

PARTICIPANT ENROLLMENT CHECKLIST

DOCUMENT	REQUIRED / OPTIONAL
Participant Onboarding Data	Required
IRS: SS-4	Required
IRS: 2678	Required
Michigan: UIA 1488	Required
Participant Release of Confidential Information Authorization	Optional
Participant Authorized Representative	Optional
Participant Backup Supports	Required
Participant Household Employer Orientation	Required

Note:

Please ensure all **REQUIRED** documents are filled out accurately before submitting them for processing.

PARTICIPANT INFORMATION

Full Name (First, Middle Initial, Last): _____

Address 1: _____

Address 2: _____

City: _____ County: _____ State: _____ Zip: _____

Phone #: _____ Mobile #: _____

Email Address: _____

Date of Birth: _____ Social Security Number: _____

Restart

New

Change

Enrollment Date: _____

PAS ID: _____ CLS ID: _____ CMH ID: _____

REPRESENTATIVE INFORMATION

Guardian

POA

Appointed Rep

Full Name (First, Middle Initial, Last): _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Mobile #: _____

Email Address: _____

Copy of Guardianship/POA documents

SERVICES RECEIVED

CLS Supports

Staffing Agent

Direct Hire

Respite Supports

Staffing Agent

Direct Hire

Family Friend Respite

Staffing Agent

Direct Hire

Representative Payee Services

STAFFING AGENT INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

Email Address: _____

DIRECT CARE PROFESSIONAL INFORMATION – 1

Full Name (First, Middle Initial, Last): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Email: _____

DIRECT CARE PROFESSIONAL INFORMATION – 2

Full Name (First, Middle Initial, Last): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Email: _____

Application for Employer Identification Number
(For use by employers, corporations, partnerships, trusts, estates, churches,
government agencies, Indian tribal entities, certain individuals, and others.)
See separate instructions for each line. Keep a copy for your records.
Go to www.irs.gov/FormSS4 for instructions and the latest information.

OMB No. 1545-0003

EIN

Type or print clearly.	1 Legal name of entity (or individual) for whom the EIN is being requested				
	2 Trade name of business (if different from name on line 1)	3 Executor, administrator, trustee, "care of" name			
	4a Mailing address (room, apt., suite no. and street, or P.O. box)	5a Street address (if different) (Don't enter a P.O. box.)			
	4b City, state, and ZIP code (if foreign, see instructions)	5b City, state, and ZIP code (if foreign, see instructions)			
	6 County and state where principal business is located				
	7a Name of responsible party		7b SSN, ITIN, or EIN		
8a Is this application for a limited liability company (LLC) (or a foreign equivalent)? <input type="checkbox"/> Yes <input type="checkbox"/> No		8b If 8a is "Yes," enter the number of LLC members			
8c If 8a is "Yes," was the LLC organized in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No					
9a Type of entity (check only one box). Caution: If 8a is "Yes," see the instructions for the correct box to check. <input type="checkbox"/> Sole proprietor (SSN) _____ <input type="checkbox"/> Partnership _____ <input type="checkbox"/> Corporation (enter form number to be filed) _____ <input type="checkbox"/> Personal service corporation _____ <input type="checkbox"/> Church or church-controlled organization _____ <input type="checkbox"/> Other nonprofit organization (specify) _____ <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Estate (SSN of decedent) _____ <input type="checkbox"/> Plan administrator (TIN) _____ <input type="checkbox"/> Trust (TIN of grantor) _____ <input type="checkbox"/> Military/National Guard <input type="checkbox"/> State/local government <input type="checkbox"/> Farmers' cooperative <input type="checkbox"/> Federal government <input type="checkbox"/> REMIC <input type="checkbox"/> Indian tribal governments/enterprises Group Exemption Number (GEN) if any _____					
9b If a corporation, name the state or foreign country (if applicable) where incorporated		State _____ Foreign country _____			
10 Reason for applying (check only one box) <input type="checkbox"/> Started new business (specify type) _____ <input type="checkbox"/> Hired employees (Check the box and see line 13.) <input type="checkbox"/> Compliance with IRS withholding regulations <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Banking purpose (specify purpose) _____ <input type="checkbox"/> Changed type of organization (specify new type) _____ <input type="checkbox"/> Purchased going business <input type="checkbox"/> Created a trust (specify type) _____ <input type="checkbox"/> Created a pension plan (specify type) _____					
11 Date business started or acquired (month, day, year). See instructions.		12 Closing month of accounting year			
13 Highest number of employees expected in the next 12 months (enter -0- if none). <table border="1"><tr><td>Agricultural</td><td>Household</td><td>Other</td></tr></table>		Agricultural	Household	Other	14 Reserved for future use
Agricultural	Household	Other			
15 First date wages or annuities were paid (month, day, year). Note: If applicant is a withholding agent, enter date income will first be paid to nonresident alien (month, day, year)					
16 Check one box that best describes the principal activity of your business. <input type="checkbox"/> Construction <input type="checkbox"/> Rental & leasing <input type="checkbox"/> Transportation & warehousing <input type="checkbox"/> Health care & social assistance <input type="checkbox"/> Wholesale-agent/broker <input type="checkbox"/> Real estate <input type="checkbox"/> Manufacturing <input type="checkbox"/> Finance & insurance <input type="checkbox"/> Accommodation & food service <input type="checkbox"/> Wholesale-other <input type="checkbox"/> Retail <input type="checkbox"/> Other (specify) _____					
17 Indicate principal line of merchandise sold, specific construction work done, products produced, or services provided.					
18 Has the applicant entity shown on line 1 ever applied for and received an EIN? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," write previous EIN here					
Third Party Designee	Complete this section only if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form.				
	Designee's name	Designee's telephone number (include area code)			
	Address and ZIP code	Designee's fax number (include area code)			
Under penalties of perjury, I declare that I have examined this application, and to the best of my knowledge and belief, it is true, correct, and complete.		Applicant's telephone number (include area code)			
Name and title (type or print clearly)		Applicant's fax number (include area code)			
Signature _____		Date _____			

