STUART T. WILSON CPA, PC
Fiscal Intermediary

Bay-Arenac Behavioral Health

In order to be considered a Medicaid provider and be paid with Medicaid funds, this packet must be completed in its entirety. Do not provide any services prior to the notification of a clear background check.
The employment relationship is with the Participant and not with Stuart T. Wilson CPA, PC or Community Mental Health.
IMPORTANT: Please ensure this checklist is completed prior to submission. There are portions of this packet that must be completed by the employer. If an incomplete packet is submitted payment may be delayed.

- ☐ Criminal Background Check Authorization
- ☐ Recipient Rights Check Authorization
- ☐ W-4
- ☐ I-9 (Identification is required. Please refer to page two for all options.)
    - Employee Signature
    - Employer Signature
- ☐ Employment Agreement
    - Employer Signature
    - Employee Signature
- ☐ Medicaid Provider Agreement
    - Provider Signature (Employee is the provider)
- ☐ Employee Wage Information
- ☐ Job Description
- ☐ Employee Eligibility Checklist
- ☐ Payroll Procedures (Please read carefully)
- ☐ Payment Options
- ☐ Required Training (Training must be submitted with/by your first timesheet)

_____ _____

Employee Email Employee Phone #

If you have any questions, please feel free to contact the Personnel Department at 989-832-5400.
Return packet via Fax: 989-832-5404 Email: training@stuartwilsonfi.com
Mail: Stuart T. Wilson CPA, PC Attn: Personnel 6300 Schade Dr. Midland, MI 48640.

STUART T. WILSON CPA, PC
Fiscal Intermediary

Criminal Background Check Authorization Form

Do not provide any services prior to authorization.
You will not be paid for any time worked prior to a clear criminal background check and the completion of required trainings.

Employer (Participant): _____ Organization/Agency: _____

Employee Full Name: _____

Previous Names Used (Include maiden name): _____

_____

Date of Birth: _____ Sex: _____ Race: _____

Driver's License #: _____

Social Security #: _____ Phone #: _____

You MUST include a copy of your Driver's License or State ID with this form.

I authorize the release of my criminal background information and driving record to my employer, to be run ongoing, and to the "Host Agency" which acts as project administrator; and to the "Fiscal Intermediary" which serves as my employer's financial administrator.

Furthermore, I acknowledge that I am required to notify Stuart T. Wilson CPA, PC as soon as possible, but no later than the next business day, if I have been convicted of any crime.

_____

Signature Date

Results are released to the participant/guardian or case manager.

For results contact:

Participant/Guardian Name: _____

Phone #: _____ Email: _____

or

Case Manager: _____

Phone #: _____ Email: _____

☐ I would also like a Driver's License Check conducted _____

Employer Initials

AUTHORIZATION TO DISCLOSE
EMPLOYEE INFORMATION
AND RELEASE OF LIABILITY
(ORR CHECK)

I, _____ authorize Bay Arenac Behavioral Health (BABH) and the
(print full name)
BABH Office of Recipient Rights to disclose to the Provider/Consumer listed below any and all information in your possession regarding any violation of recipients' rights committed by me. I recognize that any disclosure cannot include confidential client information protected by any Federal, State, or common law.

I, _____ release BABH and BABH Office of Recipient Rights, its
(print full name)
officers, its agents and its employees for disclosing the information requested by me and I shall indemnify and hold harmless should any claims, suits or actions be filed against them.

PREVIOUS PLACES OF EMPLOYMENT:

1. _____ Dates employed: _____ to _____
2. _____ Dates employed: _____ to _____
3. _____ Dates employed: _____ to _____
4. _____ Dates employed: _____ to _____

_____ _____ _____
Applicant's Signature **Date** **Previous Names Used (print)**

_____ _____ _____
Witness Signature **Date** **Applicant's Birth Date**

INFORMATION TO BE SENT TO:

Stuart Wilson
Provider/Consumer

Street Address

989-832-5404
City **State** **Zip Code** **Fax**

RIGHTS OFFICE USE ONLY

The above applicant ☐ Does ☐ Does not have a substantiated recipient rights violation(s) according to BABH records.

