

# BDS FISCAL

associated with

broadscope  
DISABILITY SERVICES

## Employee Handbook

WAUKESHA COUNTY

## Employee Handbook Instructions

### **Background Check** (pages 4-8)

The Wisconsin Caregiver Law requires employers of individuals involved in the home or personal care of others to conduct an extensive caregiver criminal background check of those considered for employment. To complete this, fill out pages 5-6. Information about and instructions for this disclosure are on page 4.

Additionally, if you have lived outside of Wisconsin during the last three years, an out-of-state background check is required. To complete this, fill out and sign pages 7-8. To review your rights under the Fair Credit Reporting Act, visit <https://www.consumer.ftc.gov/articles/pdf-0096-fair-credit-reporting-act.pdf> (BDS Fiscal will not check your credit).

### **I-9, W-4, WT-4** (pages 9-18)

Full I-9 instructions are available at <https://www.uscis.gov/i-9> and a sample is included. If you are unable to access these instructions electronically and need a printed copy, please contact BDS Fiscal. You will complete Section 1 of the I-9 as the employee. Check the appropriate box to indicate whether you used a preparer or translator.

Section 2 of the I-9 will be completed by the parent/employer after you present them with your documents (the physical items – not copies or pictures). It can also be completed by BDS Fiscal if you bring your documents to our office for us to inspect. See the List of Acceptable Documents for what may be used for this process.

W-4 and WT-4 instructions are provided on the form itself. All of these documents are required for employment in the state of Wisconsin.

### **Employee & Employer Forms** (pages 19-29)

It is best to complete this section side by side with the parent. The forms on pages 19-27 require the signatures of both you (the employee) and the parent/employer and reviewing the information together will ensure mutual understanding.

Page 28, Authorization for Use & Disclosure of Health or Confidential Information, is a consent form to allow you and Waukesha County to share information about the Employer. Complete sections 1, 3, and 6 (date of hire to one year from date signed). The parent will then sign in section 12.

Page 29, BDS Fiscal Consent for the Release of Confidential Information, is a consent form to allow you and BDS Fiscal to share information about the Employer. Fill in the name of the child and your name in the appropriate blanks. The parent will then print and sign their name. The parent may check additional boxes or add information to the form to alter its constraints if desired (not required).

### **Employee Set-Up Forms** (pages 30-35)

Direct deposit is required for all employees. BDS Fiscal does not distribute payroll via paper checks. Complete page 30 and attach the necessary bank information as described. If you do not have a bank account and need assistance setting one up, visit [www.consumerfinance.gov/consumer-tools/bank-accounts](http://www.consumerfinance.gov/consumer-tools/bank-accounts) for resources and guidance.

Employees are required to complete training with the employer before beginning work with a client (page 31).

A sample timesheet, a blank timesheet, and the payroll schedule for BDS Fiscal are provided on pages 32-34. Contact BDS if you have questions on how to properly fill out your timesheets.

Optional: submit page 35, Additional Employment Interests, if you would like to work with more families.

### **BDS Fiscal Contact Information**

Broadscope Disability Services, 6102 W Layton Avenue, Greenfield, WI 53220 • [www.broadscope.org](http://www.broadscope.org)

Phone: 414-329-4500 • Fax: 414-329-4510 • Email for documents/scans: [bdsfiscal@broadscope.org](mailto:bdsfiscal@broadscope.org)

**Reference the Forms Checklist (page 3) to ensure all necessary forms and attachments are included with your employee paperwork. Then, submit to BDS Fiscal as directed on page 3.**

## Forms Checklist for Employees Paid Through BDS Fiscal

Please return ALL of the forms listed below, including this checklist, and the required attachments to BDS Fiscal. Each form will have the heading 'Send to BDS' in the upper right corner and may be returned via mail, fax, or email. You cannot start and will not be paid until all paperwork is completed and processed. You are encouraged to make copies of anything you sign before mailing. If you need copies later, contact BDS Fiscal.

BDS Fiscal  
 c/o Broadscope Disability Services  
 6102 West Layton Avenue  
 Greenfield, WI 53220

Fax: 414-329-4510  
 Email: [bdsfiscal@broadscope.org](mailto:bdsfiscal@broadscope.org)  
*Scans or pictures of your documents  
 need to be clearly legible*

- Forms Checklist – page 3
- Wisconsin Background Information Disclosure (BID) – pages 5-6
- Disclosure Regarding and Acknowledgement & Authorization of Background Check – pages 7-8  
**\*If applicable**
- Employment Eligibility Verification (Form I-9) – pages 10 & 12
- Form W-4, Employee's Withholding Allowance Certificate – page 14
- Form WT-4, Employee's Wisconsin Withholding Exemption Certificate – page 18
- BDS Fiscal New Employee Set Up Form – page 19
- Relationship Disclosure Form – page 20
- Fiscal Agent Statement of Understanding – page 22
- Fraud Notice – page 23
- Service Definitions – page 25
- Critical Incident Reporting Overview Agreement – page 27
- Authorization for Use & Disclosure of Health of Confidential Information – page 28
- BDS Fiscal Consent for the Release of Confidential Information – page 29
- Direct Deposit Authorization – page 30  
**\*Attach a voided check OR letter from bank (not handwritten) confirming account number**
- Participant Specific Training Certification – page 31
- Additional Employment Interests (Optional) – page 35

**My signature verifies that all the above forms are filled out completely and accurately and will be returned with attachments to BDS Fiscal via the contact information listed above. Additionally, by signing, I acknowledge that any convictions found in my background check will be shared with the Employer/Client.**

\_\_\_\_\_  
 EMPLOYEE NAME

\_\_\_\_\_  
 EMPLOYEE SIGNATURE

\_\_\_\_\_  
 DATE

\_\_\_\_\_  
 EMAIL ADDRESS

\_\_\_\_\_  
 PHONE NUMBER

## BACKGROUND INFORMATION DISCLOSURE (BID) INSTRUCTIONS

- The *Background Information Disclosure* (form F-82064) gathers information as required by the Wisconsin Caregiver Background Check Law to help employers and governmental regulatory agencies make employment, contract, residency, and regulatory decisions.
- Complete and return the entire form and attach explanations as specified by employer or governmental regulatory agency.
- **NOTE:** If you are an owner, operator, board member, or non-client resident of a facility regulated by the Division of Quality Assurance (DQA), complete the *BID*, [F-82064](#), and the *BID Appendix*, [F-82069](#), and submit both forms to the address noted in the *BID Appendix Instructions*.

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### CAREGIVER BACKGROUND CHECK LAW

In accordance with the provisions of Wis. Stat. § 50.065, for persons who have been convicted of certain acts, crimes, or offenses:

1. The Department of Health Services (DHS) may not license, certify, or register the person or entity.  
*\*Note: Employers and Care Providers are referred to as "entities."*
2. An entity may not employ, contract with, or permit persons to reside at the entity.

The list of offenses affecting caregiver eligibility that require rehabilitation review is available from the regulatory agencies or through the Internet at <https://www.dhs.wisconsin.gov/caregiver/statutes.htm>.

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### The Caregiver Law covers the following EMPLOYERS / CARE PROVIDERS (aka ENTITIES) regulated under Wis. Stat. §§ 50, 51, and 146:

- Adult Family Homes (3-4 Bed)
- Ambulance Service Providers
- AODA Services
- Community Based-Residential Facilities
- Community Mental Health Programs
- Community Support Programs (CSP)
- Developmental Disabilities
- Emergency Mental Health Service Programs
- Intermediate Care Facility for Individuals with Intellectual Disabilities
- Home Health Agencies, including those that provide personal care services
- Hospices
- Hospitals
- Mental Health Day Treatment Services for Children
- Nursing Homes
- Residential Care Apartment Complexes
- Rural Medical Centers

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### The Caregiver Law covers the following PERSONS:

- Anyone employed by or contracting with a covered entity who has access to the clients served, except if the access is infrequent or sporadic and service is not directly related to care of the client. Exception: Emergency medical technicians and first responders are not covered under the Caregiver Law.
- Anyone who lives on the premises of a covered entity and is 10 years old or over, but is not a client ("non-client resident").
- Anyone who is licensed by DHS.
- Anyone certified by DHS.
- Anyone registered by DHS.
- Anyone who is a board member or corporate officer who has access to the clients served.

