

 WRAPAROUND MILWAUKEE POLICY & PROCEDURE	Date Issued: 9/1/98	Date Revised: 9/25/08	Section: FINANCE	Policy No: 018	Pages: 1 of 4 (3 Attachments)
	<input checked="" type="checkbox"/> Wraparound <input checked="" type="checkbox"/> Wraparound/REACH <input type="checkbox"/> FISS	Effective Date: 1/1/09	Subject: FAMILY SUPPORT SERVICES (MCFI)		

I. POLICY

Family Support is a category that covers the following services: Tutoring, Parent Assistant, Mentoring, Respite Services, Independent Living Skills, Crisis Home, Supported Work Environment/Job Coach, Child Care and Household Management Services. Family Support Services are provided to the youth and/or family through identified natural supports (relatives, neighbors, friends, community resources). The goal is to tailor informal/community-based services to meet the needs of each youth and family. It allows for the development of creative, non-traditional, innovative approaches to securing services that have been identified by the youth and family in response to their specific needs.

II. GENERAL INFORMATION

A. Provider /Employee

An individual employed as a Family Support Provider is the employee of the family/youth, **NOT** Wraparound/Milwaukee County. Payment of Family Support Providers is accomplished through the use of a fiscal intermediary – the Milwaukee Center For Independence (MCFI). Wraparound has initiated an application/screening process to assure the safety of our Wraparound clients/families and to assist the fiscal intermediary (MCFI). If a potential Family Support Provider is not approved through the application/screening process, and the family/youth continues to want that individual to provide services, then the family/youth has the right to appeal the administrative decision.

B. Recreational Activities

Recreational activity costs are the responsibility of the Provider/Family unless some type of exceptional activity is occurring which has been discussed in advance with the Child and Family Team and Care Coordinator. In these exceptional instances funding through discretionary funds could be sought on the Service Authorization Request (SAR).

C. Overnights

Wraparound Milwaukee **WILL NOT** fund or be liable for clients who go on overnight passes to Family Service Provider homes. A funded, overnight placement through Wraparound may occur **ONLY** within a licensed foster home with the parent's/legal guardian's authorization and Care Coordinator knowledge / approval.

NOTE: If the child goes on an overnight with the Family Support Provider, per an independent agreement between the Provider and the Family, scheduled Wraparound activities that would be planned during that time may be acceptable for reimbursement. Again, this would have to be an exceptional activity and would have to be discussed with the Child and Family Team and the Care Coordinator.

D. Mandatory Reporting of Abuse

The Family Support Provider is a “Mandatory Reporter”. It is the Family Support Provider’s responsibility to immediately report to the Care Coordinator and/or the Police/Child Protective Services/State Bureau of Child Welfare Services any reported and/or witnessed neglect or physical, sexual or emotional abuse. The family and the Family Support Provider should be made aware from day one that this would be expected of him/her. **The number for Child Protective Services is 220-SAFE (7233).**

E. Confidentiality

The Family Support Services Provider agrees that all information about the youth/family they work with is strictly confidential and will not be discussed with any person outside the Child and Family Team or any person not associated with the Wraparound Milwaukee Program.

F. Provider Service Requirements / Training / Documentation

The Family Support Provider must be informed of and encouraged to be involved in all relevant meetings/sessions, i.e., Plan of Care meetings, family sessions as appropriate, etc. Communication and collaboration with the Care Coordinator / Family Team should be stressed. The Care Coordinator must provide guidance and support to the Family Support Provider regarding the client's care, strengths, needs, etc.

The Family Support Provider must also be oriented to the Wraparound Milwaukee program and philosophy. The Family Support Provider must make a progress entry on the Family Support Services Provider Log (see Form C in packet) every time a child/family is seen. These Logs must be signed by the Care Coordinator, Provider and Parent/Guardian/Caregiver and turned in to the Care Coordinator at the end of every month. If a session with a client is cancelled for any reason, this should still be indicated on the Log. If Logs are not submitted on time, the family/Wraparound has the right to terminate any employee.

G. Provider Hours

Family Support Services will generally not be approved for more than the maximum hours allowed per service per Wraparound standards. The reason for usage of services beyond these general parameters must be clearly documented in the Plan of Care.

Family Support Services Providers can only bill for actual "face-to-face" contact. Reimbursement is not available for travel time, phone contact and/or if there is a "no show" situation with a client. The Family Support Provider can bill for the time spent attending POC meetings, Child & Family Team meetings and other client related treatment-focused meetings when the youth/family is present. Billing for attendance at these meetings will occur at the same hourly rate of reimbursement.

H. Requests for Additional Units of Services

Any requests for additional units of service for the month beyond those authorized on the Service Authorization Request (SAR) form must be discussed with the Care Coordinator. The Care Coordinator must then have these additional hours/units approved by the Wraparound Milwaukee QA Department and the additional hours/units must be entered on-line through Synthesis (Wraparound Milwaukee's IT system).

I. Provider Monitoring

The Care Coordinator will assist the family with monitoring the services provided by the Family Support Provider.

J. Liability Issues

Wraparound will not be liable in the circumstance where a youth/family may steal from a Family Support Provider and/or cause damage to a Provider's property or person. Issues related to theft/damage must be dealt with between the employer and employee, meaning the Family Support Provider and the youth/family.

III. REQUIREMENTS.

Wraparound Milwaukee requires that the following guidelines be followed when the family hires a Family Support Provider.

A. Criminal History / Criminal Background Check / Caregiver Law / County Resolution

A statewide criminal records check must be done prior to hiring the individual and there must be adherence to the Wisconsin Caregivers Law/County Resolution. The Care Coordinator should have the prospective Provider complete the BACKGROUND INFORMATION DISCLOSURE FORM (*see Attachment 1*) and send it along with the Provider Application.

Individuals convicted at any time of the following offenses cannot be hired as a Family Support Services Provider: homicide (all degrees); felony murder; mayhem; aggravated and substantial battery; 1st and 2nd degree sexual assault; armed robbery; administering dangerous or stupefying drugs; and all crimes against children as identified in Chapter 948 of Wisconsin Statutes.

Individuals convicted within the last five (5) years of any crime under the Uniformed Controlled Substances Act under Chapter 961 of Wisconsin Statutes (excluding simple possession) **cannot be hired**.

Individuals convicted within the last three (3) years of any offenses including, but not limited to, criminal gang member solicitations; simple possession; endangering public safety; robbery; theft; or two (2) or more misdemeanors involving separate incidences **cannot be hired**.

If the family chooses to hire an individual with a past record (charges or convictions), additional character references are recommended and the family will need to state in writing that they understand the risks involved in hiring this individual and that they take full responsibility in doing so.

Note: Criminal background checks must be updated every four (4) years. If the Family Support Provider has lived in the State of Wisconsin for less than three years, a Federal criminal background check must be obtained.

B. Transporting a Youth/Family Member

If the Provider will transport the youth/family at any time, the parent/legal guardian must sign a TRANSPORTATION CONSENT FORM that indicates permission for the Provider to do so (*see Attachment 2*). If the Family Support Services Provider is to pick up the client at the client's home for a session/activity, it is required that at least one parent/legal guardian/responsible adult be at home when the Provider arrives and when the client is being dropped off.

Please note: Schools, clinics, etc., will often request written permission and identification from the person picking the child up if it is not their parent/legal guardian.

IV. RECOMMENDATIONS

Wraparound **recommends** that the following guidelines be considered when the family hires a Family Support Provider.

A. Driver's License

If a Family Support Provider is to transport a youth/family at any time in a motor vehicle, they must have verification of a valid Wisconsin Driver's License and current insurance. The Family Support Provider's motor vehicle should also have working seat belts and the client must be properly wearing the seat belt at all times during transport. The family may request that the Care Coordinator complete a Motor Vehicle Check to verify a safe driving record (i.e., no Driving Under the Influence offenses within the past 5 years, no lengthy history of multiple tickets/outstanding violations in the past 5 years). **A motor vehicle check can be done by calling the Department of Transportation in Madison at (608) 266-2353.** It is recommended that a copy of a Certification of Insurance from the Provider's insurance company and a copy of a valid Driver's License also be obtained and kept in the client's chart. The family has the discretionary right when viewing the Family Support Provider's Motor Vehicle Check to determine whether or not the driving violations will potentially endanger the safety of their child and can then make the decision as to if they feel comfortable using that Family Support Provider.

B. Non-Paid Volunteers / Family Providers

Wraparound recommends that all **Non-Paid** volunteers working with a client be subject to the same screening procedures as a paid Provider. **Non-Paid volunteers would not** need to complete the MCFI specific paperwork. (The W-4 Form, the Employer Appointment of Agent Form (#2678), the MCFI Fiscal/Agent Authorization Form and The U.S. Department of Justice - Employment Eligibility Verification Form I-9). They **only** need to complete a Provider Application.