By: _____ Date: _____
BABH Office of Recipient Rights

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2024

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ _____

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) _____ **Date** _____

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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

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

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

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

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

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
	6300 Schade Dr., Midland, MI 48640

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	**OR**	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

MEDICAID PROVIDER AGREEMENT

This agreement is made on _____ between Bay Arenac Behavioral Health and _____ (known as Medicaid Provider). The purpose of this agreement is to define the roles and responsibilities of the above named parties. This agreement shall remain in effect until such time it must be terminated or modified. Any party can initiate a termination or modification by providing written notice to the other of the desire to terminate or modify this agreement.
Upon receipt of this agreement, CMHSP will certify the Medicaid Provider as available to provide services to individuals who receiving services and/or supports in accordance with their individual plans of services and supports developed in a person-centered planning process, authorized by CMHSP or one of its subcontractors, and financed through Michigan's Medicaid Specialty Pre-paid Mental Health Plan.

The Medicaid Provider stipulates that it agrees to the following
1. To keep any records necessary to disclose the extent of services and Medicaid Provider furnishes to recipients of services.

2. to furnish any information maintained under paragraph (1) of this section and any information regarding payments claimed by the Medicaid Provider for furnishing services under the individual plan of services and supports upon request to CMHSP, the State Medicaid Agency, the Secretary of the Department of Health and Human Services or the State Medicaid fraud control unit.

3. To comply with the disclosure requirements specified in 42 CFR 455, subpart B, as applicable.

4. To comply with the advance directives requirements specified in 42 CFR 489, Subpart I and 42 CFR 417.436 (d), as applicable.

Both parties expressly acknowledge that the sole purpose of this agreement is to assure compliance with 42 USC 1902 (a) 27. Further both parties recognize and reaffirm that CMHSP is not the employer of the Medicaid Provider of Services, and that the Participant is the sole employer of the Medicaid Provider of Services.

This agreement sets forth the entire understanding between the parties with respect to the subject matters, and supersedes any and all other agreements, either oral or in writing between the parties pertaining to these matters. Not change or modification of the terms of this agreement is valid unless it is in writing and signed by the parties.

The parties agree to terms and conditions of this agreement.

Self-Determination Coordinator Date

Medicaid Provider Agency/Individual Employee Date

BAY ARENAC
BEHAVIORAL HEALTH

EMPLOYMENT AGREEMENT

This contract made this date _____, by and between _____ (herein referred to as "Employer") and _____ (herein referred to as "Employee").

The employee recognizes that employment is condition on my employer's participation in the Self-Determination Initiative. If my employer is no longer a participant in the initiative, I may no longer be employed. In order to acknowledge the terms of my employment, I agree to the following:

1. During the terms of this Agreement, I shall assist my employer by performing the duties outlined in this agreement and any attachments to this agreement.

2. I agree to assist my employer in maintaining the necessary documentation and records as required by my employer or their host agency. I agree to complete all the necessary paperwork to secure necessary payroll deductions from my pay. All records I may have or assist in maintaining will be kept confidential and released only upon the consent of my employer. I acknowledge that all records I may have access to be the property of and must be returned to the employer at the time my employment relationship terminates. In addition, illness and incident reports will be filled out at appropriate times, as required or requested by the Host Agency or my employer.

3. I shall immediately notify (enter the name of the desired contact person, for example, it may be a family member or their designee _____ __ of any medical emergency or illness. I will also notify designee (if applicable) before taking my employer to the physician, except in case of an emergency.

4. I agree to participate in any meetings if requested by my employer.

5. I agree to abide by all of my employer's rules and regulations pertaining to providing support to my employer through the Self-Determination Initiative.

6. I hereby acknowledge receipt of the following rules and regulations:

    a. Recipient Rights Booklet (I understand that I shall assist my employer in filing right complaints upon request. I also understand that I have a responsibility to report rights violations, which I am aware of or any potential abusive or neglectful situations I observe. I understand that I may be requested to cooperate with a recipient rights investigation, and/or assist my employer with exercising their rights.

b. Attachment A to this agreement, which outlines the services I shall provide to my employer.
c. (Individual can add whatever additional rules thy may have…regarding phone usage, non-smoking, etc., in their home.)
d. If the Host Agency has any policies and/or procedures for the Self-Determination Initiative, or other policies the employee needs to be aware of, they should be given to the employee.
e. If there any required time cards or other documentation the employee must fill out and return to the fiscal intermediary to verify their hours that should be given to the employee, or those requirements can be put into this agreement.