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### FAIR EMPLOYMENT ACT

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

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### PERSONALLY IDENTIFIABLE INFORMATION

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

**BACKGROUND INFORMATION DISCLOSURE (BID)**

- **PENALTY: Knowingly providing false information or omitting information may result in a forfeiture of up to \$1,000 and other sanctions as provided in Wis. Admin. Code § DHS 12.05(4).**
- Completion of this form is required under the provisions of Wis. Stat. § 50.065. Failure to comply may result in a denial or revocation of your license, certification, or registration, or denial or termination of your employment or contract.
- Providing your social security number is voluntary; however, your social security number is one of the unique identifiers used to prevent incorrect matches.
- Refer to DQA form F-82064A, *BID Instructions*, for additional information.

**Check the box that applies to you.**

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

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

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

Position Title (Complete only if a prospective or current employee or contractor.) \_\_\_\_\_ Birth Date (*MM/dd/yyyy*) \_\_\_\_\_ Sex  
 Male  Female

Any Other Names By Which You Have Been Known (Including Maiden Name) \_\_\_\_\_

Race / Ethnicity (Check ONLY one.) \_\_\_\_\_ Social Security Number \_\_\_\_\_  
 American Indian or Alaskan Native  Asian or Pacific Islander  Black  White  Unknown

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Business Name and Address – Employer or Care Provider (Entity) \_\_\_\_\_

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

Note: The areas below that are designated for responses are expandable.

**SECTION A – ACTS, CRIMES, AND OFFENSES THAT MAY ACT AS A BAR OR RESTRICTION**

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

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

3. **IMPORTANT: Read before completing item 3.**  
**Wis. Stat. § 48.981 Abused and neglected children and abused unborn children. (7)(a) CONFIDENTIALITY.** “All reports made under this section, notices provided under sub. (3) (bm), and records maintained by an agency and other persons, officials, and institutions shall be confidential.” Reports and records may be disclosed only to the persons identified in this section.

**If you are the employer or prospective employer of the person completing this form and are entitled to obtain this information per the above, check this box.**

Has any government or regulatory agency (other than the police) ever found that you committed child abuse or neglect? Yes No  
 If the above box has been checked, provide an explanation below, including when and where the incident(s) occurred.

- |                                                                                                                                                                                                                                                   |                                         |                                        |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|----------------------------------------|
| <p>4. Has any government or regulatory agency (other than the police) ever found that you abused or neglected any person or client?<br/>If <b>Yes</b>, explain, including when and where it happened.</p>                                         | <p>Yes<br/><input type="checkbox"/></p> | <p>No<br/><input type="checkbox"/></p> |
| <p>5. Has any government or regulatory agency (other than the police) ever found that you misappropriated (improperly took or used) the property of a person or client?<br/>If <b>Yes</b>, explain, including when and where it happened.</p>     | <p>Yes<br/><input type="checkbox"/></p> | <p>No<br/><input type="checkbox"/></p> |
| <p>6. Has any government or regulatory agency (other than the police) ever found that you <b>abused an elderly person</b>?<br/>If <b>Yes</b>, explain, including when and where it happened.</p>                                                  | <p>Yes<br/><input type="checkbox"/></p> | <p>No<br/><input type="checkbox"/></p> |
| <p>7. Do you have a government issued credential that is not current or is limited so as to restrict you from providing care to clients?<br/>If <b>Yes</b>, explain, including credential name, limitations or restrictions, and time period.</p> | <p>Yes<br/><input type="checkbox"/></p> | <p>No<br/><input type="checkbox"/></p> |

**SECTION B – OTHER REQUIRED INFORMATION**

- |                                                                                                                                                                                                                                                                                                                                   |                                         |                                        |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|----------------------------------------|
| <p>1. Has any government or regulatory agency ever limited, denied, or revoked your license, certification, or registration to provide care, treatment, or educational services?<br/>If <b>Yes</b>, explain, including when and where it happened.</p>                                                                            | <p>Yes<br/><input type="checkbox"/></p> | <p>No<br/><input type="checkbox"/></p> |
| <p>2. Has any government or regulatory agency ever denied you permission or restricted your ability to live on the premises of a care providing facility?<br/>If <b>Yes</b>, explain, including when and where it happened and the reason.</p>                                                                                    | <p>Yes<br/><input type="checkbox"/></p> | <p>No<br/><input type="checkbox"/></p> |
| <p>3. Have you been discharged from a branch of the US Armed Forces, including any reserve component?<br/>If <b>Yes</b>, indicate the year of discharge: _____<br/>Attach a copy of your DD214, if you were discharged within the last three (3) years.</p>                                                                       | <p>Yes<br/><input type="checkbox"/></p> | <p>No<br/><input type="checkbox"/></p> |
| <p>4. Have you resided outside of Wisconsin in the last three (3) years?<br/>If <b>Yes</b>, list each state and the dates you resided there.</p>                                                                                                                                                                                  | <p>Yes<br/><input type="checkbox"/></p> | <p>No<br/><input type="checkbox"/></p> |
| <p>5. If you are employed by or applying for the State of Wisconsin, have you resided outside of Wisconsin in the last seven (7) years?<br/>If <b>Yes</b>, list each state and the dates you resided there.</p>                                                                                                                   | <p>Yes<br/><input type="checkbox"/></p> | <p>No<br/><input type="checkbox"/></p> |
| <p>6. Have you had a caregiver background check done within the last four (4) years?<br/>If <b>Yes</b>, list the date of each check, and the name, address, and phone number of the person, facility, or government agency that conducted each check.</p>                                                                         | <p>Yes<br/><input type="checkbox"/></p> | <p>No<br/><input type="checkbox"/></p> |
| <p>7. Have you ever requested a rehabilitation review with the Wisconsin Department of Health Services, a county department, a private child placing agency, school board, or DHS-designated tribe?<br/>If <b>Yes</b>, list the review date and the review result. You may be asked to provide a copy of the review decision.</p> | <p>Yes<br/><input type="checkbox"/></p> | <p>No<br/><input type="checkbox"/></p> |

**Read and initial the following statement.**

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

Name – Person Completing This Form	Date Submitted
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## Disclosure Regarding Background Investigation

Broadscope Disability Services, Inc. may obtain information about you from a third party consumer reporting agency for employment purposes. Thus, you may be the subject of a “consumer report” which may include information about your character, general reputation, personal characteristics, and/or mode of living. These reports may contain information regarding your criminal history, social security verification, motor vehicle records (“driving records”), verification of your education or employment history, or other background checks. Broadscope Disability Services, Inc. will obtain this information on behalf of and share this information with the family for whom you will be working.

These searches will be conducted by InCheck, Inc., 7500 W State Street, Suite 200, Wauwatosa, WI 53213, 414-727-1718 / 866-265-9426, [www.inchecksolutions.com](http://www.inchecksolutions.com).

Please provide the following information in full:

First Name	Middle Name (FULL)	Last Name
Social Security Number		Date of Birth

Print all home addresses resided in **outside the state of Wisconsin** in the past three years. Include any other names/aliases by which you were LEGALLY known during that time:

Street Address		City	State
Zip Code	Dates resided	Name(s) by which you were known	

Street Address		City	State
Zip Code	Dates resided	Name(s) by which you were known	

Street Address		City	State
Zip Code	Dates resided	Name(s) by which you were known	

Street Address		City	State
Zip Code	Dates resided	Name(s) by which you were known	

## Acknowledgment and Authorization for Background Check

I acknowledge receipt of the separate documents entitled DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of “consumer reports” by Broadscope Disability Services, Inc. at any time after receipt of this authorization and throughout my employment, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by InCheck, Inc., 7500 W State Street, Suite 200, Wauwatosa, WI 53213, telephone number (866) 265-9426, [www.inchecksolutions.com](http://www.inchecksolutions.com) and/or Broadscope Disability Services, Inc. I agree that a facsimile (“fax”), electronic or photographic copy of this Authorization shall be as valid as the original.

If signing electronically, I agree my electronic signature is the legal equivalent of my manual signature on this Authorization.