**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.

CAREGIVER BACKGROUND CHECK LAW

In accordance with the provisions of Chapters 48.685 and 50.065, Wis. Stats., 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. A county agency may not certify a child care or license a foster or treatment foster home;
3. A child placing agency may not license a foster or treatment foster home or contract with an adoptive parent applicant for a child adoption;
4. A school board may not contract with a licensed child care provider; and
5. An entity may not employ, contract with or, permit persons to reside at the entity.

A list of barred crimes and offenses requiring rehabilitation review is available from the regulatory agencies or through the Internet at <http://dhs.wisconsin.gov/caregiver/StatutesINDEX.HTM>.

THE CAREGIVER LAW COVERS THE FOLLOWING EMPLOYERS / CARE PROVIDERS (Referred to as "Entities"):	
Programs Regulated under Chapter 48, Wis. Stats.	Treatment Foster Care, Family Child Care Centers, Group Child Care Centers, Residential Care Centers for Children and Youth, Child Placing Agencies, Day Camps for Children, Family Foster Homes for Children, Group Homes for Children, Shelter Care Facilities for Children, and Certified Family Child Care.
Programs Regulated under Chapters 50, 51, and 146, Wis. Stats.	Emergency Mental Health Service Programs, Mental Health Day Treatment Services for Children, Community Mental Health, Developmental Disabilities, AODA Services, Community Support Programs, Community Based Residential Facilities, 3-4 Bed Adult Family Homes, Residential Care Apartment Complexes, Ambulance Service Providers, Hospitals, Rural Medical Centers, Hospices, Nursing Homes, Facilities for the Developmentally Disabled, and Home Health Agencies – including those that provide personal care services.
Others	Child Care Providers contracted through Local School Boards

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.
- Anyone who is a Child Care Provider who contracts with a School Board under Wisconsin Statute 120.13 (14).
- Anyone who lives on the premises of a covered entity and is 10 years old or over, but is not a client ("nonclient resident").
- Anyone who is licensed by DHS.
- Anyone who has a foster home licensed by DHS.
- Anyone certified by DHS.
- Anyone who is a Child Care Provider certified by a county department.
- 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, Chapters 111.31 - 111.395, Wis. Stats., 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)

Completion of this form is required under the provisions of Chapters 48.685 and 50.065, Wis. Stats. 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. Refer to the instructions (F-82064A) on page 1 for additional information. Providing your social security number is voluntary; however, your social security number is one of the unique identifiers used to prevent incorrect matches.

PLEASE PRINT YOUR ANSWERS.

Check the box that applies to you.

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

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

Name – (First and Middle)	Name – (Last)	Position Title (Complete only if you are a prospective employee or contractor, or a current employee or contractor.)		
Any Other Names By Which You Have Been Known (Including Maiden Name)		Birth Date	Gender (M / F)	Race
Address <u>Street, City, State, ZIP Code</u>			Social Security Number(s)	
Business Name and Address - Employer or Care Provider (Entity)				

SECTION A - ACTS, CRIMES, AND OFFENSES THAT MAY ACT AS A BAR OR RESTRICTION	YES	NO
<p>1. Do you have any criminal charges pending against you or were you ever convicted of any crime anywhere, including in federal, state, local, military and tribal courts?</p> <p>➤ 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 judgement of conviction, a copy of the criminal complaint, or any other relevant court or police documents.</p>		
<p>2. Were you ever found to be (adjudicated) delinquent by a court of law on or after your 10th birthday for a crime or offense? (NOTE: A response to this question is only required for group and family day care centers for children and day camps for children.)</p> <p>➤ If Yes, list each crime, when and where it happened, and the location of the court (city and state). You may be asked to supply additional information including a certified copy of the delinquency petition, the delinquency adjudication, or any other relevant court or police documents.</p>		
<p>3. Has any government or regulatory agency (other than the police) ever found that you committed child abuse or neglect? A response is required if the box below is checked:</p> <p><input type="checkbox"/> (Only employers and regulatory agencies entitled to obtain this information per sec. 48.981(7) are authorized to, and should, check this box.)</p> <p>➤ If Yes, explain, including when and where it happened.</p>		
<p>4. Has any government or regulatory agency (other than the police) ever found that you abused or neglected any person or client?</p> <p>➤ If Yes, explain, including when and where it happened.</p>		

(continued on next page)

SECTION A (continued)	YES	NO
5. Has any government or regulatory agency (other than the police) ever found that you misappropriated (improperly took or used) the property of a person or client? ➤ 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 ? ➤ 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? ➤ If Yes , explain, including credential name, limitations or restrictions, and time period.		
SECTION B – OTHER REQUIRED INFORMATION	YES	NO
1. Has any government or regulatory agency ever limited, denied, or revoked your license, certification, or registration to provide care, treatment, or educational services? ➤ 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? ➤ 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? ➤ If yes, indicate the year of discharge: _____ ➤ Attach a copy of your DD214 if you were discharged within the last 3 years.		
4. Have you resided outside of Wisconsin in the last 3 years? ➤ If Yes , list each state and the dates you lived there.		
5. Have you had a caregiver background check done within the last 4 years? ➤ 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.		
6. 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? ➤ If Yes , list the review date and the review result. You may be asked to provide a copy of the review decision.		

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

I understand, under penalty of law, that the information provided above is truthful and accurate to the best of my knowledge and that knowingly providing false information or omitting information may result in a forfeiture of up to \$1,000.00 and other sanctions as provided in DHS 12.05 (4), Wis. Adm. Code.

SIGNATURE	Date Signed
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WRAPAROUND MILWAUKEE / REACH
Family Support Services



Provider Application Packet

To: Care Coordinator

Use the Wraparound Milwaukee Family Support Services (MCFI) Policy – # 018, Section IV – Procedure to guide you through this packet.



WRAPAROUND MILWAUKEE / REACH
Family Support Services



Provider Application Information and Requirements

Please note that a separate Application, including all MCFI paperwork (if applicable) must be completed on every Provider serving a youth/parent and for every youth/parent in that family, if the Provider serves more than one person in the family.

1. All information requested on the attached Application must be submitted along with MCFI paperwork (if applicable).
2. Send or drop off the Original complete Application to: **(Do Not Fax)**

Pamela Erdman, Quality Assurance Director
WRAPAROUND MILWAUKEE
9201 Watertown Plank Road
Milwaukee, WI 53226
3. The necessary information will then be forwarded to the MCFI representative, if the Provider is a paid employee.
4. It is the Provider's responsibility to keep all information current. Any change in the ability of the Provider to provide services must be reported to the Care Coordinator. The Care Coordinator is responsible for forwarding any **address changes** to the Wraparound Milwaukee Finance Department.
5. No eligible client shall be unlawfully denied services or be subjected to discrimination because of age, race, religion, color, national origin, sex, sexual orientation, location, disability, physical condition or developmental disability as defined in 51.01 (s) Wisconsin Statutes.



Orientation Information

1. Wraparound History

In 1994, Milwaukee County was awarded a five-year Federal Grant from the Center for Mental Health Services to initiate a coordinated system of community-based care and resources, called “Wraparound Services” for children with severe emotional, behavioral and mental health needs. The system of care now established is called “Wraparound Milwaukee”. Wraparound Milwaukee is operated by the Child & Adolescent Services Branch of the Milwaukee County Behavioral Health Division. Wraparound has evolved into a managed care system providing mental health and drug and alcohol treatment services to identified children and their families. Our funding now comes primarily from Medicaid and Youth Diversion monies.

Wraparound Milwaukee consists of a consortium of agencies providing family driven services to meet the complex needs of children and families.

2. What is Wraparound / REACH

Wraparound is a strength-based approach to service delivery that is based on identifying what “Needs” a child/family has and what is required to care for that child with severe emotional or behavioral problems; to identify natural supports, community supports, and professional resources to meet those needs, and to “wrap” services around the child and family. It is an approach that individualizes care rather than “fitting” a child into an existing service that may not be what the child or family needs.

Wraparound is designed to increase parent/caregiver choices in selecting services and service providers and promotes family independence rather than dependence by stressing that most often families or other caregivers know what is best for their child and family.

3. Target Group

The Wraparound Milwaukee / REACH program is targeted at serving children who meet the following qualifications:

- A current mental health disorder as defined in the DSM-IV – R.
- Functional impairments (i.e., psychotic symptoms, danger to self or others, impairment in community functioning).
- Involved in two or more service systems (i.e., mental health, child welfare, juvenile justice, social services, special education services).
- Are at imminent risk for out-of-home placement, inpatient psychiatric hospitalization or placement in a residential care center or juvenile correctional facility.

All areas of Milwaukee County are served.



