuals or married/civil union partners filing separate returns do not need to use this chart.** If you have indicated filing status #2, 4 or 5 on the above NJ-W4 and your taxable income is greater than $50,000, you should strongly consider using the Wage Chart. (See the Rate Tables on the reverse side to estimate your withholding amount.)

PAY SELECTION & DIRECT DEPOSIT



WORKER RATE OF PAY INFORMATION

PALCO

New Jersey Worker Pay Rate Information

Select the appropriate reason for this form:

☐ New Worker Enrollment ☐ Change Existing Rate

REQUIRED INFORMATION	
Participant Name	Participant ID
Worker Name	Worker ID or Last 4 of SSN
Authorized Representative (AR) Name (if applicable)	AR ID (if applicable)

Below, please indicate the Pay Rate you are agreeing to. The Pay Rate is the amount that the Worker will receive per hour worked.

Rate Name	Hourly Rate

Mutual Responsibilities
Both parties agree to adhere to all policies and procedures of the Personal Preference Program.

Participant/Authorized Representative Responsibilities
The Participant/Authorized Representative shall:

- Verify worker qualifications, including criminal background checks.
- Schedule workers to provide services for payment only after being authorized by Palco, Inc. Palco cannot pay for any services provided before being issued a start date.
- Orient, train, schedule, and supervise workers.
- Provide a safe workplace free from excess hazards, employment discrimination, and harassment.
- Request worker to perform permitted and planned for duties, as determined in the Cash Management Plan. The worker should not perform prohibited services, such as administering medication, dressing wounds, and tube feeding.
- Notify workers in advance if services are not required or if a participant is no longer eligible for services.
- Verify services provided by workers by reviewing and approving timesheets, invoices, and documentation of services rendered, and ensuring submission to Palco, Inc.
- Accept responsibility for payment of services not authorized in approved spending plan.

Worker Responsibilities

PALCO

The Worker shall:

- Complete mandatory pre-employment training and on-going annual training
- Be punctual, neatly dressed, and respectful of employer's person, belongings, family members, and acquaintances.
- Use employer's personal property only if agreed upon by both parties.
- Report any suspected fraud, abuse, or neglect timely.

By signing below, the Participant/Authorized Representative 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 _____

Participant/Authorized Representative Signature _____ Date _____

Please return this form to Palco via fax: 1-877-859-8757, email: enrollNJ@palcofirst.com or mail: PO Box 13260, Maumelle, AR 72113

ELECTRONIC VISIT VERFICATION (EVV) LIVE-IN-EXEMPTION (OPTIONAL)

PALCO
Empowering Independence

PO Box 13260
Maumelle, AR 72113

Palco Electronic Visit Verification (EVV) Consent

This form is for the purpose of consenting to use the Palco EVV system. Electronic Visit Verification (EVV) is a technology solution which electronically verifies visit information to ensure that home and community-based services are delivered to the client. If the worker meets a live-in status requirement, this form does not need to be completed (please see the Electronic Visit Verification (EVV) Live-in Caregiver Exemption Attestation).

PARTICIPANT INFORMATION	
Full Name (First, Middle, Last):	Palco ID:

WORKER INFORMATION	
Full Name (First, Middle, Last):	Palco ID:

The Palco EVV solution provides two methods for complying with EVV. The Palco Connect Mobile Application is used via a smartphone or telephony used via the participants touch tone phone. Visit www.palcofirst.com for instructions on using the mobile application and telephony/IVR.

Location Permissions: To ensure accurate Electronic Visit Verification (EVV) records, we require your permission to access your mobile device's location. By consenting, you enable us to verify the location of visits conducted by workers using our application. Your privacy is important to us, and we assure you that this information will be used solely for EVV purposes.

Offline Mode Stipulation: In the event a worker utilizes Offline Mode, it's essential to reconnect to the mobile network within a certain number of days to ensure the integrity of the data captured during visits is uploaded to Palco. Failure to reconnect within the specified period will result in the automatic discarding of offline data.

Payment of Services: The selected method must be used for the capturing and recording of all time expected for payment reimbursement by Palco on services that have been mandated as required under the 21st Century Cures Act. Fraudulent misrepresentation of location, false registration of information, or failure to use EVV as required will result in your requirement to repay Medicaid funds.