**Residents of California, Minnesota, New York, Oklahoma, and Washington state:** You have the right to receive a copy of any report furnished by InCheck, Inc., 7500 W State Street, Suite 200, Wauwatosa, WI 53213, 414-727-1718/866-265-9426, [www.inchecksolutions.com/privacy-policy](http://www.inchecksolutions.com/privacy-policy) to Broadscope Disability Services, Inc. pursuant to your authorization. Check this box if you would like to receive a copy:

Signature: \_\_\_\_\_

Date: \_\_\_\_\_





**Employment Eligibility Verification**  
**Department of Homeland Security**  
**U.S. Citizenship and Immigration Services**

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

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

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

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

Last Name (Family Name) Doe		First Name (Given Name) John		Middle Initial P	Other Last Names Used (if any)	
Address (Street Number and Name) 123 Sesame St			Apt. Number	City or Town Milwaukee	State WI	ZIP Code 53000
Date of Birth (mm/dd/yyyy) 10/10/1900	U.S. Social Security Number 000-00-0000	Employee's E-mail Address jdoe@email.com			Employee's Telephone Number 414-000-0000	

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

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

<input checked="" type="checkbox"/> 1. A citizen of the United States
<input type="checkbox"/> 2. A noncitizen of the United States (See instructions for details)
<input type="checkbox"/> 3. A lawful permanent resident (See instructions for details)
<input type="checkbox"/> 4. An alien authorized to work in the United States (See instructions for details)

**SAMPLE**

OR Code - Section 1  
 This Space

1. Alien Registration Number/USCIS Number: \_\_\_\_\_

2. Employment Authorization Number: \_\_\_\_\_

3. Foreign Passport Number: \_\_\_\_\_

Country of Issuance: \_\_\_\_\_

**EMPLOYEE COMPLETES**

Signature of Employee John Doe	Today's Date (mm/dd/yyyy) 1/10/2019
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**Preparer and/or Translator Certification (check one):**  
 I did not use a preparer or translator.  A preparer(s) and/or translator(s) assisted the employee in completing Section 1.  
 (Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

Signature of Preparer or Translator			Today's Date (mm/dd/yyyy)		
Last Name (Family Name)			First Name (Given Name)		
Address (Street Number and Name)			City or Town	State	ZIP Code

STOP Employer Completes Next Page STOP



**Employment Eligibility Verification**  
**Department of Homeland Security**  
 U.S. Citizenship and Immigration Services

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

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

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

Last Name ( <i>Family Name</i> )		First Name ( <i>Given Name</i> )		Middle Initial	Other Last Names Used ( <i>if any</i> )	
Address ( <i>Street Number and Name</i> )			Apt. Number	City or Town		State ZIP Code
Date of Birth ( <i>mm/dd/yyyy</i> )	U.S. Social Security Number □□□□ - □□□□ - □□□□	Employee's E-mail Address			Employee's Telephone Number	

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

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

<input type="checkbox"/> 1. A citizen of the United States	
<input type="checkbox"/> 2. A noncitizen national of the United States ( <i>See instructions</i> )	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ Some aliens may write "N/A" in the expiration date field. ( <i>See instructions</i> )	
<p><i>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</i></p> <p>1. Alien Registration Number/USCIS Number: _____  <b>OR</b>          2. Form I-94 Admission Number: _____  <b>OR</b>          3. Foreign Passport Number: _____          Country of Issuance: _____</p>	
QR Code - Section 1 Do Not Write In This Space	

Signature of Employee	Today's Date ( <i>mm/dd/yyyy</i> )
-----------------------	------------------------------------

**Preparer and/or Translator Certification (check one):**

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

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

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



*Employer Completes Next Page*





**Employment Eligibility Verification**  
**Department of Homeland Security**  
**U.S. Citizenship and Immigration Services**

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

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

<b>Employee Info from Section 1</b>	Last Name (Family Name) <b>DOE</b>	First Name (Given Name) <b>JOHN</b>	M.I. <b>P</b>	Citizenship/Immigration Status <b>1</b>
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List A Identity and Employment Authorization OR List B Identity AND List C Employment Authorization

Document Title	Document Title <b>Driver's license</b>	Document Title <b>Social Security Card</b>
Issuing Authority	Issuing Authority <b>State of Wisconsin</b>	Issuing Authority <b>Social Security Administration</b>
Document Number	Document Number <b>B123-4567-8900-00</b>	Document Number <b>000-00-0000</b>
Expiration Date (if any)(mm/dd/yyyy)	Expiration Date (if any)(mm/dd/yyyy) <b>4/5/2025</b>	Expiration Date (if any)(mm/dd/yyyy) <b>N/A</b>

Document Title	<div style="border: 1px solid black; padding: 5px;"> <p align="center">Additional Information</p> <p align="center">QR Code - Sections 2 &amp; 3 Do Not Write In This Space</p> </div>	
Issuing Authority		
Document Number		
Expiration Date (if any)(mm/dd/yyyy)		
Expiration Date (if any)(mm/dd/yyyy)		

**SAMPLE**  
**PARENT COMPLETES**

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

The employee's first day of employment (mm/dd/yyyy): 06/14/2019 (See instructions for exemptions)

Signature of Employer or Authorized Representative <b>Jane Smith</b>	Today's Date (mm/dd/yyyy) <b>06/10/2019</b>	Title of Employer or Authorized Representative <b>Employer</b>
Last Name of Employer or Authorized Representative <b>SMITH</b>	First Name of Employer or Authorized Representative <b>JANE</b>	Employer's Business or Organization Name
Employer's Business or Organization Address (Street Number and Name) <b>456 W. Sesame Street</b>	City or Town <b>Milwaukee</b>	State <b>WI</b> ZIP Code <b>53000</b>

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

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

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

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

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

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



**Employment Eligibility Verification**  
**Department of Homeland Security**  
 U.S. Citizenship and Immigration Services

**Send to BDS**  
**USCIS**  
**Form I-9**  
 OMB No. 1615-0047  
 Expires 10/31/2022

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

<b>Employee Info from Section 1</b>	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
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List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date (if any) (mm/dd/yyyy)		Expiration Date (if any) (mm/dd/yyyy)		Expiration Date (if any) (mm/dd/yyyy)
Document Title		<div style="border: 1px solid black; padding: 5px;">Additional Information</div>		<div style="border: 1px solid black; padding: 5px; text-align: center;">           QR Code - Sections 2 &amp; 3            Do Not Write In This Space         </div>
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				

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

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

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

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

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

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

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

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

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

**LISTS OF ACCEPTABLE DOCUMENTS**  
**All documents must be UNEXPIRED**

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

<b>LIST A</b> Documents that Establish Both Identity and Employment Authorization	<b>OR</b>	<b>LIST B</b> Documents that Establish Identity	<b>AND</b>	<b>LIST C</b> Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card	<b>OR</b>	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	<b>AND</b>	1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <b>a.</b> Foreign passport; and <b>b.</b> Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. 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
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
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		<b>For persons under age 18 who are unable to present a document listed above:</b>		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
	12. Day-care or nursery school record			

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

**Refer to the instructions for more information about acceptable receipts.**

Form **W-4**

**Employee's Withholding Certificate**

Department of the Treasury  
Internal Revenue Service

▶ **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.**

**2021**

<b>Step 1: Enter Personal Information</b>	(a) First name and middle initial	Last name	(b) Social security number
	Address		▶ <b>Does your name match the name on your social security card?</b> If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to <a href="http://www.ssa.gov">www.ssa.gov</a> .
	City or town, state, and ZIP code		
	(c) <input type="checkbox"/> <b>Single</b> or <b>Married filing separately</b> <input type="checkbox"/> <b>Married filing jointly</b> or <b>Qualifying widow(er)</b> <input type="checkbox"/> <b>Head of household</b> (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

**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, when to use the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App), and privacy.

**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](http://www.irs.gov/W4App) for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **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 accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ▶

**TIP:** To be accurate, submit a 2021 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

**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.)

<b>Step 3: Claim Dependents</b>	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 and enter the total here . . . . .	<b>3</b>	\$ _____
<b>Step 4 (optional): Other Adjustments</b>	(a) <b>Other income (not from jobs).</b> 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 . . . . .	<b>4(a)</b>	\$ _____
	(b) <b>Deductions.</b> 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 . . . . .	<b>4(b)</b>	\$ _____
	(c) <b>Extra withholding.</b> Enter any additional tax you want withheld each pay period . . . . .	<b>4(c)</b>	\$ _____

<b>Step 5: Sign Here</b>	Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.		
	▶ _____ <b>Employee's signature</b> (This form is not valid unless you sign it.)	▶ _____ <b>Date</b>	

<b>Employers Only</b>	Employer's name and address	First date of employment	Employer identification number (EIN)

## General Instructions

### 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](http://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 2021 if you meet both of the following conditions: you had no federal income tax liability in 2020 **and** you expect to have no federal income tax liability in 2021. You had no federal income tax liability in 2020 if (1) your total tax on line 24 on your 2020 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, 29, and 30), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2021 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 15, 2022.

**Your privacy.** If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

**When to use the estimator.** Consider using the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App) if you:

1. Expect to work only part of the year;
2. Have dividend or capital gain income, or are subject to additional taxes, such as Additional Medicare Tax;
3. Have self-employment income (see below); or
4. Prefer the most accurate withholding for multiple job situations.

**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](http://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.

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

If you (and your spouse) have a total of only two jobs, you may instead 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 roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.



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

**Step 3.** This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. 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 2021 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.

