BDS FISCAL

associated with

broadscope
DISABILITY SERVICES

Parent as Employee Handbook

OZAUKEE COUNTY

Parent as 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 or not you used a preparer or translator.

Typically, Section 2 of the I-9 is completed by the parent/employer after you present them with your documents (the physical items – not copies or pictures). However, due to the current special circumstances, you will need to send copies of your documents to BDS Fiscal so that we can complete Section 2. 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)*

The forms on pages 19-27 typically require the signatures of both you (the employee) and the parent/employer. However, due to the current special circumstances, you will sign them only once as both the employee & employer.

Page 28, Authorization for Release of Confidential Information, is a consent form to allow you and Ozaukee County to share information about the Employer. Fill in the child's information as name/date of birth of client and enter your information as the name of person or organization. Then sign at the bottom and check 'Parent of Minor' or 'Legal Guardian', whichever is most appropriate.

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, then sign your name. You 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 for resources and guidance.

Employees are required to complete training with the employer before beginning work with a client (page 31). As the child's parent, you are of course already "trained". Simply sign & date this form.

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

Phone: 414-329-4500 ♦ Fax: 414-329-4510 ♦ Email for documents/scans: 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.

Send to BDS

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
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
  ***Attach copies of your documents**
- ❑ 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 Release 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 (not deposit ticket) OR letter from bank confirming account info**
- ❑ 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*.

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.

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

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.

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.

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.) ☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander ☐ Black ☐ White ☐ Unknown	Social Security Number

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?
   If **Yes**, list each charge, when it occurred or the date of the charge, and the city and state where the court is located.
   You may be asked to supply additional information, including a copy of the criminal complaint or any other relevant court or police documents.
   Yes ☐ No ☐

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

3. **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?
   If the above box has been checked, provide an explanation below, including when and where the incident(s) occurred.
   Yes ☐ No ☐

4. Has any government or regulatory agency (other than the police) ever found that you abused or neglected any person or client? Yes ☐ No ☐

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

5. Has any government or regulatory agency (other than the police) ever found that you misappropriated (improperly took or used) the property of a person or client? Yes ☐ No ☐

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

6. Has any government or regulatory agency (other than the police) ever found that you **abused an elderly person**? Yes ☐ No ☐

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

7. Do you have a government issued credential that is not current or is limited so as to restrict you from providing care to clients? Yes ☐ No ☐

If **Yes**, explain, including credential name, limitations or restrictions, and time period.

SECTION B – OTHER REQUIRED INFORMATION

1. Has any government or regulatory agency ever limited, denied, or revoked your license, certification, or registration to provide care, treatment, or educational services? Yes ☐ No ☐

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

2. Has any government or regulatory agency ever denied you permission or restricted your ability to live on the premises of a care providing facility? Yes ☐ No ☐

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

3. Have you been discharged from a branch of the US Armed Forces, including any reserve component? Yes ☐ No ☐

If **Yes**, indicate the year of discharge: _____

Attach a copy of your DD214, if you were discharged within the last three (3) years.

4. Have you resided outside of Wisconsin in the last three (3) years? Yes ☐ No ☐

If **Yes**, list each state and the dates you resided there.

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

If **Yes**, list each state and the dates you resided there.

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

If **Yes**, list the date of each check, and the name, address, and phone number of the person, facility, or government agency that conducted each check.

7. Have you ever requested a rehabilitation review with the Wisconsin Department of Health Services, a county department, a private child placing agency, school board, or DHS-designated tribe? Yes ☐ No ☐

If **Yes**, list the review date and the review result. You may be asked to provide a copy of the review decision.

Read and initial the following statement.

_____ 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

Send to BDS
IF APPLICABLE

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.

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**	

Send to BDS
IF APPLICABLE

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 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 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)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*
Doe	John	P	

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code
123 Sesame St		Milwaukee	WI	53000

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
10/10/1900	000 - 00 - 0000	jdoe@email.com	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):

- ☒ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States *(See instructions)*
- ☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number):
- ☐ 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. *(See instructions)*

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.