Do I Need an EIN?

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

IF the applicant...	AND...	THEN...
started a new business	doesn't currently have (nor expect to have) employees	complete lines 1, 2, 4a-8a, 8b-c (if applicable), 9a, 9b (if applicable), 10-13, and 16-18.
hired (or will hire) employees, including household employees	doesn't already have an EIN	complete lines 1, 2, 4a-6, 7a-b, 8a, 8b-c (if applicable), 9a, 9b (if applicable), and 10-18.
opened a bank account	needs an EIN for banking purposes only	complete lines 1-5b, 7a-b, 8a, 8b-c (if applicable), 9a, 9b (if applicable), 10, and 18.
changed type of organization	either the legal character of the organization or its ownership changed (for example, you incorporate a sole proprietorship or form a partnership) ²	complete lines 1-18 (as applicable).
purchased a going business ³	doesn't already have an EIN	complete lines 1-18 (as applicable).
created a trust	the trust is other than a grantor trust or an IRA trust ⁴	complete lines 1-18 (as applicable).
created a pension plan as a plan administrator ⁵	needs an EIN for reporting purposes	complete lines 1, 3, 4a-5b, 7a-b, 9a, 10, and 18.
is a foreign person needing an EIN to comply with IRS withholding regulations	needs an EIN to complete a Form W-8 (other than Form W-8ECI), avoid withholding on portfolio assets, or claim tax treaty benefits ⁶	complete lines 1-5b, 7a-b (SSN or ITIN as applicable), 8a, 8b-c (if applicable), 9a, 9b (if applicable), 10, and 18.
is administering an estate	needs an EIN to report estate income on Form 1041	complete lines 1-7b, 9a, 10-12, 13-17 (if applicable), and 18.
is a withholding agent for taxes on nonwage income paid to an alien (that is, individual, corporation, or partnership, etc.)	is an agent, broker, fiduciary, manager, tenant, or spouse who is required to file Form 1042, Annual Withholding Tax Return for U.S. Source Income of Foreign Persons	complete lines 1, 2, 3 (if applicable), 4a-5b, 7a-b, 8a, 8b-c (if applicable), 9a, 9b (if applicable), 10, and 18.
is a state or local agency	serves as a tax reporting agent for public assistance recipients under Rev. Proc. 80-4, 1980-1 C.B. 581 ⁷	complete lines 1, 2, 4a-5b, 7a-b, 9a, 10, and 18.
is a single-member LLC (or similar single-member entity)	needs an EIN to file Form 8832, Entity Classification Election, for filing employment tax returns and excise tax returns, or for state reporting purposes ⁸ , or is a foreign-owned U.S. disregarded entity and needs an EIN to file Form 5472, Information Return of a 25% Foreign-Owned U.S. Corporation or a Foreign Corporation Engaged in a U.S. Trade or Business	complete lines 1-18 (as applicable).
is an S corporation	needs an EIN to file Form 2553, Election by a Small Business Corporation ⁹	complete lines 1-18 (as applicable).