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



If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on only ONE Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

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

- 1 Two jobs. If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, skip to line 3
2 Three jobs. If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.
a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a
b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b
c Add the amounts from lines 2a and 2b and enter the result on line 2c
3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc.
4 Divide the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in Step 4(c) of Form W-4 for the highest paying job (along with any other additional amount you want withheld)

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



- 1 Enter an estimate of your 2021 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 10% of your income
2 Enter: { \$25,100 if you're married filing jointly or qualifying widow(er); \$18,800 if you're head of household; \$12,550 if you're single or married filing separately }
3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-"
4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information
5 Add lines 3 and 4. Enter the result here and in Step 4(b) of Form W-4

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

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

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

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



**Married Filing Jointly or Qualifying Widow(er)**

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$190	\$850	\$890	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,100	\$1,870	\$1,870
\$10,000 - 19,999	190	1,190	1,890	2,090	2,220	2,220	2,220	2,220	2,300	3,300	4,070	4,070
\$20,000 - 29,999	850	1,890	2,750	2,950	3,080	3,080	3,080	3,160	4,160	5,160	5,930	5,930
\$30,000 - 39,999	890	2,090	2,950	3,150	3,280	3,280	3,360	4,360	5,360	6,360	7,130	7,130
\$40,000 - 49,999	1,020	2,220	3,080	3,280	3,410	3,490	4,490	5,490	6,490	7,490	8,260	8,260
\$50,000 - 59,999	1,020	2,220	3,080	3,280	3,490	4,490	5,490	6,490	7,490	8,490	9,260	9,260
\$60,000 - 69,999	1,020	2,220	3,080	3,360	4,490	5,490	6,490	7,490	8,490	9,490	10,260	10,260
\$70,000 - 79,999	1,020	2,220	3,160	4,360	5,490	6,490	7,490	8,490	9,490	10,490	11,260	11,260
\$80,000 - 99,999	1,020	3,150	5,010	6,210	7,340	8,340	9,340	10,340	11,340	12,340	13,260	13,460
\$100,000 - 149,999	1,870	4,070	5,930	7,130	8,260	9,320	10,520	11,720	12,920	14,120	15,090	15,290
\$150,000 - 239,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,830	14,030	15,230	16,190	16,400
\$240,000 - 259,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,830	14,030	15,270	17,040	18,040
\$260,000 - 279,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,870	14,870	16,870	18,640	19,640
\$280,000 - 299,999	2,040	4,440	6,500	7,900	9,230	10,470	12,470	14,470	16,470	18,470	20,240	21,240
\$300,000 - 319,999	2,040	4,440	6,500	7,940	10,070	12,070	14,070	16,070	18,070	20,070	21,840	22,840
\$320,000 - 364,999	2,720	5,920	8,780	10,980	13,110	15,110	17,110	19,110	21,190	23,490	25,560	26,860
\$365,000 - 524,999	2,970	6,470	9,630	12,130	14,560	16,860	19,160	21,460	23,760	26,060	28,130	29,430
\$525,000 and over	3,140	6,840	10,200	12,900	15,530	18,030	20,530	23,030	25,530	28,030	30,300	31,800

**Single or Married Filing Separately**

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$440	\$940	\$1,020	\$1,020	\$1,410	\$1,870	\$1,870	\$1,870	\$1,870	\$2,030	\$2,040	\$2,040
\$10,000 - 19,999	940	1,540	1,620	2,020	3,020	3,470	3,470	3,470	3,640	3,840	3,840	3,840
\$20,000 - 29,999	1,020	1,620	2,100	3,100	4,100	4,550	4,550	4,720	4,920	5,120	5,120	5,120
\$30,000 - 39,999	1,020	2,020	3,100	4,100	5,100	5,550	5,720	5,920	6,120	6,320	6,320	6,320
\$40,000 - 59,999	1,870	3,470	4,550	5,550	6,690	7,340	7,540	7,740	7,940	8,140	8,150	8,150
\$60,000 - 79,999	1,870	3,470	4,690	5,890	7,090	7,740	7,940	8,140	8,340	8,540	9,190	9,990
\$80,000 - 99,999	2,000	3,810	5,090	6,290	7,490	8,140	8,340	8,540	9,390	10,390	11,190	11,990
\$100,000 - 124,999	2,040	3,840	5,120	6,320	7,520	8,360	9,360	10,360	11,360	12,360	13,410	14,510
\$125,000 - 149,999	2,040	3,840	5,120	6,910	8,910	10,360	11,360	12,450	13,750	15,050	16,160	17,260
\$150,000 - 174,999	2,220	4,830	6,910	8,910	10,910	12,600	13,900	15,200	16,500	17,800	18,910	20,010
\$175,000 - 199,999	2,720	5,320	7,490	9,790	12,090	13,850	15,150	16,450	17,750	19,050	20,150	21,250
\$200,000 - 249,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,820	20,930	22,030
\$250,000 - 399,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,820	20,930	22,030
\$400,000 - 449,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,910	21,220	22,520
\$450,000 and over	3,140	6,250	8,830	11,330	13,830	15,790	17,290	18,790	20,290	21,790	23,100	24,400

**Head of Household**

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$820	\$930	\$1,020	\$1,020	\$1,020	\$1,420	\$1,870	\$1,870	\$1,910	\$2,040	\$2,040
\$10,000 - 19,999	820	1,900	2,130	2,220	2,220	2,620	3,620	4,070	4,110	4,310	4,440	4,440
\$20,000 - 29,999	930	2,130	2,360	2,450	2,850	3,850	4,850	5,340	5,540	5,740	5,870	5,870
\$30,000 - 39,999	1,020	2,220	2,450	2,940	3,940	4,940	5,980	6,630	6,830	7,030	7,160	7,160
\$40,000 - 59,999	1,020	2,470	3,700	4,790	5,800	7,000	8,200	8,850	9,050	9,250	9,380	9,380
\$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,850	11,050	11,250	11,520	12,320
\$80,000 - 99,999	1,880	4,280	5,710	7,000	8,200	9,400	10,600	11,250	11,590	12,590	13,520	14,320
\$100,000 - 124,999	2,040	4,440	5,870	7,160	8,360	9,560	11,240	12,690	13,690	14,690	15,670	16,770
\$125,000 - 149,999	2,040	4,440	5,870	7,240	9,240	11,240	13,240	14,690	15,890	17,190	18,420	19,520
\$150,000 - 174,999	2,040	4,920	7,150	9,240	11,240	13,290	15,590	17,340	18,640	19,940	21,170	22,270
\$175,000 - 199,999	2,720	5,920	8,150	10,440	12,740	15,040	17,340	19,090	20,390	21,690	22,920	24,020
\$200,000 - 249,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,880	24,980
\$250,000 - 349,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,880	24,980
\$350,000 - 449,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,900	25,200
\$450,000 and over	3,140	6,840	9,570	12,160	14,660	17,160	19,660	21,610	23,110	24,610	26,050	27,350

## Employee's Wisconsin Withholding Exemption Certificate/New Hire Reporting

## Employee's Section (Print clearly)

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

## FIGURE YOUR TOTAL WITHHOLDING EXEMPTIONS BELOW

Complete Lines 1 through 3

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

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

Signature \_\_\_\_\_

Date Signed \_\_\_\_\_

## EMPLOYEE INSTRUCTIONS:

## • WHO MUST COMPLETE:

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

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

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

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

## • UNDER WITHHOLDING:

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

## • OVER WITHHOLDING:

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

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

## • LINE 1:

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

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

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

## • LINE 2:

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

## • LINE 3:

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

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

## Employer's Section

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

## EMPLOYER INSTRUCTIONS for Department of Revenue:

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

## EMPLOYER INSTRUCTIONS for New Hire Reporting:

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

### BDS Fiscal New Employee Set-Up Form

#### Employee Section

Employee name (print): \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_  Male  Female  Other

Email address: \_\_\_\_\_

**THIS EMAIL WILL BE USED TO SET UP ACCESS TO YOUR PAYSTUBS & W-2**

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_

#### Employer/Client Section

Child receiving services (employer/participant): \_\_\_\_\_

Employer Representative/Parent/Guardian: \_\_\_\_\_

**By signing below, I agree that the information on this form is accurate.**

\_\_\_\_\_  
Parent/Employer Signature

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

### Relationship Disclosure Form

Employee name (print): \_\_\_\_\_

Employee Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of child receiving services (Employer/Client): \_\_\_\_\_

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

**Relative (biological)**

- Grandparent *\*see below\**
- Brother / Sister
- Uncle / Aunt
- Nephew / Niece
- Cousin
- Other \_\_\_\_\_

**Relative (by marriage or partnership)**

- Step Brother / Step Sister
- Parent-in-Law
- Brother-in-Law / Sister-in-Law
- Other \_\_\_\_\_

**Non-Related Relationships**

- Friend
- Neighbor
- Worker
- Other \_\_\_\_\_

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

**Residency Disclosure**

Does the Employer/Client receiving nonmedical care live in the Employee's home?  Yes  No

Note: It is the Employee's responsibility to notify BDS Fiscal should their living situation change.