Family Support Services

Job Description

(Primarily focuses on mentoring, but applicable to other Family Support Service Providers also.)

Definition/Objective

To act as a positive role model and advocate for severely emotionally disturbed children and/or their families who are in need of guidance and opportunities for social growth. Mentoring is a trusting one-to-one relationship that focuses on developing youth and family strengths, interests and needs. The primary purpose in mentoring is role modeling and building supports and partnerships with youth and families in their communities.

Eligibility Criteria

Must be at least 18 years old. Experience in working with youth is preferred, but not required.

Working Hours

As determined by the needs of the client, family and/or program, and the availability of the Provider.

Desired Traits/Requirements

- Must be able to work as a member of a Child & Family Team.
- Must be dependable and responsible.
- Must be flexible.
- Must enjoy working with children/adolescents.
- Must be nurturing and patient.
- Must be supportive and objective.
- Must use good judgment.
- Must possess good written, verbal, listening and communication skills.
- Must be able to problem solve independently.
- Must be open to a variety of cultural experiences.
- Must be outgoing and active.
- Must be able to provide structure.
- Must be able to set limits and provide appropriate consequences for undesirable behavior.
- Must be able to provide praise and reinforcement when desirable behavior is evident.
- Must be receptive to direction and feedback from the Child & Family Team.
- Must have knowledge of wraparound philosophy and believe in the strength-based approach.
- Must be able to provide emotional support in order to help the child sort out feelings and channel them productively.
- Must be able to provide objective and unconditional care and acceptance.
- Must have a valid Wisconsin Driver's License and auto insurance, if transporting youth and/or family members. If no Driver's License, Provider cannot transport.
- Must have a criminal background check completed and have met the requirements of the Wisconsin Caregiver Law and the Milwaukee County Caregiver Resolution.

Role Description

As a member of a Child & Family Team supported by the Wraparound / REACH program, a Family Support Provider would function as both a positive role model and advocate for a child or adolescent in his/her family system and community. Children would be matched with a Family Support Provider based on their needs and interests. A Family Support Provider could be involved in a

variety of activities with the child and/or family with the focus including, but not limited to, recreation, school related activities, social skills and peer relationship building, personal care/hygiene/exercise, etc. Direction, consultation and support will be provided by the Wraparound / REACH Care Coordinator and Child & Family Team. The time commitment will vary depending upon the needs of the child/family. A Family Support Provider is a valuable link in assisting children and families in developing needed skills and relationships as they grow.

Responsibilities

1. Have knowledge of the Wraparound / REACH philosophy regarding providing services/care.
2. Have knowledge of the Wraparound Family Support Services Policy & Procedure, have signed off on the P& P Form and have completed the necessary MCFI paperwork if he/she is a paid provider.
3. Work as a member of the Child & Family Team in assisting children and families in skills development. Role models and teaches skills referred to in the Role Description and any other skills that may be identified in the Plan of Care.
4. Communicate routinely with the Care Coordinator (verbally and in writing) to assure comprehensive care.

Reminder: The Family Support Provider is to immediately report to the Care Coordinator and/or Police or Child Protective Services any reported and/or witnessed neglect or physical, sexual or emotional abuse.

5. Documentation -- The work of the Family Support Provider must be documented routinely. This means that the Provider must fill out a Family Support Services Provider Log every time a child or family is seen (*see Form C in the Family Support Services Provider Application packet*). **The parent's/guardian's signature must be on every Log**, thus verifying that the contact/service did actually occur. These Logs must be turned in to the Care Coordinator at the end of every month. If a scheduled session with a client is cancelled for any reason, this should also be indicated on the Provider Log. Every Log must be signed by the Care Coordinator. The Logs must be reviewed by the Care Coordinator and feedback should be given to the Provider, as needed.
6. Participate in Child & Family Team/Plan of Care meetings led by the Wraparound / REACH Care Coordinator, in collaboration with the family and their support systems. Assist in the development of the Plan of Care and identifying the child's and family's strengths and needs.
7. Be accessible, if needed, to the child, family, and/or Care Coordinator according to the standards set by the Child & Family Team.
8. Complete the necessary paperwork as identified in the Family Support Services Policy & Procedure.



Family Support Services Provider Application

Instructions: The Provider applicant is to complete this form and submit it to the family's Care Coordinator. The Care Coordinator and/or Agency representative should review, approve and sign the application and then forward to Pamela Erdmann, QA/QI Director.

SECTION A - General Information

Name of Provider, Address, City, State, Zip, Telephone: Home, Work, Place of Employment, How Long?, Name of youth you will be working with, Are you related to this youth/family?, If yes, how?, Name of Family's Care Coordinator, Care Coordination Agency, Care Coordinator's Telephone Numbers: Office, Pager, Cell Phone

SECTION B - Identifying Provider Information

Name/Address/Telephone number of person to contact in case of emergency, Social Security #, Height, Weight, Birthdate, Eye Color, Hair Color, Do you have a valid Wisconsin Driver's License?, If yes, Driver's License #, Do you have current car insurance?, Name of Insurance Company, Insurance Agent's Name, Phone, Policy #, Effective Date, Expiration Date, Have you been charged with Driving While Under the Influence within the last 5 years?, If yes, date of charge

Does your driving record within the last 5 years reflect unsafe driving habits? _____ Yes _____ No

If yes, please explain _____

Have you ever been arrested for or convicted of a felony/criminal act/abuse or neglect/sexual abuse?

_____ Yes _____ No If yes, please explain: _____

Please list one non-relative personal reference:

Name _____

Relation _____ Phone _____

Please list two professional references:

Name _____

Relation _____ Phone _____

Name _____

Relation _____ Phone _____

Please describe your specific skills/interest in providing services to children, adolescents and/or families:

What day(s) and time(s) would you be available each week? _____

.....
SECTION C: Services

	<u>Rate</u>	<u>Unit</u>
<input type="checkbox"/> Respite Services	_____	_____
<input type="checkbox"/> Mentor	_____	_____
<input type="checkbox"/> Tutor Services	_____	_____
<input type="checkbox"/> Independent Living Skills	_____	_____
<input type="checkbox"/> Crisis Home/Beds (must have a foster home license)	_____	_____
<input type="checkbox"/> Supported Work Environment/Job Coach	_____	_____
<input type="checkbox"/> Child Care	_____	_____
<input type="checkbox"/> House Management Services	_____	_____
<input type="checkbox"/> Parent Assistance	_____	_____

.....
The Provider certifies that the information provided on this application is true and correct. Any misrepresentation on the part of the Provider on this form may result in disqualification from participation in the Wraparound Milwaukee program and legal action or fiscal sanctions may be taken as determined appropriate by Milwaukee County or its designated representative(s).

Signature of Applicant _____ Date _____

Care Coordinator / Agency _____ Date _____

.....
For Wraparound Use Only: Date Received _____ Approval Date _____
Approved By _____



AUTHORIZATION FOR RELEASE OF INFORMATION

PURPOSE OF DISCLOSURE:

Release of Mental Health and AODA (Alcohol and Other Drug Addiction) and physical health information that will be used to plan and provide for the care, treatment and services for:

_____ (Youth's Name) _____ (Date of Birth)

I authorize Wraparound Milwaukee, its contracted Care Coordination Agencies, and/or the Mobile Urgent Treatment Team to release/exchange health related information including diagnosis, prognosis, treatment and planning related to the above named youth's enrollment in Wraparound Milwaukee to the appropriate staff at the following agency/s that authorize enrollment or provide emergency services for families enrolled in the Wraparound Milwaukee program.

- Milwaukee County Children's Court
- Medicaid/Title 19
- Bureau of Milwaukee Child Welfare

Additionally, information as indicated below may be released to/received from the following:

SHARED DOCUMENTS/INFORMATION
(Check those that apply.)

	Demographic Information Only	Plan of Care	Referral for Services	Other * (See Below)
Milwaukee Public Schools/other school _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Families United of Milwaukee, Inc. (Family Advocate): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Primary Care Physician: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatrist: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental Services Provider: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____ Agency/Individual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____ Agency/Individual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Other Document/s: _____

CONSENT FOR INFORMATION TO BE USED IN RESEARCH

I give my consent for non-identifying evaluation data obtained during my enrollment in Wraparound to be used for research to evaluate the effectiveness of the program. I understand that this research may be presented at conferences, universities and in publications. I understand that information collected for this research is part of the usual Wraparound evaluation procedures. I understand that my family's confidentiality will be protected. No information that is presented to the public will contain any identifying information such as name, address or telephone number.

EXPIRATION OF AUTHORIZATION / WITHDRAWAL OF AUTHORIZATION

If not specified below, I understand that **this Authorization for Release of Information EXPIRES 12 MONTHS from the date it was signed.** I understand that **I may cancel this authorization at any time** (see back of sheet for instructions). This does not include any information that has been shared between the time I gave my consent to share information and the time that the consent was canceled.