(Use only one option in number 7)

7. I understand that this is an employment at will relationship, which can be terminated by either party, at any time. However, I agree to give 5 days written notice to my employer if I need to terminate this Employment Agreement. *Or*

   I understand that this is a contractual position, not an at will relationship, and that either party can terminate the relationship by providing written notice to other of the desire to terminate the relation in writing 5 days prior to the termination of the agreement. It is understood that I will be compensated for any work completed while the contract is in effect. If I fail to provide requested services for the entire term of the contract, it shall be considered a breach of contract.

8. I understand that, although my pay check will be drafted by a fiscal intermediary, they are only acting as a financial administrator of my employer's budget/funds for the Self-Determination Initiative.

9. I agree to hold the fiscal intermediary harmless for their role as the financial administrator of my employer's budget/fund for the Self-Determination Initiative, and acknowledge that I have only one employer.

10. I understand and acknowledge that the Host Agency's role in this project is that of project administrator, and that the Host Agency is not my employer.

11. Further, I agree to hold the Host Agency harmless for their role as a project administrator of the Self-Determination Initiative.

12. I agree to the following compensation for the services I shall perform:
13. $ per hour Not to include any other benefits.

I agree to execute a 42 CFR 431.107 agreement with the Host Agency and acknowledge that this agreement does not alter the fact that the Host Agency is only the project administrator of the Self-Determination Initiative and that my employer is I understand that my employment is contingent on completing this agreement.

I, agree to the following: (Employer)

Provide my fiscal intermediary with the necessary documentation to assure timely compensation of my employee. Compensate my employee in the following manner: $ per hour, Not to include any other benefits.

1. Assure appropriate training to my employee. Further, I will assure that my providers meet the five minimum requirements of Chapter Three of the State Medicaid Manual: 1) at least 18 years of age; 2) able to prevent transmission of any communicable disease from self to others in the environment in which they are providing supports; 3) able to communicate expressively and receptively with me in order to follow individual plan requirements and participant-specific emergency procedures, and report on activities performed; 4) in good standing with the law (i.e. not a fugitive from justice, a convicted felon, or an illegal alien); 5) able to perform basic first aid procedures. Further the Host Agency shall assure all other providers of services (i.e. clinical services, supports coordination, personal agents); meet the required standards of Chapter Three of the State Medicaid Manual.

2. Evaluate the performance of my employees or contractors, and provide appropriate feedback to assure I am purchasing quality of services.

3. Provide training to my employees on my health needs, my medications and medication procedures, safety and emergency procedures specific to my needs and my home, and my IPOS.

4. **Assure that my employee executes a Medicaid Provider Agreement with the specified Community Mental Health Services Program** BABH **.**

_____

Employee Signature Date

_____

Employer Signature Date

STUART T. WILSON CPA, PC
Fiscal Intermediary

Employee Wage Information

Employee Name: _____

Employee Phone #: (_____) _____

Employee Email: _____

Is your address the same as your employer? ☐ yes ☐ no

Are you the parent or legal guardian of your employer? ☐ yes ☐ no

This portion to be completed by the employer/representative.
Employers, please review your budget to ensure accuracy.

Hourly Rate: _____

Benefits: (If applicable)

Holiday Pay ☐
Employees receive time and a half for the 7 standard holidays, if worked. Seven standard holidays are New Year's Day, Easter, Memorial Day, July 4, Labor Day, Thanksgiving Day and Christmas Day.

Vacation/PTO ☐ _____hours per calendar year
Vacation time is calculated January-December. If left unused, it does not roll over. If employment is terminated or participant leaves the program, any unused vacation is forfeited.

Benefits are subject to budget allocation.