**By signing below, I agree that the information on this form is accurate.**

\_\_\_\_\_  
Parent/Employer Signature

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

## Choosing a Fiscal Agent: Statement of Understanding

Using the Fiscal Agent method of employing one or more individuals to work with a child receiving CLTS Waiver services makes the child the employer. BDS Fiscal does **not** have any authority over the job performance of any such employee – nor does the county authorizing the child’s CLTS services (hereafter known as the CLTS Waiver Agency). That means the child’s parent/guardian will act as the employer representative and must voluntarily accept the responsibilities that an employer would have. Those include:

- Recruiting, interviewing, and hiring the employee
- Providing initial and ongoing training regarding the care needs of the child and their job-related responsibilities
- Providing training regarding confidentiality concerns and expectations
- Setting the employee’s wage (within the limits of what the waiver will reimburse for the particular service the employee performs and with the approval of BDS Fiscal and the CLTS Waiver Agency), realizing that wages will be withheld if employee and parent/employer representative are not compliant with BDS Fiscal and CLTS guidelines and timelines
- Supervising employee performance, providing feedback as appropriate
- Setting and enforcing expectations with regard to professionalism in the home, scheduling changes or conflicts, types of acceptable communication, amount of notice requested for vacating the position, etc.
- Preparing a back-up plan in the event that the scheduled employee is not able to meet the needs of the child/family
- Ensuring that the employee does NOT work over 40 hours/week**  
*(unless employee is authorized to provide full day respite at day rate)*
- Disciplining and terminating the employee, if parent/employer feels that to be appropriate and necessary
- Considering insurance coverage/implications in the event that the employee is injured while providing care. Employees will be eligible for Worker’s Compensation under BDS Fiscal.
- Ensuring that all paperwork (both employer’s and employee’s) is submitted to BDS Fiscal and approved by BDS Fiscal prior to the employee’s first date of service to the child  
**\*\*No services provided prior to BDS Fiscal’s approval date will be paid.**

Please be clear that neither BDS Fiscal nor the CLTS Waiver Agency is the employer. In many cases, BDS Fiscal and the CLTS Waiver agency do not even know these prospective privately retained service providers. BDS Fiscal and the CLTS Waiver agency do not hire, train, supervise, discipline, or terminate these individuals; nor do they verify the employment history or check references of these individuals. It is up to the family hiring the individual to ask for references (personal and professional) and to verify those references prior to employment.

Parent/guardian: If BDS Fiscal or your CLTS Service Coordinator provides you with names of people who are willing to work in your community, it remains your responsibility to interview them and make your own judgment as to their appropriateness to work in your home with your child. Neither BDS Fiscal nor your Service Coordinator are endorsing or recommending these people for employment. Rather, they are merely putting you in touch with individuals who have expressed a willingness to work with children with disabilities.

BDS Fiscal's role is limited to completing the employee's criminal background check, ensuring the employee's ongoing training is completed, processing the employee's payroll, and completing end of year federal tax processes for the employee. The CLTS Service Coordinator's role is to determine the authorized number of hours for the child.

Employers are not able to offer benefits such as vacation, sick time, etc. The waiver can only reimburse for hours actually provided to the recipient. Additionally, the employer is responsible for the final approval of hours worked by the employee to be paid through BDS Fiscal. Employers should verify hours worked as listed on the timesheet before signing it. **The employee cannot work more than 40 hours for the same employer/child in a work week (Sunday-Saturday).**

Parent/guardian and service provider: If you have any questions about any of these responsibilities, or about using BDS Fiscal, please contact BDS Fiscal or the CLTS Service Coordinator. If you have any questions that are of a legal nature about the employer/employee relationship, you are encouraged to seek the advice of an attorney.

**\*\*As an employer-representative of a fiscal agent worker, I understand the stated information and accept responsibility. I understand that all employee paperwork including the 'Participant Specific Training Certification' must be completed and received by BDS Fiscal PRIOR to working with the client.**

\*\*As an employee, I understand the role of my employer and the CLTS Waiver requirements.

\_\_\_\_\_  
Parent/Employer Signature

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of child receiving services

## Fraud Notice

Misuse of Children’s Long Term Support (CLTS) funding is fraud. Due to being a Medicaid funded program, this would be **Medicaid fraud**, which is a federal offense. The following information is provided with the intent of educating and informing parents and providers regarding the use of these funds, and to ensure understanding and compliance with their intended use.

**Please initial the beginning of each paragraph as you read.**

EMPLOYEE EMPLOYER

\_\_\_\_\_ \_\_\_\_\_ CLTS monies are to be used only for the benefit of the child who has qualified for services. Any use of acceptance of money for anything other than goods or services to the eligible child is considered fraud.

\_\_\_\_\_ \_\_\_\_\_ Timesheets for in-home workers should reflect the number of service hours actually provided to the eligible child. Any alteration of the timesheet to inflate or misrepresent the number of hours provided to that child is considered fraud.

\_\_\_\_\_ \_\_\_\_\_ Families cannot benefit financially from providers other than by the direct benefit of the service that their eligible child receives. A provider giving a “kickback” to a parent is considered fraud.

\_\_\_\_\_ \_\_\_\_\_ CLTS funds can only be used for allowable services that are pre-approved by the child’s Service Coordinator. Misrepresentation of a service that you provide or receive in order to claim reimbursement for non-allowable services is considered fraud.

\_\_\_\_\_ \_\_\_\_\_ If you are aware or become aware of a situation involving misuse of CLTS Waiver funds, please contact the Service Coordinator assigned to the case immediately. In the interest of good stewardship of public funds; and to maintain public trust, program continuation, and adherence to program objectives, Waukesha County will aggressively follow up on any such report if sufficient information is offered. If the initial review suggests intentionality, Waukesha County would be obligated to report such suspicion to law enforcement for further investigation.

My signature below indicates that I have read and understand the statements made above. If I have any questions about those statements, I know that I can contact my CLTS Service Coordinator directly.

\_\_\_\_\_  
Parent/Employer Signature

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of child receiving services

## Service Definitions

Service definitions apply to independent workers paid through BDS Fiscal. This document is intended to describe the employee's responsibilities/tasks for CLTS Waiver purposes. Please refer to the current CLTS Waiver Manual or contact your CLTS Service Coordinator for full definitions & exclusions of each service.

Requirements to provide these services include showing proof of at least two years of experience working with children with disabilities and child specific training.

Please note: **Employees are not allowed to work over 40 hours in a work week (Sunday-Saturday).**

- **Child Care** - Child care services ensure the child or youth's exceptional physical, emotional, behavioral, or personal care needs are met during times when their family members are working, pursuing education or employment goals, or participating in training to strengthen the family's capacity to care for their child.

Children under 12 years of age: this service includes the supplemental cost of child care to meet the child's exceptional care needs. This includes staffing necessary to meet the child's care needs above and beyond the cost of basic child care that all families with young children may incur. The basic cost of child care is the rate charged by and paid to a child care provider for children who do not have special needs. The basic cost of child care does not include the provision of supplementary staffing, which may be covered by this service.

Children 12 years of age and older: the total cost of child care may be included. The total cost of child care is available when the child has aged out of their traditional child care settings (typically available up to age 12), but due to a disability the child continues to require care or supervision.

- **Daily Living Skills Training** – Daily living skills training (DLST) services provide education and skill development or training to support the child or youth's ability to independently perform routine daily activities and effectively use community resources. These instructional services, provided by qualified professionals, focus on skill development and include personal hygiene, food preparation, home upkeep, money management, and accessing & using community resources.

DLST does NOT include activities recreational in nature, social skill training, educational related services, behavior modification, or substitute task performance. An initial goal setting report is required at the start of services with progress reports every six months.

- **Mentoring** - Mentoring services improve the child or youth's ability to interact in their community in socially advantageous ways. The mentor provides the child or youth with experiences in peer interaction, social and/or recreational activities, and employability skill-building opportunities during spontaneous and real-life situations, rather than in a segregated or classroom-type environment. The mentor implements learning opportunities by guiding and shadowing the child or youth in the community while practicing and modeling interaction skills.