This authorization expires on the _____ day of _____, 20_____.

REDISCLASURE NOTICE: I understand that information used or disclosed based on this authorization may be subject to redisclosure and no longer protected by Federal privacy standards.

Parent or Legal Guardian Signature _____ Date

Youth Signature (age 14 and older should sign) _____ Date

Witness Signature _____ Date

CLIENT RIGHTS RELATED TO AUTHORIZATION FOR RELEASE OF INFORMATION

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive Copy of This Authorization - I understand that if I sign this authorization, I will be provided with a copy of this authorization.

Right to Refuse to Sign This Authorization - I understand that I am under no obligation to sign this form and that Wraparound Milwaukee may not condition treatment, payment, or enrollment on my decision to sign this authorization.

Failure to Sign - I understand that failure to sign this authorization may severely limit the treatment / service options available for my child or family and/or may result in a request to the courts to modify the court order that allows for enrollment in the Wraparound Milwaukee program.

Right to Withdraw This Authorization - I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to Pamela Erdman, Wraparound Milwaukee Quality Assurance. (The statement must be dated and signed). I am aware that my withdrawal will not be effective until received by Wraparound Milwaukee and will not be effective regarding the uses and/or disclosures of my health information that Wraparound Milwaukee has made prior to receipt of my withdrawal statement

Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Pamela Erdman in the Wraparound Milwaukee Quality Assurance Department.

HIV Test Results - I understand my child's HIV test results may be released without authorization to persons/organizations that have access under State law and a list of those persons/organizations is available upon request.

Submit your written requests for withdrawal to:

Ms. Pamela Erdman, Wraparound Milwaukee Quality Assurance Director
Wraparound Milwaukee Administrative Offices
9201 Watertown Plank Road
Milwaukee, WI 53226 Phone: (414) 257-7608



AUTHORIZATION FOR RELEASE OF INFORMATION

PURPOSE OF DISCLOSURE:

Release of Mental Health and AODA (Alcohol and Other Drug Addiction) and physical health information that will be used to plan and provide for the care, treatment and services for:

(Youth's Name)

(Date of Birth)

I authorize Wraparound Milwaukee, its contracted Care Coordination Agencies, and/or the Mobile Urgent Treatment Team to release/exchange health related information including diagnosis, prognosis, treatment and planning related to the above named youth's enrollment in Wraparound Milwaukee to the appropriate staff at the State of Wisconsin/Title 19 Program that authorizes enrollment or provide emergency services for families enrolled in the Wraparound Milwaukee program.

Additionally, information as indicated below may be released to/received from the following:

SHARED DOCUMENTS/INFORMATION (Check those that apply.)

Table with 5 columns: Demographic Information Only, Plan of Care, Referral for Services, Other * (See Below). Rows include Milwaukee Public Schools, Families United of Milwaukee, Inc., Primary Care Physician, Psychiatrist, Dental Services Provider, and Other (Agency/Individual).

*Other Document/s: _____

CONSENT FOR INFORMATION TO BE USED IN RESEARCH

I give my consent for non-identifying evaluation data obtained during my enrollment in Wraparound to be used for research to evaluate the effectiveness of the program. I understand that this research may be presented at conferences, universities and in publications. I understand that information collected for this research is part of the usual Wraparound evaluation procedures. I understand that my family's confidentiality will be protected. No information that is presented to the public will contain any identifying information such as name, address or telephone number.

EXPIRATION OF AUTHORIZATION / WITHDRAWAL OF AUTHORIZATION

If not specified below, I understand that this Authorization for Release of Information EXPIRES 12 MONTHS from the date it was signed. I understand that I may cancel this authorization at any time (see back of sheet for instructions). This does not include any information that has been shared between the time I gave my consent to share information and the time that the consent was canceled.

This authorization expires on the _____ day of _____, 20_____.

REDISCLASURE NOTICE: I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

Parent or Legal Guardian Signature _____ Date _____

Youth Signature (age 14 and older should sign) _____ Date _____

Witness Signature _____ Date _____

CLIENT RIGHTS RELATED TO AUTHORIZATION FOR RELEASE OF INFORMATION

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive Copy of This Authorization - I understand that if I sign this authorization, I will be provided with a copy of this authorization.

Right to Refuse to Sign This Authorization - I understand that I am under no obligation to sign this form and that Wraparound Milwaukee may not condition treatment, payment, or enrollment on my decision to sign this authorization.

Failure to Sign - I understand that failure to sign this authorization may severely limit the treatment / service options available for my child or family and/or may result in a request to the courts to modify the court order that allows for enrollment in the Wraparound Milwaukee program.

Right to Withdraw This Authorization - I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to Pamela Erdman, Wraparound Milwaukee Quality Assurance. (The statement must be dated and signed). I am aware that my withdrawal will not be effective until received by Wraparound Milwaukee and will not be effective regarding the uses and/or disclosures of my health information that Wraparound Milwaukee has made prior to receipt of my withdrawal statement

Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Pamela Erdman in the Wraparound Milwaukee Quality Assurance Department.

HIV Test Results - I understand my child's HIV test results may be released without authorization to persons/organizations that have access under State law and a list of those persons/organizations is available upon request.

Submit your written requests for withdrawal to:

Ms. Pamela Erdman, Wraparound Milwaukee Quality Assurance Director
Wraparound Milwaukee Administrative Offices
9201 Watertown Plank Road
Milwaukee, WI 53226 Phone: (414) 257-7608



Admissions Consent Form

Youth's Name _____

The following items needing consent are essential to the care and treatment of your child, please read each section and indicate your consent by initialing the appropriate line at the end of this form. If you do not consent, do not place your initials on the line.

Consent For Emergency Care

I authorize the Family Support Provider to act on my behalf in case my child is victim of major accident, injury or illness when immediate medical or surgical care is needed, provided that the Family Support Provider make diligent effort to get in touch with me are unsuccessful. I authorize the Family Support Provider to make such action and give such consent on my behalf as his/her judgment dictates. In the event of any such emergency, I can be reached at this telephone number:

_____. Initials: _____

Consent or Participation in Activities

I hereby give consent for my child to participate in supervised sports and recreational activities which are scheduled as part of the Plan of Care recognizing that some of these activities may be provided outside of the home and require transportation outside of the county.

I understand and acknowledge that some of the activities may involve unanticipated risks that could result in injury to the child, to myself, to property or to third parties.

I expressly agree and promise to accept and assume all of the risks involved in activities within and outside my home. Initials:

Consent/Waiver of Responsibility for Personal Property

I give my consent for my child to possess certain items of personal property. I understand that the Wraparound Program/Service Provider is not responsible for the loss, theft or damage of personal property or money which your child may have in their possession while on outings. Initials: _____

.....

I have read all the information pertaining to the above items needing consent and have indicated my approval by initialing the appropriate lines.

By signing this document, I acknowledge that if anyone is hurt or property is damaged during my son's/daughter's participation in any activity supervised the by Family Support Providers, I will have no right to make a claim or file a lawsuit against the Wraparound Milwaukee Agencies, their agents, owners, officers, employees or any other person or entity acting in any capacity on their behalf.

Date, Event or Condition upon which Consent will Expire

If not specified above, I understand that this Admissions Consent expires 12 months from the date it was signed. I also understand that I may cancel this consent at any time by stating so in writing with the date and my signature. This does not include any information which has been shared between the time I gave my consent to share information and the time that such consent was canceled.

Parent or Guardian's Signature

Date

Care Coordinator / Witness Signature

Date

Family Service Provider Signature

Date



PROVIDER REFERRAL FORM

Reminder: Providers please assure that the initial visit is done with the Care Coordinator.