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

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

³ Don't use the EIN of the prior business unless you became the "owner" of a corporation by acquiring its stock.

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

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

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

⁷ See also *Household employer agent* in the instructions. **Note:** State or local agencies may need an EIN for other reasons, for example, hired employees.

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

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

Form **2678** **Employer/Payer Appointment of Agent**

(Rev. December 2024) Department of the Treasury — Internal Revenue Service

OMB No. 1545-0029

Use this form if you want to request approval to have an agent file returns and make deposits or payments of employment or other withholding taxes or if you want to revoke an existing appointment.

- If you're an employer or payer who wants to request approval, complete Parts 1 and 2 and sign Part 2. Then give it to the agent. Have the agent complete Part 3 and sign it.

Note: This appointment isn't effective until we approve your request. See the instructions for more information.

- If you're an employer, payer, or agent who wants to revoke an existing appointment, complete all three parts. In this case, only one signature is required.

For IRS use:**Part 1: Why you're filing this form.**

(Check one)

- ☒ You want to **appoint** an agent for tax reporting, depositing, and paying.
- ☐ You want to **revoke** an existing appointment.

Part 2: Employer or Payer Information: Complete this part if you want to appoint an agent or revoke an appointment.**1 Employer identification number (EIN)**

		-							
--	--	---	--	--	--	--	--	--	--

2 Employer's or payer's name
(not your trade name)

--

3 Trade name (if any)

--

4 Address

Number	Street	Suite or room number

City	State	ZIP code

Foreign country name	Foreign province/county	Foreign postal code

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

	For ALL employees/ payees/payments	For SOME employees/ payees/payments
Form 940, Employer's Annual Federal Unemployment (FUTA) Tax Return* (all 940 series)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Form 941, Employer's QUARTERLY Federal Tax Return (all 941 series)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Form 943, Employer's Annual Federal Tax Return for Agricultural Employees (all 943 series)	<input type="checkbox"/>	<input type="checkbox"/>
Form 944, Employer's ANNUAL Federal Tax Return (all 944 series)	<input type="checkbox"/>	<input type="checkbox"/>
Form 945, Annual Return of Withheld Federal Income Tax	<input type="checkbox"/>	<input type="checkbox"/>
Form CT-1, Employer's Annual Railroad Retirement Tax Return	<input type="checkbox"/>	<input type="checkbox"/>
Form CT-2, Employee Representative's Quarterly Railroad Tax Return	<input type="checkbox"/>	<input type="checkbox"/>

* Generally, you can't appoint an agent to report, deposit, and pay tax reported on Form 940, unless you're a home care service recipient.

- ☒ Check here if you're a home care service recipient, and you want to appoint the agent to report, deposit, and pay FUTA tax for you. See the instructions.

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

**Sign your
name here**

--

Print your name here

--

Print your title here

--

Date

/	/
---	---

Best daytime phone

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Now give this form to the agent to complete.