Providers must develop a written plan documenting the objectives for the child and the objectives for the mentor. A written summary of the progress toward and changes to the objectives for the child or youth and their mentor is required every three months. At a minimum, team review meetings are held quarterly.

- **Respite Care** – Respite care services maintain and strengthen the child or youth's natural supports by easing the daily stress and care demands for their family, or other primary caregiver(s), on a short-term basis. These services provide a level of care and supervision appropriate to the child or youth's needs while their family or other primary caregiver(s) are temporarily relieved from daily caregiving demands.

Home-based respite may be used for overnight stays or partial day stays for the child or youth, in their primary residence or at the home of a caregiver. The provider is required to receive training specific for the child or youth's support and care needs.

Respite care group rates may apply if respite is being provided for more than one child at the same time.



- **Supportive Home Care** – Supportive home care (SHC) directly assists the child or youth with daily living activities and personal needs, to promote improved functioning and safety in their home and community. SHC may be provided in the child or youth’s home or in a community setting.

Services include direct assistance with instrumental activities of daily living, observation or cueing of the child to safely & appropriately complete activities of daily living and instrumental activities of daily living, supervision necessary for safety at home and in the community (e.g. observation to assure appropriate self-administration of medications, money management, assistance with communication, arranging and using transportation, checking out library books, ordering food from a menu); and intermittent major household tasks that must be performed seasonally or in response to a natural or other periodic event for reasons of health and safety or the need to assure the youth’s continued community living.

- **Transportation** – Transportation maintains or improves the child’s mobility and increases their inclusion, independence, and participation in the community. This service funds the child’s or youth’s nonmedical, nonemergency transportation needs related to engaging with their community—with the people, places, and resources that are meaningful for their self-determination—and to meet their goals and daily needs. If needed, transportation charges for an attendant (including parent/guardian) to accompany the child or youth when accessing the community are included.

Providers are required to have a current driver’s license issued by the Department of Transportation and current insurance and must provide copies of both to BDS Fiscal. Vehicles used to provide transportation must be insured and in good repair, with all operating and safety systems functioning.

**Please check all authorized service(s) the employee will provide for the employer/participant:**

✓	Service Type	Pay Rate	Hours or Days per Month
	Child Care		
	Daily Living Skills Training		
	Mentoring		
	Respite Care		
	Respite Care Group		
	Supportive Home Care		
	Transportation		

By signing below, I demonstrate that I understand and accept the above responsibilities. Both parties understand that we may not charge in excess of the amount authorized on the Child/Participant’s plan. After the Employee has performed the services per this agreement, timesheets are due to BDS Fiscal according to the Payment Schedule. Both signers agree to only submit timesheets within the hours authorized. Without prior approval, excess hours claimed above authorization may be rejected for payment.

\_\_\_\_\_  
Parent/Employer Signature

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of child receiving services

**CRITICAL INCIDENT REPORTING OVERVIEW**

**What is a critical incident?**

A critical incident is any actual or alleged event or situation that creates a significant risk or serious harm to the physical, mental health, safety, or well being of the child. The critical incidents that must be reported to your Support and Service Coordinator include:

- Any abuse or neglect of the child known or suspected
- Errors in medical or medication management that result in a significant adverse reaction that requires medical attention
- The initiation of an investigation by law enforcement of an event or allegation regarding a child as either a perpetrator or victim, unless such action is a component of an approved crisis or treatment plan.
- Significant and substantial damage to the residence of the child or service provider.
- Use of isolation, seclusion, or restraint by a service provider which is not included and approved as part of a behavior support plan.
- An unexpected event or behavior that causes a serious injury or risk to the child; which may include running away, setting a fire, violence, hospitalization resulting from an accident, suspected or confirmed suicide attempts, or death of the child.

**If any of these incidents occur please contact your Support & Service Coordinator.**

**Contact Name & Phone Number:** Waukesha County DHHS: 262-548-7212

**Why is a critical incident reported?**

- The assurance of health, safety, and welfare of the child is a condition of all Medicaid Waivers by the federal Centers for Medicare and Medicaid Services.
- One of the ways both the State and contracted agents assure health, safety, and welfare of the child is by individually reporting, monitoring, and resolving critical incidents.
- To address incidents as they occur and decrease the likelihood of a recurrence.

**How is a critical incident reported?**

- As soon as possible families and providers are required to report critical incidents to their agency Support and Service Coordinator.
- Agency Support and Service Coordinators are required to immediately report critical incidents to the State staff responsible for the CLTS Waiver program to ensure necessary steps have been taken to protect the child and assure safety.
- Agency Support & Service Coordinators are required to submit a final report within 30 days of the incident.

**What happens after a critical incident is reported?**

- Support and Service Coordinators are expected to address and resolve situations and implement systems to decrease the likelihood of a recurrence.
- The State staff responsible for the CLTS Waiver program will use information collected in critical incident reports to identify statewide or regional trends, which will then allow for the development of training or interventions to decrease the likelihood of recurrence.

***If a critical incident occurs, families and providers should seek all necessary care and assistance from medical or emergency personnel as appropriate. This reporting procedure does not provide an immediate response or replace other mandatory reporting expected of agency personnel.***

## Critical Incident Reporting Overview Agreement

**Employee:**

I have received a copy of the Children's Long Term Support (CLTS) Waiver Critical Incident Reporting Overview in writing and have reviewed the information it contains. I understand that as a service provider, if a critical incident occurs when I am providing a CLTS Waiver-funded service to a child, I must follow the critical incident reporting procedure and contact the child's CLTS Support and Service Coordinator. I also understand that I should seek all necessary care and assistance from medical or emergency personnel as appropriate, including mandated reporting. If I have questions about critical incident reporting, I can contact the child's Support and Service Coordinator.

If I do not have contact information for the child's Support and Service Coordinator, I understand that I should instead contact Waukesha County's Department of Health and Human Services at 262-548-7212.

I also understand that as a service provider, I am a mandated reporter and I must report known or suspected abuse or neglect of a child under the age of 18 immediately to either child protection services or law enforcement (for more information, see Chapter 48.981(2) of the Wisconsin State Statutes).

\_\_\_\_\_  
Employee/Provider Signature

\_\_\_\_\_  
Date

**Employer:**

I have received a copy of the Children's Long Term Support (CLTS) Waiver Critical Incident Reporting Overview in writing and have reviewed the information it contains. I understand that if a critical incident occurs while my child is receiving a CLTS Waiver-funded service, the employee/provider must follow the critical incident reporting procedure and contact my child's CLTS Support and Service Coordinator. If I have questions about critical incident reporting, I can contact my child's Support and Service Coordinator.

\_\_\_\_\_  
Employer/Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of child receiving services

WAUKESHA COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES  
AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH OR CONFIDENTIAL INFORMATION

Send to BDS

1) CLIENT INFORMATION: (please print)

Name/Previous Name(s): \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address (include City, State, Zip Code): \_\_\_\_\_

2) AUTHORIZES WAUKESHA COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES (WCDHHS) AT:

- Health & Human Services - 514 Riverview Ave., Waukesha, WI 53188  Outpatient AODA/MH Clinic at HHS - 514 Riverview Ave., Waukesha, WI 53188
- Mental Health Center - 1501 Airport Rd., Waukesha, WI 53188  Public Health - 514 Riverview Ave., Waukesha, WI 53188

Attention: CLTS Waiver Service Coordinator

3) TO:  DISCLOSE TO:  OBTAIN FROM:  VERBALLY EXCHANGE WITH:

Name of Individual/Agency/Organization/Other: (Name of fiscal agent employee) \_\_\_\_\_

Address (include City, State, Zip Code): \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Method of Release:  Paper Release  Electronic/Digital Release (specify) Any and all information  
Release By:  US Mail  Fax  Pick-Up: Location \_\_\_\_\_  
 To be picked up by: \_\_\_\_\_

4) INFORMATION TO BE DISCLOSED:

Note: Information to be released may be in Written, Verbal, Voicemail, Fax or Electronic Form

- Intake/Initial Assessment  Discharge Summary  Appointments/Attendance  Child & Family Records
- Medications  Medical Evaluations/H & P  Access Reports  Juvenile Records
- Staffing/Progress Notes  Psychological Evaluation  Educational Records  Public Health Records
- Treatment Plan/Reviews  Psychiatric Evaluation  Financial Information  Social History
- Adult Human Services Records  Laboratory Reports  Other (Specify): Information specific to the CLTS Waiver Program

5) In compliance with WI Statutes, which require special permission to release otherwise privileged information, please release records pertaining to (check all that apply):