Referral Completion Date _____

Referred by:

Name of Care Coordinator _____ Name of Care Coordination Agency _____
Phone (____) _____ Pager (____) _____ Cell Phone (____) _____

Name of Provider/Agency being referred to: _____

Address _____

City _____ State _____ Zip _____

Name of Provider Contact Person _____ Phone (____) _____

1. **Service being requested:** _____ Service Code _____

Frequency / Days & Times being requested: _____

2. **Service being requested:** _____ Service Code _____

Frequency / Days & Times being requested: _____

3. **Service being requested:** _____ Service Code _____

Frequency / Days & Times being requested: _____

4. **Service being requested:** _____ Service Code _____

Frequency / Days & Times being requested: _____

Name of Client being Referred: _____ Phone (____) _____

Address _____

City _____ State _____ Zip _____

Name of associated WM Enrollee (if different than client being referred) _____

Relationship of Referred Client to WM Enrollee (if not the same – i.e., mother, sibling, etc.) _____

Client Lives With: _____ **Relationship:** _____

Ethnicity: African American Caucasian Hispanic Native American Asian Other _____

Gender: Male Female **DOB:** _____ **SSN:** _____

Special Accommodation Needs, if any (i.e., physical and sensory disabilities, medical needs, limitations, etc):

FAMILY/SCHOOL INFORMATION

Mother/Legal Guardian _____ Home Phone (____) _____

Address _____ Work Phone (____) _____

City _____ State _____ Zip _____

Father/Legal Guardian _____ Home Phone (____) _____
Address _____ Work Phone (____) _____
City _____ State _____ Zip _____

Other Emergency Contact _____ Home Phone (____) _____
Address _____ Work Phone (____) _____
City _____ State _____ Zip _____
Relationship to Client _____

Siblings/Children: *(Not required for transportation services if only transporting identified client.)*

- 1. _____ **DOB** _____
- 2. _____ **DOB** _____
- 3. _____ **DOB** _____
- 4. _____ **DOB** _____

School _____ Not Attending Not Enrolled N/A

Grade _____ **Special Education:** Yes No

GENERAL INFORMATION

Diagnosis: *(Required only if referring to medical or mental health providers.)*

Currently on Medication? Yes No **If yes, what type?** _____

Strengths/Interests: *(Not required for transportation referrals.)*

Needs/Reason for Referral: *(Not required for transportation referrals.)*

Safety Concerns: _____

.....

(For Provider Agency Use Only)

Date Referral was Received _____

**MCFI FISCAL AGENT PROGRAM**

(for Payments to Non-Agency Providers)

Procedure

Note: The Care Coordinator should assist the Provider with the completion of these forms. Please complete the forms using Black Ink only.

1. **Provider Application** (for specific child/family) – Should be completed and signed by the individual Provider. The Care Coordinator should also sign the application. Be sure the Provider has indicated the agreed upon unit and rate on the form.
Note: A separate application, including all the MCFI paperwork, must be completed on every youth/parent receiving Family Support Services.
2. **W-4 Form** – The Individual Provider should complete and sign. The Provider should indicate the number of exemptions they wish to claim for tax purposes. Deductions will be taken from each check based on the information from the W-4 Form (*see attached sample & blank form*).
3. **Employer/Payer Appointment of Agent Form (#2678)** – Should be signed by parent/legal guardian. This form authorizes MCFI to act as the fiscal agent for the parent/legal guardian, who is employing the individual Providers. MCFI will obtain an Employer Identification Number for the parent/legal guardian after this form is received (*see attached sample & blank form*).
4. **MCFI Fiscal Agent Authorization Form** – Should be completed by the Care Coordinator and signed by the parent/legal guardian. This simply lists the Provider(s) who will provide services for the child/family, and the specific rates/units approved for each service. The Care Coordinator should keep a copy of this form, as this form can be used to add and delete Providers or Clients.
Note: This form should be submitted each time there is a change in Providers, service, rate, or authorized payroll signature (*see attached sample & blank form*).
5. **U.S. Department of Justice - Employment Eligibility Verification Form I-9**
This form is required to verify that the potential Provider/Employee is eligible to work in the United States (*see attached sample & blank form*).
Section One -- Employee Information and Verification are to be completed by the Provider/Employee, who must sign and date the form.
Section Two -- Employer Review and Verification are completed by the Care Coordinator utilizing the guide entitled “Lists of Acceptable Documents” located on the back of the form. The Care Coordinator must get information from one document under List A or one document from both List B & C. The Care Coordinator should then sign and date Section Two.
Section Three -- Updating and Reverification. **DO NOT COMPLETE THIS SECTION.**
6. Care Coordinator to give Provider copies of the “MCFI – Fiscal Agent – Direct Deposit Informational Letter” and “Direct Deposit Authorization Form” (*see Samples in Packet*).

Once the forms have been completed and signed, the **Originals** should be submitted to Wraparound Milwaukee – Pamela Erdman, who will approve the Application and then complete the paperwork and forward it to MCFI.

Note: The Care Coordinator should keep a copy of all the forms and provide the parent/legal guardian and Provider with copies, as requested.

Authorization / Payment Process Requirements

1. Once Wraparound has processed the paperwork, the Care Coordinator can request the identified services the SAR through Synthesis.
2. Individual Providers will receive a monthly Employee Time Report from MCFI, along with an envelope addressed to MCFI (*see sample of Time Report attached*). Wraparound Milwaukee will send the initial Employee Time Report to all new Providers.
Care Coordinator: Please share the sample with the Provider so that they are aware of how to complete the Employee Time Report. The Employee Time Report will inform them of the total number of units authorized for the month.
3. Providers will need to list, by date, the time services were provided, and the number of units provided each day. Providers will then need to total the number of units for the month. Providers will need to sign the Employee Time Report, which also **needs to be signed by the parent/guardian as the employer verifying that the services occurred.**
4. Providers will need to write a brief summary of the activities for the month (i.e., describe the services provided) on the Employee Time Report.
5. Time Reports should be mailed directly to MCFI for payment. Payments will be processed on the 15th and 30th of the month.
6. Time Reports are due **no later than 60 days after the end of the service period.**

Responsibilities

Individual Provider (Employee)

1. With assistance from the Care Coordinator complete Wraparound Provider Application (for specific child), W-4 form, and Employment Eligibility Verification Form I-9.
2. Log services provided daily on the Employee Time Report; total for month.
3. Sign the Employee Time Report, and have the parent/guardian sign it verifying provision of services.
4. Mail Employee Time Report to MCFI for payment.
5. Notify Care Coordinator of any changes in address/phone number or other significant information. The Care Coordinator is then responsible for relaying this information to Pamela Erdman in the Wraparound Milwaukee Quality Assurance Department.

Parent/Guardian (Employer)

1. With the assistance of the Care Coordinator, complete and sign the Employer/Payer Appointment of Agent (form #2678) and the Fiscal Agent Authorization form.
2. Sign monthly Employee Time Report of the Provider verifying services occurred.

Wraparound Milwaukee

1. Forward all necessary paperwork to MCFI for processing.
2. Send confirmation of services being rendered, initial timecard and other paperwork to employee.
3. Enter all applicable information into Synthesis, enabling Provider to be entered onto a Service Authorization Request (SAR) and be paid through MCFI.

MCFI

1. Obtain Employer Identification Numbers for Parents.
2. Process W-4 forms for non-agency Providers.
3. Based on information provided by Wraparound, MCFI will handle the payroll for all non-agency Providers.
4. Access monthly client authorizations through Synthesis.

Form W-4 (2009)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2009 expires February 16, 2010. See Pub. 505, Tax Withholding and Estimated Tax.

Note. You cannot claim exemption from withholding if (a) your income exceeds \$950 and includes more than \$300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on their tax return.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earner/multiple job situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or

dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 919 for details.

Nonresident alien. If you are a nonresident alien, see the Instructions for Form 8233 before completing this Form W-4.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2009. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself if no one else can claim you as a dependent	A	_____			
B	Enter "1" if: <table border="0" style="display: inline-table; vertical-align: middle;"> <tr> <td style="font-size: 3em; vertical-align: middle;">{</td> <td style="padding: 0 10px;"> <ul style="list-style-type: none"> • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. </td> <td style="font-size: 3em; vertical-align: middle;">}</td> </tr> </table>	{	<ul style="list-style-type: none"> • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. 	}	B	_____
{	<ul style="list-style-type: none"> • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. 	}				
C	Enter "1" for your spouse . But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C	_____			
D	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return	D	_____			
E	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above)	E	_____			
F	Enter "1" if you have at least \$1,800 of child or dependent care expenses for which you plan to claim a credit	F	_____			
(Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)						
G	Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. <ul style="list-style-type: none"> • If your total income will be less than \$61,000 (\$90,000 if married), enter "2" for each eligible child; then less "1" if you have three or more eligible children. • If your total income will be between \$61,000 and \$84,000 (\$90,000 and \$119,000 if married), enter "1" for each eligible child plus "1" additional if you have six or more eligible children. 	G	_____			
H	Add lines A through G and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.) ▶	H	_____			
For accuracy, complete all worksheets that apply. <table border="0" style="display: inline-table; vertical-align: middle;"> <tr> <td style="font-size: 3em; vertical-align: middle;">{</td> <td style="padding: 0 10px;"> <ul style="list-style-type: none"> • If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2. • If you have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$40,000 (\$25,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld. • If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below. </td> <td style="font-size: 3em; vertical-align: middle;">}</td> </tr> </table>				{	<ul style="list-style-type: none"> • If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2. • If you have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$40,000 (\$25,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld. • If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below. 	}
{	<ul style="list-style-type: none"> • If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2. • If you have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$40,000 (\$25,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld. • If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below. 	}				