Home Health Aide/Personal Care Assistant
Job Description/Task List

Employee Name: _____ **Date:** _____

Participant/Employer: _____ **Date:** _____

Qualifications/Training:

CPR Training: _____ **Universal Precautions:** _____

Blood Borne Pathogens: _____ **First Aid:** _____

Additional Training Requirements: _____

Services Performed:

CLS (personal care/homemaking): _____

In Home Respite: _____ **Chore Service:** _____

Community Living Services Functions (including but not limited to):

a. **Bathing/Assist:** _____
b. **Shampooing:** _____
c. **Skin care/Nail care:** _____
d. **Oral Hygiene:** _____
e. **Shaving:** _____
f. **Dressing/Assist:** _____
g. **Ambulation:** _____
h. **Toileting/Incontinence:** _____
i. **Linen Change** _____

Community Living Service Functions Continue:

a. **Meal Preparation:** _____

b. **Feeding:** _____

c. **Laundry:** _____

d. **Cleaning:** _____

e. **Other:** _____

Chore Services (including, but not limited to):

a. **Yard Work:** _____

b. **Snow Removal:** _____

Transportation Needs: (drivers license confirmation required)

a. _____

b. _____

Scheduling (Days/Hours)

***Contact employer if arriving more than 10 min. late or need to change schedule*. All changes to the schedule is made with the approval of the participant/employer.**

S M T W TH F S Days and time may vary not to exceed _____ per week.

It is important to me that my worker: (e.g. does not smoke in my home, maintains confidentiality, is punctual, honors my requests, treats me with respect, etc.) as well as the following:

a._____ **b.** _____

c._____ **d.** _____

Workers will not be paid for hours when the employer is in the hospital, if time sheets are not signed by the appropriate person or for duplicated hours with other workers.

I expect my worker to perform other related duties and responsibilities as deemed necessary.

_____ ____/____/____

Employer Signature **Date**

_____ ____/____/____

Employee Signature **Date**

STUART T. WILSON CPA, PC
Fiscal Intermediary

Bay CMH Employee Eligibility Checklist

Please fill out and sign below to validate that Stuart Wilson FI has informed you on prohibited conflicts of interest based on Medicaid requirements.

Please check if any apply to you. If you **do** check any of the items below, you are **NOT** qualified to work for that "employer" (person receiving the service). If you have any questions please call your Supports Coordinator/Case Manager.

1. Community Living Supports (CLS) may not be provided by the following individuals.
Are you:

___ A spouse of the employer?
___ Parent of an employer who is a minor child?
___ The guardian of the employer, or co-guardian or alternate/standby guardian of employer?
___ Spouse of the employer's guardian or spouse of employer's co-guardian or alternate/standby guardian?
___ Individual designated by the employer as attorney-in-fact, or an alternate attorney-in-fact under a durable power of attorney?
___Spouse of individuals designated by the employer as attorney-in-fact or alternate attorney-in-fact under a durable power of attorney?
___ "Live-together" partner in which one partner is the guardian or attorney-in-fact for the employer?

2. Respite Care may not be provided by any of the persons listed above or the following.
Are you:

___Any of the persons listed above in section 1?
___Living in the home?
___ Unpaid primary caregiver of the person receiving services?

3. Stricter rules apply if your employer is enrolled in Children's Waiver (CW). CLS or Respite Care may not be provided by the following if your employer is enrolled in CW.
Are you:

___ Any of the persons listed above in sections 1 or 2?
___ Living in the same home as the employer?

If none of the above pertains to you, please check here____

_____ _____

Employee Signature **Date**

If at any time the above mentioned conditions should change, it is the responsibility of the employee to notify the supports coordinator/case manager.

STUART T. WILSON CPA, PC
Fiscal Intermediary

CMH PAYROLL PROCEDURES

To be paid correctly and avoid any delay with payments, payroll procedures must be followed.

Turning in Timesheets for Payment:

- **Please refer to the payroll calendar for scheduled pay days.**
  - All time worked must be reported within 14 days of the end of the pay period.

- **Timesheets received late and/or separate may not be paid on time.**
  - All timesheets for a Participant are to be faxed/e-mailed together by noon on Monday each week.

- **Only correct timesheets will be processed.**
  - If a timesheet contains omissions or errors, it will be returned to the employer and payment may be delayed.
    - Overlapping time with another provider will not be processed
    - Only authorized hours will be paid

- **Mileage logs must be turned in weekly with the corresponding timesheet.**

- **No Photocopied signatures will be accepted.**
  - A new timesheet must be used each week. Duplicated timesheets are not accepted.

Payment Methods:

- **Direct Deposit or Netspend Skylight ONE Payroll Card**
  - Check stubs are sent via email.