Consent:
By signing below, both the participant and worker (collectively, "parties") attest that the information provided is true and accurate. Both parties acknowledge that Palco will use the information provided herein to complete EVV registration on their behalf, which will include exchanging Personal Health Information ("PHI"), as defined at 45 CFR 160.103, and other personally identifiable information ("PII") with the EVV vendor, any EVV aggregators, and other related organizations

PALCO
Empowering Independence

PO Box 13260
Maumelle, AR 72113

required for the treatment, payment, and operations under the self- directed program. Both parties have read and agree to Palco's Notice of Privacy Practices, Palco's EVV policies posted at palcofirst.com, and the Terms and Conditions of Palco's online system; agree to receive information, notifications, and other correspondence, which may contain PHI/PII, to the email address / phone number provided in this document; and accept all risks associated with the transmission of such information. The parties understand it is their responsibility to obtain the credentials required to access the system by properly completing this form and using this form to update their information, and that Palco is not responsible for incorrect information that is submitted.

Participant/Authorized Representative Signature

Worker Signature

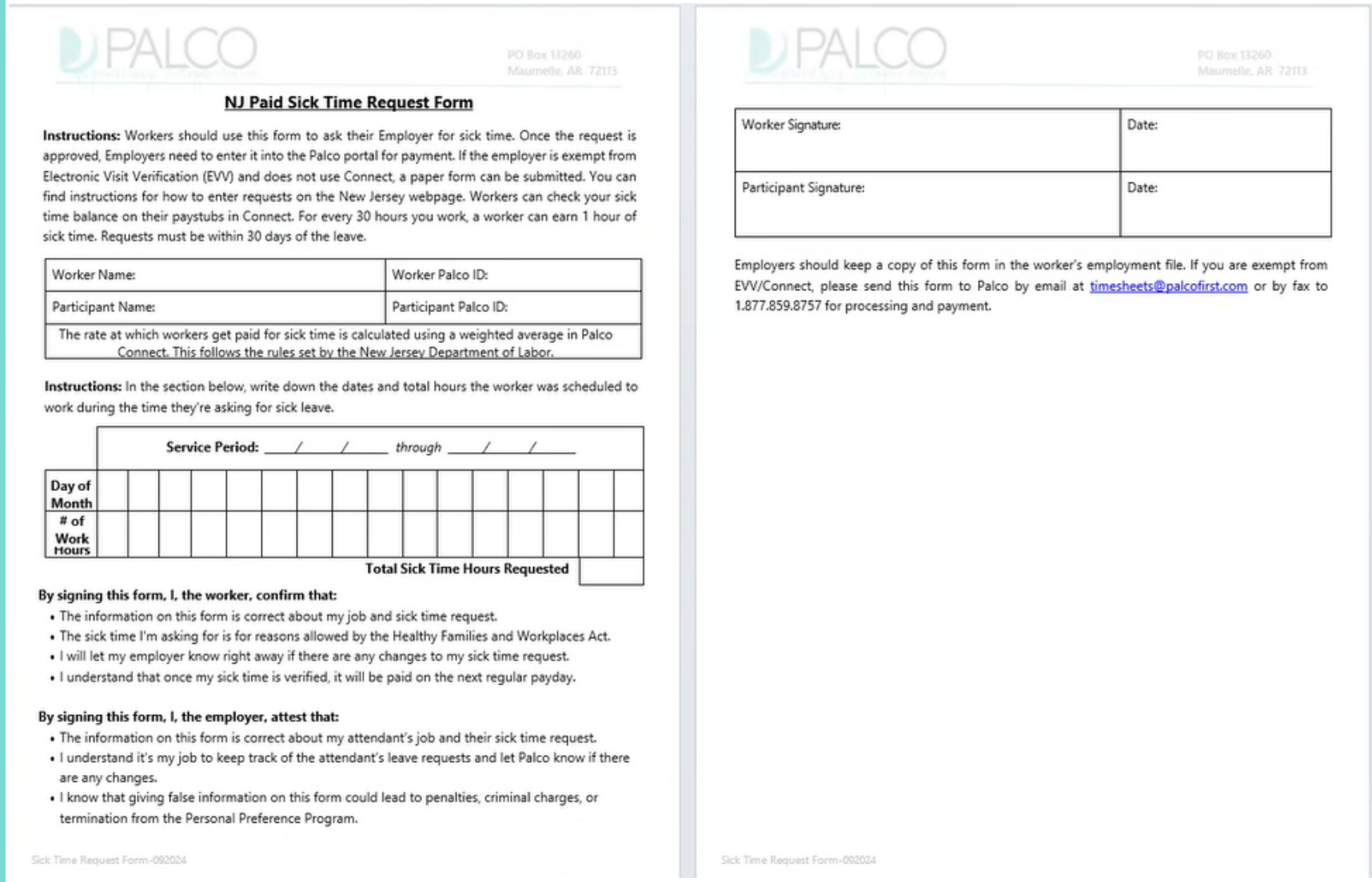
Date

Date

Program Reminders

NJ Sick Time

- Sick Time must be submitted within 30 days
- Sick Time can be requested on "Sick Time Request Form"
  OR
  submit via Connect.
- Sick Time can be rolled over from previous calendar year, up to 40 hours.
- Sick Time is submitted by the Participant



PALCO

PO Box 13260
Maumelle, AR 72113

NJ Paid Sick Time Request Form

Instructions: Workers should use this form to ask their Employer for sick time. Once the request is approved, Employers need to enter it into the Palco portal for payment. If the employer is exempt from Electronic Visit Verification (EVV) and does not use Connect, a paper form can be submitted. You can find instructions for how to enter requests on the New Jersey webpage. Workers can check your sick time balance on their paystubs in Connect. For every 30 hours you work, a worker can earn 1 hour of sick time. Requests must be within 30 days of the leave.