Part 3: Agent Information: If you'll be an agent for an employer or payer, or want to revoke an appointment, complete this part.**6 Agent's employer identification number (EIN)**

2	6	–	0	1	3	0	3	7	0
---	---	---	---	---	---	---	---	---	---

7 Agent's name (not trade name)**Personal Accounting Services Inc as Fiscal Agent****8 Trade name** (if any)**9 Address****20500 Eureka Rd Unit 112**

Number

Street

Suite or room number

Taylor

City

MI

State

48180

ZIP code

Foreign country name

Foreign province/county

Foreign postal code

☒ Check here if the employer is a home care service recipient receiving home care services through a program administered by a federal, state, or local government agency.

Under penalties of perjury, I declare that I have examined this form and any attachments, and to the best of my knowledge and belief, they are true, correct, and complete.

**Sign your
name here**

Print your name here

Ashley Lyver

Print your title here

Payroll Tax Manager

Date

/ /

Best daytime phone

612-808-8941



STATE OF MICHIGAN
DEPARTMENT OF LABOR AND ECONOMIC OPPORTUNITY
UNEMPLOYMENT INSURANCE AGENCY
www.michigan.gov/uia

Power of Attorney (POA)

Complete this form if you wish to appoint someone to represent you with the State of Michigan Unemployment Insurance Agency (UIA), or if you wish to revoke or change your current Power of Attorney representation. Read the instructions on page 3 before completing this form.

PART 1: EMPLOYER INFORMATION

Name and Address	If business, enter DBA, Trade or Assumed Name		
	Telephone Number	Extension	Fax Number
	FEIN Number	UIA Account Number *	
E-mail Address			

PART 2: REPRESENTATIVE INFORMATION AND AUTHORIZATION DATES

Your authorized representative may be an organization, firm, or individual. If your representative is not an individual, designate a contact person. Please ensure that you submit a separate form for each representative.

Representative Name and Address	Contact Name		E-mail Address
	Telephone Number	Extension	Fax Number
	Beginning Authorization Date (mm/dd/yyyy)		Ending Authorization Date (mm/dd/yyyy) **
	Representative FEIN		Representative UIA Account Number

The representative is a(n): ☐ PEO ☐ CPA ☐ Human Resources ☐ Bookkeeper ☐ Other Service Provider

PART 3: TYPES OF AUTHORIZATION

☐ GENERAL AUTHORIZATION

Authorizes my representative to: (1) inspect or receive confidential information, (2) represent me and provide oral or written presentations of fact and/or argument, (3) sign quarterly reports or registration reports, (4) enter into agreements, and (5) receive mail from the UIA (includes forms, billings, and notices.) This authorization applies to all tax related/non-tax related matters and all years or periods.

☐ LIMITED AUTHORIZATION

Select the type of authorization by checking the appropriate boxes to the right of each item listed below. You may check up to 4 boxes. If 5 boxes apply, please complete the "General Authorization" section above.

1. Inspect or receive confidential information
2. Represent me and make oral or written presentation of facts or argument
3. Sign reports
4. Enter into agreements
5. Receive mail from the UIA (including forms, billings, and notices)

<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>

If the box for Line 5 above is checked, please select the category/categories of forms that you want mailed to this POA:

Tax ☐ Claims Control ☐ Contested Claims ☐ All ☐

UIA correspondence will be sent based on your selections above to the representative at the address indicated in Part 2.

☐ **WORK OPPORTUNITY TAX CREDIT (WOTC)**

Select this box if you have been appointed to represent the taxpayer before the Internal Revenue Services (IRS) for the Work Opportunity Tax Credit.

Othorization Dates: _____(Required Beginning Date) through _____(Required End Date).

PART 4: CHANGE IN POWER OF ATTORNEY

☐ **CHANGE IN POWER OF ATTORNEY REPRESENTATION:** This form replaces all earlier Powers of Attorney documents except those attached on file for the same tax related/non-tax related matters and years, or periods covered by this Power of Attorney.

☐ **REVOKE PREVIOUS AUTHORIZATION:** I Revoke all Powers of Attorney submitted and will represent myself in all tax and benefit matters.

PART 5: EMPLOYER'S SIGNATURE

If signed by a corporate officer, partner or fiduciary on behalf of the employer, I certify that I have the authority to execute this Power of Attorney.