- **Changes in payment method must be submitted in writing and may take 2-3 weeks to become effective.**
  - Do not close your bank account without providing our office with enough notification; otherwise your payment will be delayed.
  - Address changes must be submitted in writing.

STUART T. WILSON CPA, PC
Fiscal Intermediary

Payment Options

Name: _____ Employer's Name: _____

Email Address (**required**):_____

(Must choose one)

☐ **Direct Deposit** A voided check, a letter from the bank or a copy of a membership card that includes both the account and routing number **must** be attached. *See information below Account Type: ☐ Checking ☐ Savings	☐ **Netspend Skylight ONE Payroll Card** *See attached information

When you apply for direct deposit you authorize Stuart T. Wilson CPA, PC to deposit your payroll automatically into your checking or savings account.

- All cancellations must be submitted in writing.
- Any changes may take up to 2 pay periods.
- **Do not close your bank account without providing our office with sufficient notification; otherwise, your payment will be delayed.**
- On payday you will receive your check stub **via email**. This also serves as your notice of deposit. The email comes from no_reply@stuartwilsonfi.com. Please check your spam folder if you do not receive your notice.
- Stuart T. Wilson CPA, PC is not held accountable for any overdraft fees that you may incur for using funds prior to their **actual confirmed deposit.**
- Stuart T. Wilson CPA, PC is authorized to correct errors that may occur. This authority remains in effect until we are notified in writing that you no longer want direct deposit.

I have read and understood the terms of my chosen payment option with Stuart T. Wilson CPA, PC.

I understand that if I do not submit my banking information
I will automatically be signed up for the Netspend Skylight ONE Payroll Card.

_____ _____

Signature Date Phone #

Return via Fax: 989-832-5404 Email: payroll@stuartwilsonfi.com
Mail: Stuart T. Wilson CPA, PC Attn: Personnel 6300 Schade Dr. Midland, MI 48640

Your Skylight Account Info Is With You Wherever You Are

With the Skylight ONE® Mobile App, you can get updates on your Skylight Account from the palm of your hand.[1]

Card account usage is subject to card activation and identity verification.*

Check your balance at a glance

Log in to your Skylight Account, and see how much money is there, right from your smartphone.

Find the nearest ATM

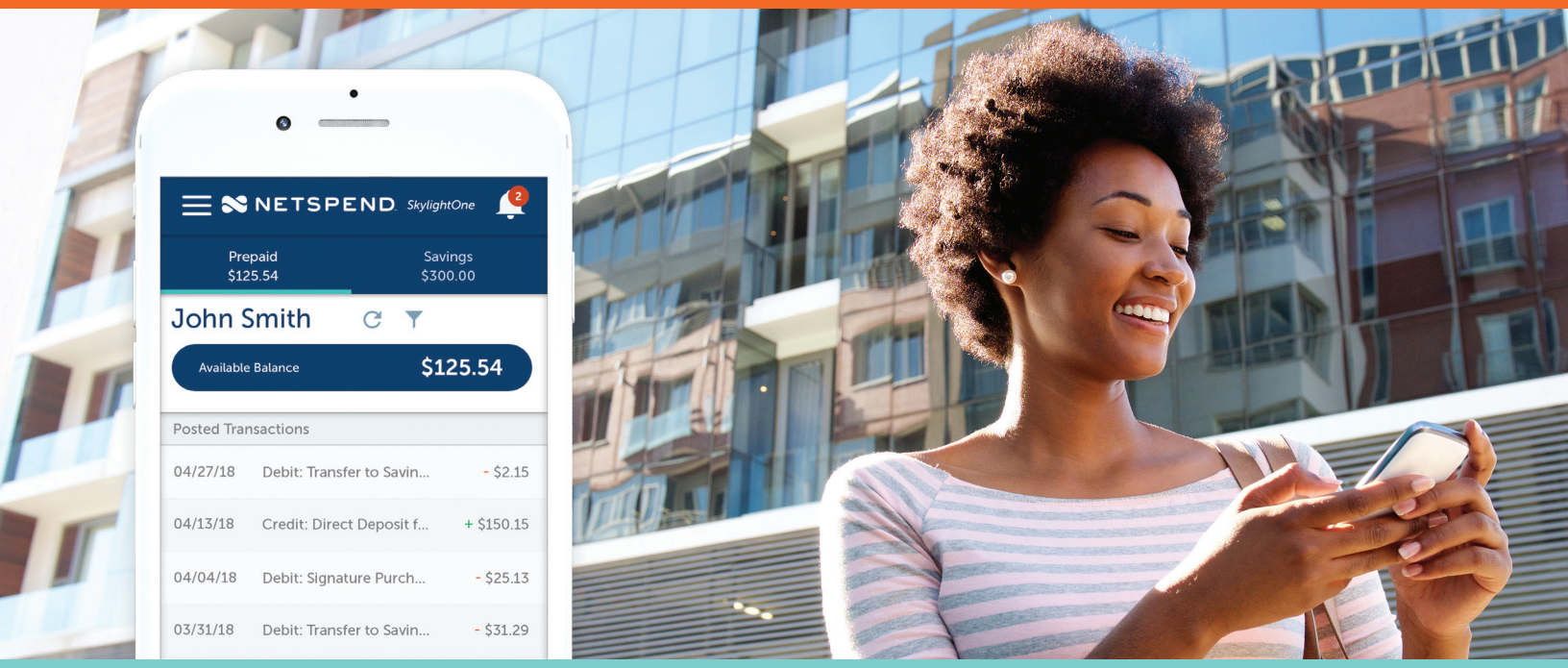
Need some cash? Locate the surcharge-free ATM[2] that is closest to where you are, wherever you are.