Worker Name:	Worker Palco ID:
Participant Name:	Participant Palco ID:
The rate at which workers get paid for sick time is calculated using a weighted average in Palco Connect. This follows the rules set by the New Jersey Department of Labor.	

Instructions: In the section below, write down the dates and total hours the worker was scheduled to work during the time they're asking for sick leave.

	Service Period: ___/___/___ *through* ___/___/___															
Day of Month																
# of Work Hours																
															Total Sick Time Hours Requested	

By signing this form, I, the worker, confirm that:

- The information on this form is correct about my job and sick time request.
- The sick time I'm asking for is for reasons allowed by the Healthy Families and Workplaces Act.
- I will let my employer know right away if there are any changes to my sick time request.
- I understand that once my sick time is verified, it will be paid on the next regular payday.

By signing this form, I, the employer, attest that:

- The information on this form is correct about my attendant's job and their sick time request.
- I understand it's my job to keep track of the attendant's leave requests and let Palco know if there are any changes.
- I know that giving false information on this form could lead to penalties, criminal charges, or termination from the Personal Preference Program.

Sick Time Request Form-092024

PALCO

PO Box 13260
Maumelle, AR 72113

Worker Signature:	Date:
Participant Signature:	Date:

Employers should keep a copy of this form in the worker's employment file. If you are exempt from EVV/Connect, please send this form to Palco by email at timesheets@palcofirst.com or by fax to 1.877.859.8757 for processing and payment.

Sick Time Request Form-092024

PalCare

PalCare is Palco's self-direction job board for connecting prospective Participants and Caregivers for long-term meaningful career relationships.