1. Alien Registration Number/USCIS Number:

OR

2. Form I-94 Admission Number:

OR

3. Foreign Passport Number:

Country of Issuance:

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*
John Doe	1/10/2019

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

Send to BDS

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

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

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

Date of Birth *(mm/dd/yyyy)*	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):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 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. *(See instructions)*

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.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

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

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.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status
	DOE	JOHN	P	1

List A OR List B AND List C
Identity and Employment Authorization	**Identity**	**Employment Authorization**
Document Title	Driver's license	Social Security Card
Issuing Authority	State of Wisconsin	Social Security Administration
Document Number	B123-4567-8900-00	000-00-0000
Expiration Date *(if any)(mm/dd/yyyy)*	4/5/2025	N/A
Document Title		
Issuing Authority		
Document Number		
Expiration Date *(if any)(mm/dd/yyyy)*		
Document Title		
Issuing Authority		
Document Number		
Expiration Date *(if any)(mm/dd/yyyy)*		

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

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	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
Jane Smith	06/10/2019	Employer

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
SMITH	JANE	

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code
456 W. Sesame Street	Milwaukee	WI	53000

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

A. New Name *(if applicable)*			B. Date of Rehire *(if applicable)*
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

Send to BDS

Employment Eligibility Verification

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

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.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

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

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

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.)*

A. New Name *(if applicable)*			**B.** Date of Rehire *(if applicable)*
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.

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

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

Refer to the instructions for more information about acceptable receipts.

Send to BDS

Employee's Wisconsin Withholding Exemption Certificate/New Hire Reporting

WT-4

Employee's Section (Print clearly)

Employee's legal name *(first name, middle initial, last name)*			Social security number
Employee's address *(number and street)*			Date of birth
City	State	Zip code	Date of hire

☐ Single
☐ Married
☐ Married, but withhold at higher Single rate.
Note: If married, but legally separated, check the Single box.

FIGURE YOUR TOTAL WITHHOLDING EXEMPTIONS BELOW

Complete Lines 1 through 3

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

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

Signature _____ Date Signed _____ , _____

EMPLOYEE INSTRUCTIONS:

- **WHO MUST COMPLETE:**
  Effective on or after January 1, 2020, every newly-hired employee is required to provide a completed Form WT-4 to each of 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/ for more information.

Send to BDS

BDS Fiscal New Employee Set-Up Form

Employee (Parent) 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: _____

I am the employer's parent/legal guardian and have been temporarily authorized as a paid caregiver through the CLTS exemption program. By signing below, I agree that the information on this form is accurate.

_____ _____

Parent Signature Date

Send to BDS

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)

- ❑ Parent ***see below***
- ❑ 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 _____

*Grandparents & parents: 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.

*Parents: Due to your relationship with the Employer/Client and current legislation, you are exempt from payroll taxes for Social Security and Medicare (FICA). By not paying into Social Security and Medicare (FICA), it means you are not earning Social Security work credits.

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.

I am the employer's parent/legal guardian and have been temporarily authorized as a paid caregiver through the CLTS exemption program. By signing below, I agree that the information on this form is accurate.

_____ _____

Parent 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.

Send to BDS

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.

I am the employer's parent/legal guardian and have been temporarily authorized as a paid caregiver through the CLTS exemption program. By signing below, I agree that the information on this form is accurate.

_____ _____

Parent Signature Date

_____

Name of child receiving services

Send to BDS

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, Ozaukee County will aggressively follow up on any such report if sufficient information is offered. If the initial review suggests intentionality, Ozaukee County would be obligated to report such suspicion to law enforcement for further investigation.

I am the employer's parent/legal guardian and have been temporarily authorized as a paid caregiver through the CLTS exemption program. 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 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 <u>authorized</u> 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 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 your 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: Ozaukee County Department of Human Services: 262-284-8200

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.

Send to BDS

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 the Ozaukee County Department of Human Services at 262-284-8200.