See your most recent transactions

See if a payment has posted, or if your paycheck has arrived in just a few taps.

Manage your alerts

Enroll to get a text message[1] or email whenever you get paid, for every transaction, or just periodic balance updates with Anytime Alerts™.



Download the Skylight ONE Mobile App Today!

Download on the App Store

GET IT ON Google Play

* **IMPORTANT INFORMATION FOR OPENING A CARD ACCOUNT:** To help the federal government fight the funding of terrorism and money laundering activities, the USA PATRIOT Act requires us to obtain, verify, and record information that identifies each person who opens a Card Account. **WHAT THIS MEANS FOR YOU:** When you open a Card Account, we will ask for your **name, address, date of birth, and your government ID number**. We may also ask to see your driver's license or other identifying information. Card activation and identity verification required before you can use the Card Account. If your identity is partially verified, full use of the Card Account will be restricted, but you may be able to use the Card for in-store purchase transactions. Restrictions include: no ATM withdrawals, international transactions, account-to-account transfers and additional loads. Use of Card Account also subject to fraud prevention restrictions at any time, with or without notice.

[1] No charge for this service, but your wireless carrier may charge for messages or data.

[2] Surcharge free ATM options will vary by card program. Please see your Cardholder Agreement for surcharge free options. An ATM Cash Withdrawal Fee applies at ATMs outside the surcharge free network specified in your Cardholder Agreement. A separate ATM owner fee may also apply.

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Google Play and the Google Play logo are trademarks of Google Inc.

The Skylight ONE® Visa Prepaid Card is issued by Bofl Federal Bank, Republic Bank & Trust Company or SunTrust Bank pursuant to a license from Visa U.S.A. Inc. and may be used everywhere Visa debit cards are accepted. The Skylight ONE® Prepaid Mastercard is issued by Bofl Federal Bank, Republic Bank & Trust Company, or SunTrust Bank pursuant to a license by Mastercard International Incorporated. Please see back of card for Issuing Bank. Bofl Federal Bank, Republic Bank & Trust Company and SunTrust Bank; Members FDIC. Netspend, a TSYS® Company, is a registered agent of Bofl Federal Bank, Republic Bank & Trust Company, and SunTrust Bank. Certain products and services may be licensed under U.S. Patent Nos. 6,000,608 and 6,189,787. Use of the Card Account is subject to activation, ID verification and funds availability. Transaction fees, terms, and conditions apply to the use and reloading of the Card Account. See the Cardholder Agreement for details.

Mastercard is a registered trademark, and the circles design is a trademark of Mastercard International Incorporated.

Card may be used everywhere Debit Mastercard is accepted.

Frequently Asked Questions

The Skylight® PayOptions™ Program

What is the Skylight PayOptions Program?