----- Cut here and give Form W-4 to your employer. Keep the top part for your records. -----

Form W-4 Department of the Treasury Internal Revenue Service	<h2 style="margin: 0;">Employee's Withholding Allowance Certificate</h2> <p style="margin: 0;">▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</p>	OMB No. 1545-0074 2009
1 Type or print your first name and middle initial. Last name		2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
City or town, state, and ZIP code		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ <input type="checkbox"/>
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		5 _____ 6 \$ _____
7 I claim exemption from withholding for 2009, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here ▶		7 _____
Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.		
Employee's signature (Form is not valid unless you sign it.) ▶		Date ▶
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)		9 Office code (optional) 10 Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions, claim certain credits, adjustments to income, or an additional standard deduction

1 Enter an estimate of your 2009 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions. (For 2009, you may have to reduce your itemized deductions if your income is over \$166,800 (\$83,400 if married filing separately). See *Worksheet 2* in Pub. 919 for details.) . . . **1** \$ _____

2 Enter: $\left\{ \begin{array}{l} \$11,400 \text{ if married filing jointly or qualifying widow(er)} \\ \$ 8,350 \text{ if head of household} \\ \$ 5,700 \text{ if single or married filing separately} \end{array} \right\}$ **2** \$ _____

3 **Subtract** line 2 from line 1. If zero or less, enter “-0-” **3** \$ _____

4 Enter an estimate of your 2009 adjustments to income and any additional standard deduction. (Pub. 919) **4** \$ _____

5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from *Worksheet 8* in Pub. 919.) **5** \$ _____

6 Enter an estimate of your 2009 nonwage income (such as dividends or interest) **6** \$ _____

7 **Subtract** line 6 from line 5. If zero or less, enter “-0-” **7** \$ _____

8 **Divide** the amount on line 7 by \$3,500 and enter the result here. Drop any fraction **8** _____

9 Enter the number from the **Personal Allowances Worksheet**, line H, page 1 **9** _____

10 **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet**, also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 **10** _____

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) **1** _____

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However**, if you are married filing jointly and wages from the highest paying job are \$50,000 or less, do not enter more than “3.” **2** _____

3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter “-0-”) and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet **3** _____

Note. If line 1 is *less than* line 2, enter “-0-” on Form W-4, line 5, page 1. Complete lines 4–9 below to calculate the additional withholding amount necessary to avoid a year-end tax bill.

4 Enter the number from line 2 of this worksheet **4** _____

5 Enter the number from line 1 of this worksheet **5** _____

6 **Subtract** line 5 from line 4 **6** _____

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here **7** \$ _____

8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed **8** \$ _____

9 Divide line 8 by the number of pay periods remaining in 2009. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2008. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck **9** \$ _____

Table 1

Table 2

Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above	If wages from HIGHEST paying job are—	Enter on line 7 above	If wages from HIGHEST paying job are—	Enter on line 7 above
\$0 - \$4,500	0	\$0 - \$6,000	0	\$0 - \$65,000	\$550	\$0 - \$35,000	\$550
4,501 - 9,000	1	6,001 - 12,000	1	65,001 - 120,000	910	35,001 - 90,000	910
9,001 - 18,000	2	12,001 - 19,000	2	120,001 - 185,000	1,020	90,001 - 165,000	1,020
18,001 - 22,000	3	19,001 - 26,000	3	185,001 - 330,000	1,200	165,001 - 370,000	1,200
22,001 - 26,000	4	26,001 - 35,000	4	330,001 and over	1,280	370,001 and over	1,280
26,001 - 32,000	5	35,001 - 50,000	5				
32,001 - 38,000	6	50,001 - 65,000	6				
38,001 - 46,000	7	65,001 - 80,000	7				
46,001 - 55,000	8	80,001 - 90,000	8				
55,001 - 60,000	9	90,001 - 120,000	9				
60,001 - 65,000	10	120,001 and over	10				
65,001 - 75,000	11						
75,001 - 95,000	12						
95,001 - 105,000	13						
105,001 - 120,000	14						
120,001 and over	15						

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

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

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

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

Form W-4 (2007)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Because your tax situation may change, you may want to refigure your withholding each year.

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2007 expires February 16, 2008. See Pub. 505, Tax Withholding and Estimated Tax.

Note. You cannot claim exemption from withholding if (a) your income exceeds \$650 and includes more than \$300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on their tax return.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 adjust your withholding allowances based on

itemized deductions, certain credits, adjustments to income, or two-earner/multiple job situations. Complete all worksheets that apply. However, you may claim fewer (or zero) allowances.

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependents, or other qualifying individuals.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax

for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners/Multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others.

Nonresident alien. If you are a nonresident alien, see the instructions for Form 8233 before completing this Form W-4.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the dollar amount you are having withheld compares to your projected total tax for 2007. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for yourself if no one else can claim you as a dependent. A _____

B Enter "1" if: B _____

- You are single and have only one job; or
- You are married, have only one job, and your spouse does not work; or
- Your wages from a second job or your spouse's wages (or the total of both) are \$1,000 or less.

C Enter "1" for your spouse. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) C _____

D Enter number of dependents (other than your spouse or yourself) you will claim on your tax return D _____

E Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above) E _____

F Enter "1" if you have at least \$1,500 of child or dependent care expenses for which you plan to claim a credit F _____

(Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

G Child Tax Credit (including additional child tax credit). See Pub 972, Child Tax Credit, for more information. G _____

- If your total income will be less than \$57,000 (\$85,000 if married), enter "2" for each eligible child.
- If your total income will be between \$57,000 and \$84,000 (\$85,000 and \$119,000 if married), enter "1" for each eligible child plus "1" additional if you have 4 or more eligible children.

H Add lines A through G and enter total here. Note. This may be different from the number of exemptions you claim on your tax return. H _____

For accuracy, complete all worksheets that apply. ▶

- If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$40,000 (\$25,000 if married) see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.

Cut here and give Form W-4 to your employer. Keep the top part for your records.

Form W-4 Department of the Treasury Internal Revenue Service	<h2>Employee's Withholding Allowance Certificate</h2> <p>▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</p>	OMB No. 1545-0074 <div style="font-size: 2em; font-weight: bold;">2007</div>
1 Type or print your first name and middle initial. Last name Mary A. MARKS		2 Your social security number 999 00 9999
Home address (number and street or rural route) 99 S. 60th ST.		3 <input checked="" type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
City or town, state, and ZIP code WEST ALLIS, WI 53000		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. <input type="checkbox"/>
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		5 <u>7</u>
6 Additional amount, if any, you want withheld from each paycheck		6 \$
7 I claim exemption from withholding for 2007, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here ▶ 7		
Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.		
Employee's signature (Form is not valid unless you sign it.) ▶ Mary A MARKS		Date ▶ 5/18/07
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.) JOHN DOE 31N. FLOWER ST. MILW, WI		9 Office code (optional) 10 Employer identification number (EIN) 53331

✱ youths name & address

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions, claim certain credits, or claim adjustments to income on your 2007 tax return.

- 1 Enter an estimate of your 2007 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions. (For 2007, you may have to reduce your itemized deductions if your income is over \$156,400 (\$78,200 if married filing separately). See *Worksheet 2* in Pub. 919 for details.) 1 \$ _____
- 2 Enter:

{	\$10,700 if married filing jointly or qualifying widow(er) \$ 7,850 if head of household \$ 5,350 if single or married filing separately	}
---	--	---

2 \$ _____
- 3 Subtract line 2 from line 1. If zero or less, enter "-0-" 3 \$ _____
- 4 Enter an estimate of your 2007 adjustments to income, including alimony, deductible IRA contributions, and student loan interest 4 \$ _____
- 5 Add lines 3 and 4 and enter the total. (Include any amount for credits from *Worksheet 8* in Pub. 919) 5 \$ _____
- 6 Enter an estimate of your 2007 nonwage income (such as dividends or interest) 6 \$ _____
- 7 Subtract line 6 from line 5. If zero or less, enter "-0-" 7 \$ _____
- 8 Divide the amount on line 7 by \$3,400 and enter the result here. Drop any fraction 8 _____
- 9 Enter the number from the **Personal Allowances Worksheet**, line H, page 1 9 _____
- 10 Add lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet**, also enter this total on line 1 below. Otherwise, stop here and enter this total on Form W-4, line 5, page 1 10 _____

Two-Earners/Multiple Jobs Worksheet (See *Two earners/multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

- 1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) 1 _____
- 2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. However, if you are married filing jointly and wages from the highest paying job are \$50,000 or less, do not enter more than "3." 2 _____
- 3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. Do not use the rest of this worksheet 3 _____

Note. If line 1 is *less than* line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4-9 below to calculate the additional withholding amount necessary to avoid a year-end tax bill.