To get started with PalCare, visit:
palcare.palcofirst.com

PALCARE

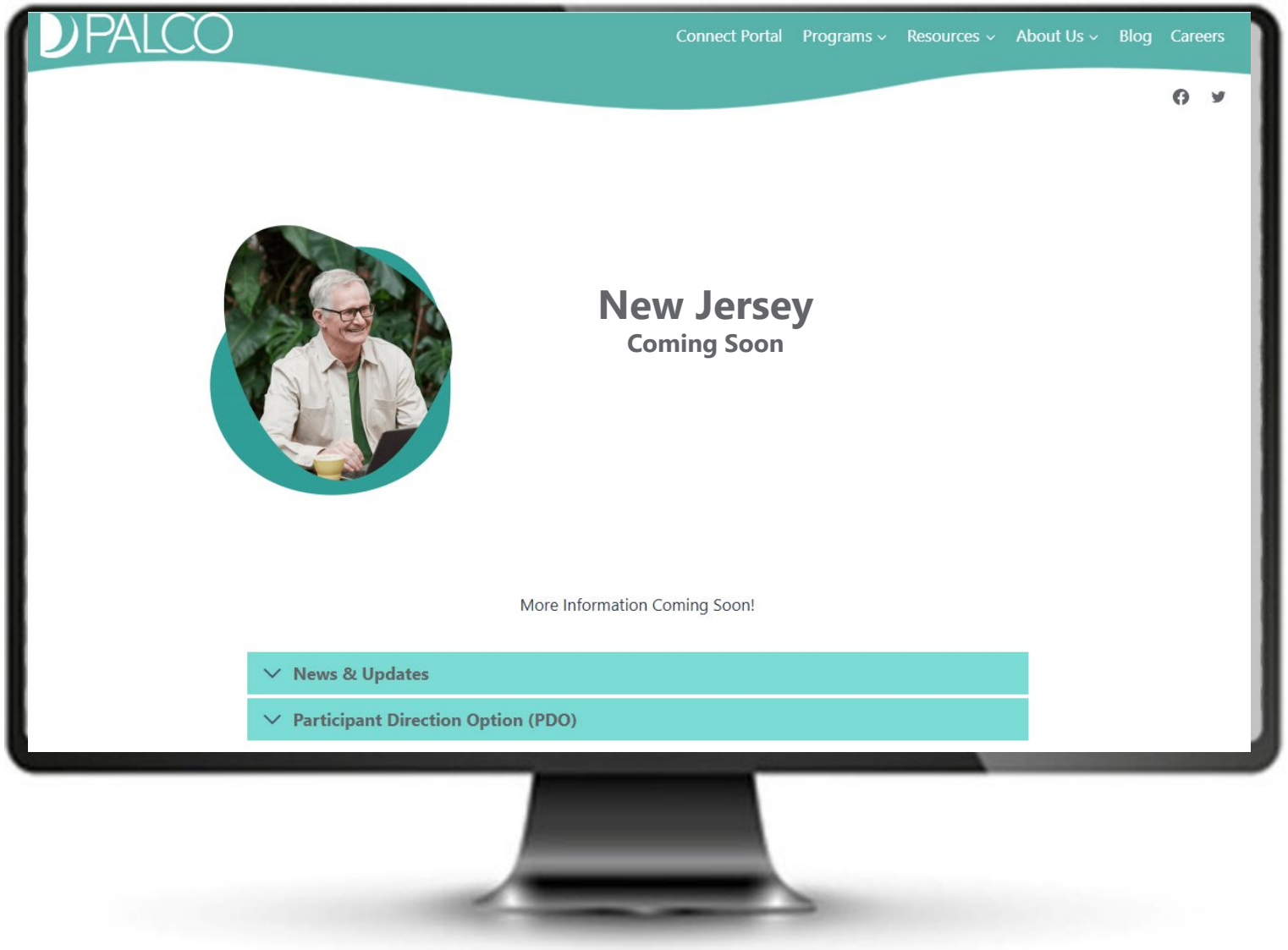
- Caregivers can create a profile to showcase skills and availability in hopes of gaining employment.
- Participant can post job description for positions they are seeking to fill.
- Totally free and is operational for all Palco's self-direction programs!


PALCO
CUSTOMER SUPPORT & RESOURCES

RESOURCES

You can find many helpful resources, training documents, forms, and videos on the Palco website!

https://palcofirst.com/new-jersey-ppp/



VF/EA PPP Handbook

- Participant Handbook
  - Key Terms and Information
  - Roles and Responsibilities
  - Role of the VF/EA, FMS
  - Role of the Participant/AR
  - Hiring a Worker

CUSTOMER SUPPORT

Palco NJ Enrollment Email: EnrollNJ@palcofirst.com
Palco NJ Customer Support Email: NJPPP@palcofirst.com
Website: https://palcofirst.com/new-jersey-ppp/

Important Phone Numbers:

Customer Support Line: 732-351-4804
Toll Free Number: 877-710-0457
Customer Support Fax Line: 877-859-8757

Horizon PPP Contact Information
Phone: 1-855-465-4777


PALCO
QUESTIONS

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THANK YOU FOR YOUR TIME!

For more information about Palco, visit:

Website: https://www.palcofirst.com
Email: NJPPP@palcofirst.com
Customer Support Contact: 1-877-710-0457