- Alcohol or Drug Abuse/Treatment (AODA)  Mental/Behavioral Health Conditions  HIV/AIDS
- Developmental Disabilities  Sexually Transmitted Diseases

6) DATE(S) OF INFORMATION TO BE DISCLOSED: FROM: \_\_\_\_\_ TO: \_\_\_\_\_

7) PURPOSE OF DISCLOSURE:

- Continuing Care  Legal Matters  Insurance/Eligibility/Benefits
- Educational Planning  Personal  Other: (Please specify): Information specific to the CLTS Waiver Program

8) YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Receive a Copy of the Confidential Information to be Used or Disclosed: I understand that I have the right to inspect or receive a copy of the health or confidential information I have authorized to be used or disclosed by this authorization form except for the information not authorized by law. I may arrange to inspect my health or confidential information or obtain copies of my confidential information by contacting WCDHHS. I understand that I may be charged a reasonable fee for record copies. Right to Receive a Copy of this Authorization: I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. Right to Refuse to Sign this Authorization: I understand that I am under no obligation to sign this form and that WCDHHS may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. \*\*WI Statutes 51.30 and 252.15 requires client authorization to disclose health information for payment purposes. A consequence of refusal to sign an authorization for disclosure pursuant to WI Statutes 51.30 or 252.15 records may be non-payment. Right to Revoke this Authorization: I understand that I can cancel this authorization at any time by providing a written notification to the WCDHHS Centralized Records Supervisor or to the disclosing individual/organization in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures of my health or confidential information that the person(s) and/or organization(s) above have already made in reliance upon this Authorization before receipt of the written notice of revocation; or needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. \*\*HIV/AIDS Test Results: I understand my HIV test results may be released without an authorization to persons/organizations that have access under state laws and a list of those persons/organizations is available upon request. Re-Disclosure Notice: I understand that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law. The third party may not be required to abide by this Authorization or applicable Federal and State laws governing the use and disclosure of my health or confidential information. This information has been disclosed from records protected by Federal (42 CFR Part 2) and Wisconsin (51.30) confidentiality rules. The Federal rules prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client. A copy or facsimile (FAX) of this authorization will be considered valid as the original.

9) EXPIRATION: This authorization is good until the following event/date: \_\_\_\_\_ or for up to one year from the date signed.

10) By signing this authorization, I am confirming that I have had an opportunity to review and understand the content of this authorization form and that it accurately reflects my wishes. I am also confirming that I have read and understand the rights with respect to this authorization.

11) SIGNATURE OF CLIENT: \_\_\_\_\_ DATE: \_\_\_\_\_

12) SIGNATURE OF PARENT/GUARDIAN/OTHER: \_\_\_\_\_ DATE: \_\_\_\_\_

If signed by a person other than the client, complete the following:

- 1. Client is:  Minor  Incompetent  Unable to sign due to disability  Deceased
- 2. Legal Authority:  Parent of Minor  Legal Guardian\*  Power of Attorney (POA)\*  Other\*: \_\_\_\_\_

\*If you check any of the above boxes, you must have proof of legal authority attached to this authorization before any records will be released. (i.e. Guardianship Papers, Power of Attorney documents)\*

For Office Use Only: Staff Person Assisting Client to Complete Authorization: \_\_\_\_\_  
HHS-FM-6246-AA, 07/12, 09/13 ROUTING: White: Agency Pink: Client

### BDS Fiscal Consent for the Release of Confidential Information

As the Parent/Guardian and Employer Representative for \_\_\_\_\_,  
*name of Employer/Client (child)*

I authorize BDS Fiscal to disclose to \_\_\_\_\_ the following information:  
*name of Employee/Provider*

- The above Employee’s pay rates, hours, and payment amounts
- My budget details, including pay rates and services
- All details regarding my Employer/Client-directed services from BDS Fiscal
- Other information as described in detail: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

- Upon my termination from receiving Employer/Client-directed services from BDS Fiscal
- Upon the termination of my relationship with the person/agency written above
- Upon other circumstances as described in detail: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Employer’s Representative/Parent Name – Printed

\_\_\_\_\_  
Employer’s Representative/Parent Signature

\_\_\_\_\_  
Date

### Direct Deposit Authorization

In order to receive payment through BDS Fiscal, you must enroll in direct deposit. BDS Fiscal does not distribute payroll via paper checks or any method other than direct deposit. For guidance about opening and managing a bank account, visit [www.consumerfinance.gov/consumer-tools/bank-accounts](http://www.consumerfinance.gov/consumer-tools/bank-accounts).

To set up your direct deposit, complete this form and attach the required documents. Please note that funds will be deposited into your account by our accounting firm, **O’Leary & Anick**.

**ATTENTION:** Your first paystub will be mailed to you with instructions on how to view all future paystubs and your W-2 online. Paystubs and W-2s are available online only. Your W-2 will not be mailed to you.

Employee name (print): \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Name of Financial Institution: \_\_\_\_\_

Type of Account:     Checking     Savings

### Required Documents

**Attach either a voided check or a letter/form from your bank with the account and routing numbers for verification of your account information.**

- Deposit tickets or starter checks **may not** be used.
- Handwritten information will not be accepted.
- Bank letters must be printed on bank letterhead and state the account number, routing number, type of account (checking or savings), and account holder’s name.
- The employee’s name must be listed on the account.

I hereby authorize Broadscope Disability Services, Inc., hereafter known as BDS Fiscal, to initiate credit entries and, if necessary, debit entries and adjustments for any credit entries in error to my bank account at the financial institution noted above. This authorization will remain in effect until BDS Fiscal receives written notice from me of its modification or termination, in such time and manner as to allow BDS Fiscal and the financial institution a reasonable opportunity to act on it.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employer/Child Name

## Participant Specific Training Certification

This form is completed for those who provide in-home services such as Child Care, Daily Living Skills, Mentoring, and/or Respite. The Parent/Employer is to train the Employee/Provider on the below topics.

Based on experience, education, and/or training, \_\_\_\_\_ (employee) meets the knowledge and skill level required for direct services through a fiscal agent to enable them to competently work with the Participant to meet the objectives and goals.

Please check the boxes below to indicate the training completed. Any box/skill left blank must result in training before employment may start.

<b>Knowledge/skill level required</b>	
<b><u>Yes</u></b>	Policies, procedures, and expectations of the employer, including training on participant and provider rights and responsibilities; record keeping and reporting; and other information deemed necessary and appropriate.
<b><u>Yes</u></b>	Information specific to disabilities, abilities, needs, functional deficits, and strengths of the population to be served. This training should be person-specific for the child or youth to be served and generally focused.
<b><u>Yes</u></b>	Recognizing and appropriately responding to all conditions that might adversely affect the person's health and safety including how to respond to emergencies and critical incidents.
<b><u>Yes</u></b>	Developing interpersonal and communications skills that are appropriate and effective for working with the population to be served. These skills include understanding the principles of person-centered services; person rights; respect for age; cultural, linguistic, and ethnic differences; active listening, responding with emotional support and empathy; ethics in dealings with people including: family and other providers; conflict resolution skills; ability to deal with death and dying; and other topics relevant to the specific population to be served.
<b><u>Yes</u></b>	Understanding of all confidentiality and privacy laws and rules.
<b><u>Yes</u></b>	Understanding of procedures for handling complaints.
<b><u>Yes</u></b>	Understanding of the person who needs support, including personal hygiene needs, preferences, and techniques for assisting with activities of daily living including, where relevant, bathing, grooming, skin care, transfer, ambulation, exercise, feeding, dressing, and use of adaptive aids and equipment.
<b><u>Yes</u></b>	Understanding the personal health and wellness-related needs of the person needing supports including nutrition, dietary needs, exercise needs, and weight monitoring and control.
<b>List relevant training &amp; two years' experience (please attach additional sheet if needed):</b>	

We the Employer and Employee agree that the above training has been completed.