- 4 Enter the number from line 2 of this worksheet 4 _____
- 5 Enter the number from line 1 of this worksheet 5 _____
- 6 Subtract line 5 from line 4 6 _____
- 7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here 7 \$ _____
- 8 Multiply line 7 by line 6 and enter the result here. This is the additional annual withholding needed 8 \$ _____
- 9 Divide line 8 by the number of pay periods remaining in 2007. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2006. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck 9 \$ _____

Table 1

Married Filing Jointly		All Others	
If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above
\$0 - \$4,500	0	\$0 - \$6,000	0
4,501 - 9,000	1	6,001 - 12,000	1
9,001 - 18,000	2	12,001 - 19,000	2
18,001 - 22,000	3	19,001 - 26,000	3
22,001 - 26,000	4	26,001 - 35,000	4
26,001 - 32,000	5	35,001 - 50,000	5
32,001 - 38,000	6	50,001 - 65,000	6
38,001 - 46,000	7	65,001 - 80,000	7
46,001 - 55,000	8	80,001 - 90,000	8
55,001 - 60,000	9	90,001 - 120,000	9
60,001 - 65,000	10	120,001 and over	10
65,001 - 75,000	11		
75,001 - 95,000	12		
95,001 - 105,000	13		
105,001 - 120,000	14		
120,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from HIGHEST paying job are—	Enter on line 7 above	If wages from HIGHEST paying job are—	Enter on line 7 above
\$0 - \$65,000	\$510	\$0 - \$35,000	\$510
65,001 - 120,000	850	35,001 - 80,000	850
120,001 - 170,000	950	80,001 - 150,000	950
170,001 - 300,000	1,120	150,001 - 340,000	1,120
300,001 and over	1,190	340,001 and over	1,190

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

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

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

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

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

OMB No. 1545-0748

(Rev. May 2007) Department of the Treasury — Internal Revenue Service

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.

For IRS use:

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

Note: This appointment is not effective until we approve your request. See the instructions for your reporting, deposit, and payment requirements while we are processing your request.

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

Part 1: Why you are filing this form...

(Check one)

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

Part 2: Employer or Payer Information: If you want to appoint an agent or revoke an appointment, complete this part.

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

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	For SOME employees/ payees
Form 941, 941-PR, 941-SS (Employer's QUARTERLY Federal Tax Return)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Form 943, 943-PR (Employer's Annual Federal Tax Return for Agricultural Employees)	<input type="checkbox"/>	<input type="checkbox"/>
Form 944, 944-PR, 944-SS, 944(SP) (Employer's ANNUAL Federal Tax Return)	<input type="checkbox"/>	<input type="checkbox"/>
Form 945 (Annual Return of Withheld Federal Income Tax)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Form 1042 (Annual Withholding Tax Return for U.S. Source Income of Foreign Persons)	<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"/>

Note: You may NOT appoint an agent to report, deposit, and pay taxes reported on Form 940, Employer's Annual Federal Unemployment (FUTA) Tax Return.

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.

X Sign your name here Print your name here
 Date / / Print your title here **Employer**
 Best daytime phone (414) 937 - 2174

Now give this form to the agent to complete. →

Part 3: Agent Information: If you will be an agent for an employer or payer, or want to revoke an appointment, complete this part.

6 Agent's employer identification number (EIN) -

7 Agent's name (not trade name)

8 Trade name (if any)

9 Address

Number Street Suite or room number

City State ZIP code

Check here if the employer is a disabled individual or other welfare recipient receiving home-care services through a state or local program

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

X Sign your name here

Richard Zalewski

Print your name here

Print your title here

Date

Best daytime phone

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

OMB No. 1545-0748

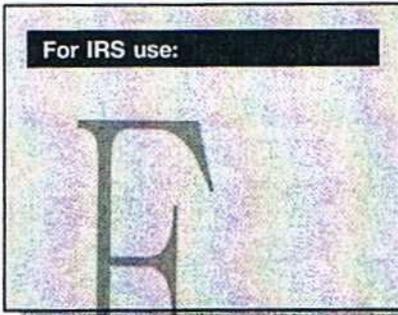
(Rev. May 2007) Department of the Treasury — Internal Revenue Service

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

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

Note: This appointment is not effective until we approve your request. See the instructions for your reporting, deposit, and payment requirements while we are processing your request.

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



Part 1: Why you are filing this form...

(Check one)

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

Part 2: Employer or Payer Information: If you want to appoint an agent or revoke an appointment, complete this part.

1 Employer identification number (EIN)

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

3 Trade name (if any)

4 Address *NEED youth's address*

Number Street Suite or room number

City State ZIP 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	For SOME employees/ payees
Form 941, 941-PR, 941-SS (Employer's QUARTERLY Federal Tax Return)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Form 943, 943-PR (Employer's Annual Federal Tax Return for Agricultural Employees)	<input type="checkbox"/>	<input type="checkbox"/>
Form 944, 944-PR, 944-SS, 944(SP) (Employer's ANNUAL Federal Tax Return)	<input type="checkbox"/>	<input type="checkbox"/>
Form 945 (Annual Return of Withheld Federal Income Tax)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Form 1042 (Annual Withholding Tax Return for U.S. Source Income of Foreign Persons)	<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"/>

Note: You may NOT appoint an agent to report, deposit, and pay taxes reported on Form 940, Employer's Annual Federal Unemployment (FUTA) Tax Return.

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.

X Sign your name here Print your name here *NEED PRINTED NAME of legal guardian*

Date Print your title here

Best daytime phone

Now give this form to the agent to complete. →

NEED signature of legal guardian

Part 3: Agent Information: If you will be an agent for an employer or payer, or want to revoke an appointment, complete this part.

6 Agent's employer identification number (EIN) -

7 Agent's name (not trade name)

8 Trade name (if any)

9 Address

Number Street Suite or room number

City State ZIP code

Check here if the employer is a disabled individual or other welfare recipient receiving home-care services through a state or local program

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

X Sign your name here

Richard Zalewski

Print your name here

Print your title here

Date

Best daytime phone

Please read instructions carefully before completing this form. The instructions must be available during completion of this form. **ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work eligible individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification. To be completed and signed by employee at the time employment begins.

Print Name: Last	First	Middle Initial	Maiden Name
Address (Street Name and Number)		Apt. #	Date of Birth (month/day/year)
City	State	Zip Code	Social Security #

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):

- A citizen or national of the United States
- A Lawful Permanent Resident (Alien #) A _____
- An alien authorized to work until _____
(Alien # or Admission #) _____

Employee's Signature	Date (month/day/year)
----------------------	-----------------------

Preparer and/or Translator Certification. (To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Preparer's/Translator's Signature	Print Name
Address (Street Name and Number, City, State, Zip Code)	
Date (month/day/year)	

Section 2. Employer Review and Verification. To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number and expiration date, if any, of the document(s).

List A	OR	List B	AND	List C
Document title: _____		_____		_____
Issuing authority: _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____

CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) _____ and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment.)

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name	Address (Street Name and Number, City, State, Zip Code)	
		Date (month/day/year)

Section 3. Updating and Reverification. To be completed and signed by employer.

A. New Name (if applicable)	B. Date of Rehire (month/day/year) (if applicable)
C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.	
Document Title: _____	Document #: _____
Expiration Date (if any): _____	

I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible 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	Date (month/day/year)
--	-----------------------

LISTS OF ACCEPTABLE DOCUMENTS

LIST A	LIST B	LIST C		
Documents that Establish Both Identity and Employment Eligibility	Documents that Establish Identity	Documents that Establish Employment Eligibility		
<ol style="list-style-type: none"> 1. U.S. Passport (unexpired or expired) 2. Certificate of U.S. Citizenship (Form N-560 or N-561) 3. Certificate of Naturalization (Form N-550 or N-570) 4. Unexpired foreign passport, with I-551 stamp or attached Form I-94 indicating unexpired employment authorization 5. Permanent Resident Card or Alien Registration Receipt Card with photograph (Form I-151 or I-551) 6. Unexpired Temporary Resident Card (Form I-688) 7. Unexpired Employment Authorization Card (Form I-688A) 8. Unexpired Reentry Permit (Form I-327) 9. Unexpired Refugee Travel Document (Form I-571) 10. Unexpired Employment Authorization Document issued by DHS that contains a photograph (Form I-688B) 	OR	<ol style="list-style-type: none"> 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 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 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <li style="padding-left: 20px;">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 	AND	<ol style="list-style-type: none"> 1. U.S. social security card issued by the Social Security Administration (other than a card stating it is not valid for employment) 2. Certification of Birth Abroad issued by the Department of State (Form FS-545 or Form DS-1350) 3. Original or certified copy of a birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. ID Card for use of Resident Citizen in the United States (Form I-179) 7. Unexpired employment authorization document issued by DHS (other than those listed under List A)

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274)

Please read instructions carefully before completing this form. The instructions must be available during completion of this form. ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification. To be completed and signed by employee at the time employment begins.