Signature	Name or Title Printed or Typed	Date
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* The Unemployment Insurance Agency is abbreviated throughout this form as the "UIA."

**If no ending Authorization Date is provided, the above-named representative will be authorized to represent you until you notify the UIA in writing to revoke this Power of Attorney.

INSTRUCTIONS FOR POWER OF ATTORNEY (FORM UIA 1488)

Complete and file Form UIA 1488, *Power of Attorney*, if you wish to appoint an individual, firm, or organization as your representative in tax or benefit matters before the UIA. **Failure to complete this form will prohibit the UIA from discussing your information with another person or releasing your information to another person, to protect your Firm's confidential information.**

PART 1: EMPLOYER INFORMATION

Enter the employer's name, address, telephone number, fax number, and email address. If the taxpayer is a business operating under another name, enter the doing business as, trade or assumed name. Enter the Federal Employer Identification Number (FEIN), any other applicable FEIN, and the UIA Account Number, leave the indicated space blank.

PART 2: REPRESENTATIVE INFORMATION AND AUTHORIZATION DATES

You must submit a separate Power of Attorney form for each representative. Enter the authorized representative's telephone number, fax number, and email address. If your representative is not an individual, please designate a contact person. Make sure to indicate the beginning and end ending dates of authorization. Provide the FEIN associated with the representative and the representative's UIA account number, if available. In addition, indicate whether the representative is a professional employer organization (PEO), certified public accountant (CPA), human resources specialist, bookkeeper, or other service provider. More than one box may be checked, if applicable.

PART 3: TYPE OF AUTHORIZATION

Check the General Authorization box to allow your representative to act on your behalf to do all of the following: (1) inspect and receive confidential information, (2) represent you and provide oral or written presentations of fact and/or argument, (3) sign reports, (4) enter into agreements, and (5) receive all mailings (including forms, billings, and payment notices). This authorization applies to all tax/non-tax matters and for all years or periods.

You may restrict your representative's authorization to act on your behalf by checking the Limited Authorization box, and then checking the appropriate specific powers boxes. The authorizations selected apply to all tax related/non-tax related matters and for all years or periods. If all 5 boxes apply, complete the "General Authorization" section only. If you check the box for line five, you may select the category/categories of forms that you want mailed to the Power of Attorney indicated on this form. The categories of forms are: (1) Tax, (2) Claims Control, (3) Contested Claims or (4) All.

All mail will be sent to the address you entered in Part 2 of this form. To change the mailing address after submission of this form, use your Michigan Web Account Manager (MiWAM) at www.michigan.gov/uia.

WORK OPPORTUNITY TAX CREDIT (WOTC):

The Work Opportunity Tax Credit (WOTC) is a Federal tax credit incentive that Congress provides to the private-sector businesses for hiring individuals from nine target groups who have consistently faced significant barriers to employment. To learn more about WOTC and how to apply, visit www.doleta.gov.

PART 4: CHANGE IN POWER OF ATTORNEY

Unless otherwise specified, this Power of Attorney replaces or revokes any previous Power of Attorney form on file with the Michigan UIA for the same tax matters identified on this form. You must identify any previous authorizations to this form when filed.

PART 5: EMPLOYER SIGNATURE

Sign and date the form if you have the authority to execute the Power of Attorney on behalf of an employer.

FILING POWER OF ATTORNEY

To file this form, mail or fax it to:
UIA Tax Office, P.O. Box 8068, Royal Oak, MI 48068-8068

Fax (517) 636-0014

Direct any questions to the Office of Employer Ombudsman (OEO) through your MiWAM account at www.michigan.gov/uia or call 1-855-484-2636. TTY service is available at 1-866-366-0004.

PARTICIPANT
RELEASE OF CONFIDENTIAL
INFORMATION AUTHORIZATION FORM

Instructions: Please review, complete and sign at the bottom. Submit the form to PAS via one of the following options:

Mail or Drop-Off

20500 Eureka Road, Ste 112
Taylor, MI 48180

Email

HR@PASselfdirection.com

Fax

734.206.1433

This form authorizes PAS (Personal Accounting Services, Inc.) to disclose any information regarding the services you receive, wages and payment information for your workers and/or anything else related to your service and support plan. You have the right to revoke this Authorization by providing PAS with written notice of revocation.