\_\_\_\_\_  
Parent/Employer Signature

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of child receiving services

## BDS Fiscal 2021 Payroll Payment Schedule

<b>Pay Period Dates</b> 12:00am start date thru 11:59pm end date	<b>DEADLINE:</b> Timesheets received by:	<b>Pay Date</b> Will be paid on:
<b>P1:</b> 12/16/2020 - 12/31/2020	<b>Monday, January 4<sup>th</sup></b>	1/15/2021
<b>P2:</b> 1/1/2021 - 1/15/2021	<b>Monday, January 18<sup>th</sup></b>	1/29/2021
<b>P3:</b> 1/16/2021 - 1/31/2021	<b>Tuesday, February 2<sup>nd</sup></b>	2/15/2021
<b>P4:</b> 2/1/2021 - 2/15/2021	<b>Wednesday, February 17<sup>th</sup></b>	2/26/2021
<b>P5:</b> 2/16/2021 - 2/28/2021	<b>Wednesday, March 3<sup>rd</sup></b>	3/15/2021
<b>P6:</b> 3/1/2021 - 3/15/2021	<b>Thursday, March 18<sup>th</sup></b>	3/31/2021
<b>P7:</b> 3/16/2021 - 3/31/2021	<b>Monday, April 5<sup>th</sup></b>	4/15/2021
<b>P8:</b> 4/1/2021 - 4/15/2021	<b>Monday, April 19<sup>th</sup></b>	4/30/2021
<b>P9:</b> 4/16/2021 - 4/30/2021	<b>Monday, May 3<sup>rd</sup></b>	5/14/2021
<b>P10:</b> 5/1/2021 - 5/15/2021	<b>Tuesday, May 18<sup>th</sup></b>	5/31/2021
<b>P11:</b> 5/16/2021 - 5/31/2021	<b>Thursday, June 3<sup>rd</sup></b>	6/15/2021
<b>P12:</b> 6/1/2021 - 6/15/2021	<b>Friday, June 18<sup>th</sup></b>	6/30/2021
<b>P13:</b> 6/16/2021 - 6/30/2021	<b>Friday, July 2<sup>nd</sup></b>	7/15/2021
<b>P14:</b> 7/1/2021 - 7/15/2021	<b>Monday, July 19<sup>th</sup></b>	7/30/2021
<b>P15:</b> 7/16/2021 - 7/31/2021	<b>Tuesday, August 3<sup>rd</sup></b>	8/13/2021
<b>P16:</b> 8/1/2021 - 8/15/2021	<b>Tuesday, August 17<sup>th</sup></b>	8/31/2021
<b>P17:</b> 8/16/2021 - 8/31/2021	<b>Friday, September 3<sup>rd</sup></b>	9/15/2021
<b>P18:</b> 9/1/2021 - 9/15/2021	<b>Friday, September 17<sup>th</sup></b>	9/30/2021
<b>P19:</b> 9/16/2021 - 9/30/2021	<b>Monday, October 4<sup>th</sup></b>	10/15/2021
<b>P20:</b> 10/1/2021 - 10/15/2021	<b>Monday, October 18<sup>th</sup></b>	10/29/2021
<b>P21:</b> 10/16/2021 - 10/31/2021	<b>Wednesday, November 3<sup>rd</sup></b>	11/15/2021
<b>P22:</b> 11/1/2021 - 11/15/2021	<b>Wednesday, November 17<sup>th</sup></b>	11/30/2021
<b>P23:</b> 11/16/2021 - 11/30/2021	<b>Friday, December 3<sup>rd</sup></b>	12/15/2021
<b>P24:</b> 12/1/2021 - 12/15/2021	<b>Friday, December 17<sup>th</sup></b>	12/31/2021

- **PAY PERIODS:** the 1<sup>st</sup>–15<sup>th</sup> and the 16<sup>th</sup>–last day of each month from 12:00am (midnight) to 11:59pm.
- **DEADLINE:** timesheets must be received by this date in order to be paid on the next Pay Date (no exceptions).
- **PAY DATES:** the 15<sup>th</sup>/last day of the month, or the business day before if falling on a weekend or holiday.

**How to submit your timesheet:** Text: 262-373-9870 ♦ Fax: 414-329-4510 ♦ [bdsfiscal@broadscope.org](mailto:bdsfiscal@broadscope.org)

*Timesheets may also be mailed to our office: 6102 W Layton Ave, Greenfield, WI 53220. Drop off during business hours only. BDS Fiscal is associated with Broadscope Disability Services, Inc. and can be reached at 414-329-4500.*





Employee/Provider Name *(one per timesheet)*

 Employer/Service Recipient Name *(child's name)*

Pay Period: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer/Service Recipient County of Residence

**ATTENTION**

- One pay period per timesheet.
- Round to nearest 15-minute increment for hour totals (15min = .25 30min = .5 45min = .75).
- Must have authorization from county to use full days.
- Neither BDS Fiscal nor the CLTS Waiver program are responsible for paying for hours submitted after 60 days, hours that exceed 40 per week (Sun-Sat), or hours that exceed the amount authorized.

Date	Service	Start	End	# Hours <i>9 max per day</i>	Check if full day
		AM	AM		<input type="checkbox"/>
		PM	PM		<input type="checkbox"/>
		AM	AM		<input type="checkbox"/>
		PM	PM		<input type="checkbox"/>
		AM	AM		<input type="checkbox"/>
		PM	PM		<input type="checkbox"/>
		AM	AM		<input type="checkbox"/>
		PM	PM		<input type="checkbox"/>
		AM	AM		<input type="checkbox"/>
		PM	PM		<input type="checkbox"/>
		AM	AM		<input type="checkbox"/>
		PM	PM		<input type="checkbox"/>
		AM	AM		<input type="checkbox"/>
		PM	PM		<input type="checkbox"/>
		AM	AM		<input type="checkbox"/>
		PM	PM		<input type="checkbox"/>
<b>Service types:</b> Child Care = <b>CC</b> Respite Care = <b>R</b> Daily Living Skills = <b>DLS</b> Respite Group = <b>RG</b> Supportive Home Care = <b>SHC</b> Mentoring = <b>M</b>				<b>Totals:</b>	

I/We certify that the information provided on this form is a true and accurate statement of the services provided, that the services were provided in accordance with the care plan, and that the Client/Service Recipient was not hospitalized during the time services were provided. I/We understand that payment for services provided are subject to payroll taxes and that falsification of this timesheet is considered Medicaid fraud and may result in dismissal from employment and/or criminal prosecution.

Employee/Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

Employer Representative/Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

**Timesheets must be submitted to BDS Fiscal within 60 days of service via one of the following methods:**

Mail: 6102 W Layton Avenue, Greenfield, WI 53220 ♦ Fax: 414-329-4510  
 Email: [bdsfiscal@broadscope.org](mailto:bdsfiscal@broadscope.org) ♦ Text: 262-373-9870

*For questions concerning payroll matters or how to fill out this form, call BDS Fiscal at 414-329-4500.  
 Refer to current payroll schedule for pay dates. BDS Fiscal is associated with Broadscope Disability Services, Inc.*

## Additional Employment Interests – Waukesha County

Please complete the following if you are interested in having your name included on a list of providers that will be shared with other parents in the Waukesha County CLTS Waiver program. If you sign this, your contact information will be given to the parents seeking providers. The list will be maintained by BDS Fiscal.

Name: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Email: \_\_\_\_\_ Current child: \_\_\_\_\_

**Services I can provide:**

- Child Care
- Daily Living Skills Training
- Mentoring
- Respite Care

**I am available on short notice**

- Yes
- No
- Possibly

**I am willing to work**

- Mon-Fri days
- Mon-Fri evenings
- Sat-Sun days
- Sat-Sun evenings

**I am willing to work with**

- Children age 0-12
- Teens age 13-18
- Siblings

**I am trained in**

- CPR
- First Aid
- Sign language
- Handling special cares (*e.g. diapers, G-tubes, seizures*)

Comments on training or availability: \_\_\_\_\_

Check all cities/towns you are willing to drive to and work within:

- |                                     |                                          |                                        |                                   |
|-------------------------------------|------------------------------------------|----------------------------------------|-----------------------------------|
| <input type="checkbox"/> Big Bend   | <input type="checkbox"/> Eagle           | <input type="checkbox"/> Mukwonago     | <input type="checkbox"/> Sussex   |
| <input type="checkbox"/> Brookfield | <input type="checkbox"/> Elm Grove       | <input type="checkbox"/> Muskego       | <input type="checkbox"/> Wales    |
| <input type="checkbox"/> Butler     | <input type="checkbox"/> Genesee         | <input type="checkbox"/> New Berlin    | <input type="checkbox"/> Waukesha |
| <input type="checkbox"/> Colgate    | <input type="checkbox"/> Hartland        | <input type="checkbox"/> North Prairie |                                   |
| <input type="checkbox"/> Delafield  | <input type="checkbox"/> Menomonee Falls | <input type="checkbox"/> Oconomowoc    |                                   |
| <input type="checkbox"/> Dousman    | <input type="checkbox"/> Merton          | <input type="checkbox"/> Pewaukee      |                                   |

I give permission to put my name on the list of available care providers maintained by BDS Fiscal. I understand my name and contact information will be released to parents/guardians seeking providers in the counties I indicated above, and they may call or email me. I understand that this release will remain valid until I contact BDS Fiscal and request my name be removed from the list.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date