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

Send to BDS

DEPARTMENT OF HUMAN SERVICES *LIZA DRAKE, Director*

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, _____ authorize the Ozaukee County Department of Human Services,
(**Print name of client**) (Date of Birth)

☒ *to disclose to* (-or-) ☒ *receive from* **[check one or both]** the records and information specified below:

_____
(Name of Person or Organization)

_____
(Address)

- **TYPE OF INFORMATION TO BE RELEASED:** **X** Verbal **X** Written
- **SPECIFIC INFORMATION TO BE RELEASED:**

NO	YES		NO	YES	
☐	☐	TREATMENT SUMMARY PLAN	☐	☐	SUMMARY OF ALL SERVICES
☐	☒	PROGRESS NOTES			FROM ____ TO _____
☐	☐	ASSESSMENT RESULTS	☐	☐	PSYCHOLOGICAL EVALUATION
☐	☐	RECOMMENDATIONS	☐	☐	PSYCHIATRIC EVALUATION
☐	☐	DRUG TESTING RESULTS	☐	☐	SOCIAL HISTORY/ASSESSMENT
☐	☐	DIAGNOSIS/PROGNOSIS	☐	☐	MEDICATIONS
☐	☒	ONGOING VERBAL EXCHANGE OF INFORMATION BETWEEN TWO PARTIES ABOVE			
☐	☐	OTHER (SPECIFY) _____			

- **THE PURPOSE FOR THE DISCLOSURE OF THE INFORMATION IS:**

	NO	YES
A. To assist in evaluation, treatment planning and service coordination	☐	☒
B. To facilitate family involvement in treatment/evaluation	☒	☐
C. To coordinate treatment services between providers	☐	☒
D. To complete Juvenile Court Intake/Disposition Assessment	☒	☐
E. To determine eligibility for services	☒	☐
F. Other reasons: (Specify reason if YES is checked)	☐	☒

Case management – CLTS Waiver Program

I understand that my records are protected under the Federal and specific State confidentiality laws and regulations **(Initial one or both):** ~~_____ Chemical Dependency, Federal Regs 42 CFR, Part 2 or _____ Mental Health, Chapter 51.30 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that by my written notification 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 described below. I understand that if the person and/or agency listed above are not governed by applicable federal and state laws and administrative codes, the confidential information disclosed as a result of this authorization may no longer be protected from further redisclosure without obtaining my authorization.~~ N/A

I understand that I have a right to inspect and receive a copy of the material to be disclosed as required under Wisconsin law, ss.51.30(4) and HFS 92.05 and 92.06 of the Wisconsin Administrative Code, as well as the Privacy Rule of the Administrative Simplification provisions of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). 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. A copy of this authorization will be considered as valid as the original.

I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will.

THIS RELEASE EXPIRES UPON THE FULFILLMENT OF THE PURPOSE FOR WHICH THIS RELEASE WAS ENACTED AND IN ANY EVENT, SPECIFICALLY **EXPIRES ONE YEAR FROM THE DATE OF SIGNATURE.**

Signature of Client/Legal Representative: _____ **Date:** _____
Signature is that of: ☐ Client/Patient ☐ Parent of Minor ☐ Legal Guardian ☐ Other Legal Representative

Signature of witness (or legally authorized minor): _____

Agency Worker obtaining Consent: _____

DISTRIBUTION: White Copy – Source of Information Yellow Copy – Client/Patient OCDHS REVISED: May 2016

Send to BDS

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

Send to BDS

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.

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.

_____ _____

Parent Signature Date

_____

Employer/Child Name

Send to BDS

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.

	Knowledge/skill level required
Yes	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.
Yes	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.
Yes	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.
Yes	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.
Yes	Understanding of all confidentiality and privacy laws and rules.
Yes	Understanding of procedures for handling complaints.
Yes	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.
Yes	Understanding the personal health and wellness-related needs of the person needing supports including nutrition, dietary needs, exercise needs, and weight monitoring and control.
List relevant training & two years' experience (please attach additional sheet if needed):	

I am the employer's parent/legal guardian and have been temporarily authorized as a paid caregiver through the CLTS exemption program.