Print Name: Last PROVIDER First COMPLETES Middle Initial _____ Maiden Name _____
 Address (Street Name and Number) _____ Apt # _____ Date of Birth (month/day/year) _____
 City _____ State _____ Zip Code _____ Social Security # _____

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:
 A citizen or national of the United States
 A Lawful Permanent Resident (Alien #) A _____
 An alien authorized to work until _____
 (Alien # or Admission #) _____

Employee's Signature PROVIDERS SIGNATURE Date (month/day/year) DATE SIGNED

Preparer and/or Translator Certification. (To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Preparer's/Translator's Signature _____ Print Name COMPLETE THIS SECTION IF SECTION 1 ABOVE IS
 Address (Street Name and Number, City, State, Zip Code) _____ Date (month/day/year) filled out by someone other than Provider

Section 2. Employer Review and Verification. To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number and expiration date, if any, of the document(s).

EXAMPLE

List A	OR	List B	AND	List C
Document title: <u>US PASSPORT</u>		<u>DRIVERS LICENSE</u>		<u>SOCIAL SECURITY CARD</u>
Issuing authority: <u>US Govt.</u>		<u>DEPT. OF MOTOR VEHICLES</u>		<u>S.S. ADMINISTRATION</u>
Document #: <u>6666789</u>		<u># 7895032106</u>		<u># 035-56-2359</u>
Expiration Date (if any): <u>1/1/09</u>		<u>11/16/08</u>		<u>-</u>
Document #: _____				
Expiration Date (if any): _____				

CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) _____ and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment.)

Signature of Employer or Authorized Representative CARE COORDINATOR STIGNS & Print Name _____ Title _____
 Business or Organization Name COMPLETES THIS AREA Address (Street Name and Number, City, State, Zip Code) _____ Date (month/day/year) _____

Section 3. Updating and Reverification. To be completed and signed by employer.

A. New Name (if applicable) _____ B. Date of Rehire (month/day/year) (if applicable) _____
 C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility. Document Title _____ Document #: _____ Expiration Date (if any): _____
 I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible 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 _____ Date (month/day/year) _____

LISTS OF ACCEPTABLE DOCUMENTS

LIST A	LIST B	LIST C		
Documents that Establish Both Identity and Employment Eligibility	Documents that Establish Identity	Documents that Establish Employment Eligibility		
<ol style="list-style-type: none"> 1. U.S. Passport (unexpired or expired) 2. Certificate of U.S. Citizenship (Form N-560 or N-561) 3. Certificate of Naturalization (Form N-550 or N-570) 4. Unexpired foreign passport, with I-551 stamp or attached Form I-94 indicating unexpired employment authorization 5. Permanent Resident Card or Alien Registration Receipt Card with photograph (Form I-151 or I-551) 6. Unexpired Temporary Resident Card (Form I-688) 7. Unexpired Employment Authorization Card (Form I-688A) 8. Unexpired Reentry Permit (Form I-327) 9. Unexpired Refugee Travel Document (Form 1-571) 10. Unexpired Employment Authorization Document issued by DHS that contains a photograph (Form I-688B) 	OR	<ol style="list-style-type: none"> 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 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 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <p style="text-align: center; margin: 5px 0;">For persons under age 18 who are unable to present a document listed above:</p> <ol style="list-style-type: none"> 10. School record or report card 11. Clinic, doctor or hospital record 12. Day-care or nursery school record 	AND	<ol style="list-style-type: none"> 1. U.S. social security card issued by the Social Security Administration (other than a card stating it is not valid for employment) 2. Certification of Birth Abroad issued by the Department of State (Form FS-545 or Form DS-1350) 3. Original or certified copy of a birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. ID Card for use of Resident Citizen in the United States (Form I-179) 7. Unexpired employment authorization document issued by DHS (other than those listed under List A)

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274)

**MCFE FISCAL AGENT PROGRAM
FISCAL AGENT AUTHORIZATION**

WRAPAROUND MILWAUKEE PROJECT
Effective Date: _____

CASE STATUS:

Opening _____
Closing _____
Change _____

Care Coordinators Name: _____
Agency Name: _____
Phone Number: _____

Closing Explanation: _____

Wraparound Case Name and Address

Child's DOB: _____

Child's Social Security No. Case No.

Employee (Provider) Information:

Name and Address	Birthdate	Social Security No.	Service	Unit	Rate	Relationship to Child
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Authorized Payroll Signature _____ Date _____
(parent/legal guardian)

I have informed the employer and the provider(s) of their rights and responsibilities.

Care Coordinators Approval: _____ Date: _____

Wraparound Milwaukee Approval: _____ Date: _____



MCFI – Fiscal Agent

Dear Employee:

MCFI now has direct deposit available for Fiscal Agent employees. Employees can avoid the hassle of waiting for checks to be delivered by mail. No more worries about lost or stolen checks. No more hassles on payday when you or your employer are on vacation, sick or traveling because on payday, we will mail an earnings statement listing gross pay, deductions, and the net payroll amount will be transmitted to your bank account. The money will be available two banking days after it is transmitted by MCFI. That means if payday is on Monday, your net payroll amount will be at your bank on Wednesday morning. If payday is on Friday, the funds will be at your bank on Tuesday morning. Your money will be available for your use at the beginning of the day.

If you wish to enroll in the direct deposit program of MCFI - Fiscal Agent, you need to complete the authorization form enclosed with this letter. Attach a voided check to the authorization form and return in the business reply envelope. The voided check will be used to verify account and routing numbers.

Once the authorization form is received, the information will be transmitted and verified. For accuracy the first payroll run after account information input will be a trial run between our bank and yours. This gives your bank time to let us know if we have any incorrect numbers. The following payroll should go directly to your account. Some banks do not verify the account numbers until there is a money transaction, which may result in the direct deposit not being live when we first expect it.

MCFI has added this service to alleviate mail problems experienced by some of our providers. If you have any questions, please call our payroll department at 414-937-2172.

Sincerely,

A handwritten signature in cursive script that reads "Pat Keefer".

Pat Keefer
Payroll Manager

MCFI – Fiscal Agent

Direct Deposit Authorization

Phone: 414-1-937-2172

Fax: 1-414-937-2037

*****To ensure accurate direct deposit, please enclose a voided check for verification of numbers*****

If you do not have a checking account ask about our Bank One paycards*

I hereby authorize MCFI – Fiscal Agent to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my bank account as indicated below at the *depository* (bank) named below.

Bank Name _____ Branch _____

Routing Number _____ Account No. _____

Type of Account: Checking _____ Savings _____

This authorization is to remain in full force and effect until MCFI has received written notification from me of its termination in such time and in such manner as to afford MCFI and *Depository* a reasonable opportunity to act on it.

County _____

Name _____

(Please Print)

Signature _____

Date _____

Employee Time Report

Service Provider
JANE SMITH

Date Worked	# of Hours to be paid	# of Days to be Paid	Service Type
1st			
2nd	2		
3rd			
4th			
5th	3		
6th			
7th			
8th	2.5		
9th			
10th			
11th			
12th	7		
13th			
14th			
15th	2		
TOTALS	10.5		
PAID MILEAGE	N/A		

Service Types:
S=SHC P=Personal Care R=Respite
O=Outside Chores

Service Period End **9/30/05**
NOTE: Reports Must be submitted within 60 days of service

Employer's Name and Address
Pam Johnson
1111 S. 12th St.
Milwaukee WI 53215

I (We) certify that the information provided on this form is a true and accurate statement of the services provided. I (We) understand that payment for services provided are subject to payroll taxes.

Note: Time Reports Must be submitted within 60 days of service. Reports for service provided more than 60 days ago will not be paid.

Service Provider's (Employee's) Signature
Jane Smith
Date
10/1/05

Client/Employer/Representative's Signature
Jane Johnson
Date
10/2/05

Mail this time report, in the envelope provided to:
MCFI Fiscal Agent
2020 W Wells St.
53202
Milwaukee, WI
Please call MCFI Fiscal Agent at 14-937-2172 with any questions on how to fill out this form.

Date Worked	# of Hours to be paid	# of Days to be Paid	Service Type
16th			
17th			
18th	2		
19th			
20th			
21st	7		
22nd			
23rd			
24th	3		
25th			
26th			
27th	1.5		
28th			
29th			
30th			
31st			
TOTALS	7.5		
PAID MILEAGE	N/A		

S=SHC P=Personal Care R=Respite
O=Outside Chores