The Skylight PayOptions Program provides you with a safe and convenient alternative to cash and traditional paper paychecks. Your money is direct deposited into an account at BofI Federal Bank, Member FDIC, and can be accessed either through your Skylight ONE® Visa® Prepaid Card or Skylight ONE® Prepaid MasterCard®, or by using a Skylight Check to withdraw all of the cash from your Skylight Account.

Where can I use my Skylight ONE Card?

Your Skylight ONE® Card can be used at millions of ATMs to withdraw cash, and anywhere Visa debit cards or Debit MasterCard (based on the logo on the front of your card) are accepted for purchases, such as supermarkets and other retail locations.

What are Skylight Checks and how can I use them?

If you prefer, you can use Skylight Checks to write your own paycheck! Each payday, whether you're at work, at home, or on vacation, you can use a Skylight Check to withdraw all of the cash from your Skylight Account. Skylight Checks can be cashed free of charge at all U.S. Bank branch locations, at participating Walmart locations, and at participating ACE Cash Express locations.[1] You will receive 2 checks in your new account packet. Order additional checks at no cost by calling Customer Service at the number on the back of your card.

What does the Skylight PayOptions Program cost?

There is no cost to sign up and there are many ways to access your wages for free. Some fees may apply based on how you use your Skylight Account. You will receive a fee schedule with your new account packet.

Will I get a new card each payday?

No. Once you are enrolled in the program, you'll automatically receive a personalized Skylight ONE Card. Your pay will be added to the card by 8 a.m. CT each payday. If you accidentally lose the card, just give Skylight a call to request a replacement. Your first replacement card per year is available at no additional cost.[2]

My Skylight ONE Card doesn't have my name on it. Can I still use it to make purchases?

Yes. The first card you receive is a temporary card but it can be used to make signature-based purchases in restaurants, stores, online, and by phone anywhere Visa debit cards or Debit MasterCard are accepted.[3] Once you are enrolled in the program, a card with your name on it will automatically be sent to your mailing address.

Can I request more than one card?

You can add an additional cardholder to your account simply by calling the number on the back of your card.[2,3]

What happens if I lose my card?

When you lose cash, your money is gone. If you lose your card, contact Skylight immediately so your lost card can be cancelled and your money stays safe.[4] When you call, you can ask that a replacement card be sent to you. Your first replacement card per year is available at no additional cost.[2]

How can I check my balance and track my spending?

Skylight makes it convenient for you to manage your money. A toll-free automated telephone service provides 24/7 account information. Plus, when you register for online access at skylightpaycard.com, you can visit the Online Account Center anytime to check your balance, review your transactions, and view or print your statements. You can also enroll in Anytime Alerts™ to schedule balance, deposit, or payment updates to be sent directly to your cell phone or email inbox.[5] Or, text us and we'll text your balance back to you!

What if I want to talk to someone about my account?

Skylight's friendly, specially trained Customer Service representatives are available to assist you between 6 a.m. and midnight CT Monday through Friday and on weekends between 8 a.m. and 8 p.m. CT, with bilingual service available. You can reach someone by calling the number on the back of your card.[6]

[1] Skylight Checks can be cashed free of charge at all U.S. Bank branch locations, at participating Walmart locations, and at participating ACE Cash Express locations. Other check cashers set their own policies regarding check acceptance and may charge you a fee to cash Skylight Checks. See the Skylight Checks for step-by-step instructions.
[2] There may be a cost for additional replacement cards. Consult your Cardholder Agreement and fee schedule for details.
[3] There is no application or credit approval process for the Skylight PayOptions Program. **IMPORTANT INFORMATION ABOUT PROCEDURES FOR OPENING A NEW CARD ACCOUNT:** To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens a Card Account. **What this means for you:** When you open a Card Account, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents. In accordance with federal regulations, until it is activated and registered, a prepaid card is subject to initial load limitations, may not be used for ATM use, international transactions or account-to-account transfers, or be reloaded.
[4] To minimize losses, Cardholder must notify Skylight promptly of any loss of the card or compromise of the Skylight Account. Other terms apply. See the Cardholder Agreement for details.
[5] Skylight does not charge for this service, but your wireless carrier may charge you for messages or data.
[6] A fee may apply for this call. Consult your Fee Schedule for details.