AUTHORIZATION

I, _____, hereby authorize PAS or any of its staff to disclose, by any acceptable means, information regarding the services I receive, wages and payment information for my direct care professionals, including fax or email, and/or anything else related to my service and support plan described as follows:

I, _____, hereby authorize the release of the above information to the following person:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

**This authorization does not grant the individual authority to sign off on
timesheets or any other program-related documents.**

Participant or Legal Representative Name: _____

Participant or Legal Representative Signature: _____

Participant Date of Birth: _____ Form Completion Date: _____

Instructions: Please complete Sections 1 and 2, where applicable. Participants are required to sign and date at the bottom of the form. If a Participant has an Authorized Representative (AR), the AR must also sign and date the form. Please submit the completed form to PAS via one of the following options:

Mail

20500 Eureka Rd
Suite 112
Taylor, MI 48180

Email

HR@PASselfdirection.com

Fax

734.206.1433

SECTION 1: PARTICIPANT INFORMATION

Full Name (First, Middle Initial, Last): _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Mobile #: _____ Work #: _____

Email Address: _____

Date of Birth: _____ Social Security Number: _____

SECTION 2: AUTHORIZED REPRESENTATIVE INFORMATION *(if applicable)*

Full Name (First, Middle Initial, Last): _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Mobile #: _____

Work #: _____ Email Address: _____

Date of Birth: _____ Social Security Number: _____

By signing below, you certify that the information on this form is accurate and that you have all supporting documentation that may be needed to verify your selection. For any questions or concerns, please contact our office at **734.729.3100, Prompt 1**.

Participant Signature: _____ Date: _____

Authorized Representative Signature: _____ Date: _____

As a participant self-directing your services, a backup plan is required for times when your primary Direct Care Professional is unable to provide services. A backup plan should be tested and updated periodically to assure that it works and changes are not needed. Always confirm with backup Direct Care Professional's their willingness to provide backup care before adding them to your backup plan.

Participant: _____

Authorized Representative (if applicable): _____

BACKUP DIRECT CARE PROFESSIONAL INFORMATION

Name	Address	Phone	Availability

Or I may use the Agency, _____, as my Backup provider.

Agency Telephone: _____

NATURAL SUPPORTS BACKUP INFORMATION

Name	Address	Phone	Availability

I understand that if my backup worker is a paid worker he/she must be a credentialed employee before being able to provide services as a backup and be paid. They must also have a completed Medicaid Provider Agreement signed by both the employer and employee to be valid.

Participant Signature: _____ Date: _____

Authorized Representative Signature: _____ Date: _____

Participant: _____

Authorized Representative (if applicable): _____

REVIEW

1. Employer Tax Forms
2. Workers Compensation
3. Authorization to Release Information
4. Contact List
5. Designated Representative (if applicable)
6. Budget and/or Authorization
7. Employee Pay Schedule
8. Time and Attendance, if applicable
9. Time sheet, Service Log, Health Report
10. Privacy Notice
11. Overtime Guidelines
12. Direct Care Professional Start Date
13. Employment Agreement
14. Direct Care Professional Training Requirements
15. Backup Direct Care Professionals
16. Household Employer Guide
17. Hiring and Managing Assistance
18. Reporting of Incident(s)
 - a. Accidents
 - b. Hospital
 - c. Recipient Rights
 - d. Medicaid Fraud
 - e. Adult Protective Services
19. False Claim Act (FCA)

ORIENTATION ACKNOWLEDGEMENT

I acknowledge that I have received documentation and orientation on becoming a Household Employer. The PAS (Personal Accounting Services, Inc.) Enrollment Specialist has reviewed each of the above policies, guidelines, and forms for me to fulfill my responsibilities as a Household Employer. I further understand that I may contact my agency Support Coordinator/Care Manager, or PAS if I may have questions or need additional assistance.

Participant Signature: _____ Date: _____

Authorized Representative Signature: _____ Date: _____