_____ _____

Parent Signature Date

_____

Name of child receiving services

BDS FISCAL

BDS Fiscal 2021 Payroll Payment Schedule

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

- **PAY PERIODS:** the 1st–15th and the 16th–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 15th/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

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.

SAMPLE

BDS FISCAL

Fiscal Agent Employee Timesheet

John Doe
Employee/Provider Name

Jane Smith
Employer/Service Recipient (Child) Name

Pay Period: 1/20/19 (Sunday) to 2/2/19 (Saturday)

Waukesha
Employer/Service Recipient County of Residence

•• ATTENTION ••

- ONLY ONE PAY PERIOD PER TIMESHEET. TIMESHEETS MUST BE SUBMITTED WITHIN 60 DAYS OF SERVICE.
- ROUND TO NEAREST 15-MINUTE INCREMENT FOR HOUR TOTALS (15MIN = .25, 30MIN = .5, 45MIN = .75)
- TIMESHEETS RECEIVED AFTER THE DUE DATE ON THE PAYMENT SCHEDULE WILL BE PAID ON THE FOLLOWING PAY DATE.
- NEITHER BDS FISCAL NOR THE CLTS WAIVER PROGRAM ARE RESPONSIBLE FOR PAYING FOR HOURS SUBMITTED AFTER 60 DAYS OR HOURS THAT EXCEED THE NUMBER OF AUTHORIZED HOURS.

Date	Service	Start	End	# Hours	Full Day
1/22/19	R	3:30 (PM)	6:30 (PM)	3	
1/25/19	R	11:00 (AM)	4:30 (PM)	5.5	
1/31/19	DLS	12:15 (PM)	2:30 (PM)	2.25	
2/1/19	R	10:00 (AM)	10:00 (PM)		1
		AM / PM	AM / PM		
		AM / PM	AM / PM		
		AM / PM	AM / PM		
		AM / PM	AM / PM		
		AM / PM	AM / PM		
		AM / PM	AM / PM		
		AM / PM	AM / PM		
		AM / PM	AM / PM		
		AM / PM	AM / PM		
Service types: Child Care = CC; Respite Care = R; Daily Living Skills = DLS; Mentoring = M			Totals:	10.75	1

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.

John Doe — Employee/Provider Signature — 2/5/19 — Date

Mary Smith — Employer/Client/Representative Signature — 2/5/19 — Date

Timesheets may be submitted to BDS Fiscal via the following methods:

Mail: 6102 W Layton Avenue, Greenfield, WI 53220 • Fax: 414-329-4500
Email: 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.
BDS Fiscal is associated with Broadscope Disability Services, Inc.

BDS FISCAL

Fiscal Agent Employee Timesheet

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 *9 max per day*	Check if full day
		AM PM	AM PM		☐
		AM PM	AM PM		☐
		AM PM	AM PM		☐
		AM PM	AM PM		☐
		AM PM	AM PM		☐
		AM PM	AM PM		☐
		AM PM	AM PM		☐
		AM PM	AM PM		☐
		AM PM	AM PM		☐
		AM PM	AM PM		☐
		AM PM	AM PM		☐
		AM PM	AM PM		☐
Service types: Child Care = **CC**; Daily Living Skills = **DLS**; Supportive Home Care = **SHC**; Respite Care = **R**; Respite Group = **RG**; Mentoring = **M**				**Totals:**	

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 ♦ 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.

Send to BDS
♦OPTIONAL♦

Additional Employment Interests – Ozaukee 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 Ozaukee 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 willing to work with

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

I am available on short notice

- ❑ Yes
- ❑ No
- ❑ Possibly

I am trained in

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

I am willing to work

- ❑ Mon-Fri days
- ❑ Mon-Fri evenings
- ❑ Sat-Sun days
- ❑ Sat-Sun evenings
- ❑ Overnight
- ❑ Holidays

Comments on training or availability: _____

_____

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

- ❑ Belgium
- ❑ Cedarburg
- ❑ Fredonia
- ❑ Grafton
- ❑ Mequon
- ❑ Port Washington
- ❑ Saukville
- ❑ Thiensville
- ❑ Waubeka

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