STUART T. WILSON CPA, PC
Fiscal Intermediary

Senior Services

Medicaid PROVIDER Paperwork for Self-Determination Participants

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 the Waiver Agency.

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.

- ☐ W-4
- ☐ I-9 (Identification is required. Please refer to page two for all options.)
  - Employer Signature
  - Employee Signature
- ☐ Employment Agreement
  - Employer Signature
  - Employee Signature
- ☐ Medicaid Provider Agreement
  - Provider Signature (Employee is the provider)
  - Our office obtains the second signature after the paperwork is processed
- ☐ Job Description
- ☐ Employee Wage Information
- ☐ 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.

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)

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2024 if you meet both of the following conditions: you had no federal income tax liability in 2023 **and** you expect to have no federal income tax liability in 2024. You had no federal income tax liability in 2023 if (1) your total tax on line 24 on your 2023 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2024 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2025.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

1. Expect to work only part of the year;

2. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

3. Prefer the most accurate withholding for multiple job situations.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

Nonresident alien. If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

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

Instead, if you (and your spouse) have a total of only two jobs, you may check the box in option **(c).** The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

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

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2024 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

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

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

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

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . **1** $

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . **2a** $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . **2b** $

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . **2c** $

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3**

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . **4** $

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

1 Enter an estimate of your 2024 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $

2 Enter:
- $29,200 if you're married filing jointly or a qualifying surviving spouse
- $21,900 if you're head of household
- $14,600 if you're single or married filing separately

. . . . . **2** $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . **3** $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . **4** $

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . **5** $

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$780	$850	$940	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,370
$10,000 - 19,999	0	780	1,780	1,940	2,140	2,220	2,220	2,220	2,220	2,220	2,570	3,570
$20,000 - 29,999	780	1,780	2,870	3,140	3,340	3,420	3,420	3,420	3,420	3,770	4,770	5,770
$30,000 - 39,999	850	1,940	3,140	3,410	3,610	3,690	3,690	3,690	4,040	5,040	6,040	7,040
$40,000 - 49,999	940	2,140	3,340	3,610	3,810	3,890	3,890	4,240	5,240	6,240	7,240	8,240
$50,000 - 59,999	1,020	2,220	3,420	3,690	3,890	3,970	4,320	5,320	6,320	7,320	8,320	9,320
$60,000 - 69,999	1,020	2,220	3,420	3,690	3,890	4,320	5,320	6,320	7,320	8,320	9,320	10,320
$70,000 - 79,999	1,020	2,220	3,420	3,690	4,240	5,320	6,320	7,320	8,320	9,320	10,320	11,320
$80,000 - 99,999	1,020	2,220	3,620	4,890	6,090	7,170	8,170	9,170	10,170	11,170	12,170	13,170
$100,000 - 149,999	1,870	4,070	6,270	7,540	8,740	9,820	10,820	11,820	12,830	14,030	15,230	16,430
$150,000 - 239,999	1,960	4,360	6,760	8,230	9,630	10,910	12,110	13,310	14,510	15,710	16,910	18,110
$240,000 - 259,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$260,000 - 279,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$280,000 - 299,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,380
$300,000 - 319,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,980	17,980	19,980
$320,000 - 364,999	2,040	4,440	6,840	8,310	9,710	11,280	13,280	15,280	17,280	19,280	21,280	23,280
$365,000 - 524,999	2,720	6,010	9,510	12,080	14,580	16,950	19,250	21,550	23,850	26,150	28,450	30,750
$525,000 and over	3,140	6,840	10,540	13,310	16,010	18,590	21,090	23,590	26,090	28,590	31,090	33,590

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$240	$870	$1,020	$1,020	$1,020	$1,540	$1,870	$1,870	$1,870	$1,870	$1,910	$2,040
$10,000 - 19,999	870	1,680	1,830	1,830	2,350	3,350	3,680	3,680	3,680	3,720	3,920	4,050
$20,000 - 29,999	1,020	1,830	1,980	2,510	3,510	4,510	4,830	4,830	4,870	5,070	5,270	5,400
$30,000 - 39,999	1,020	1,830	2,510	3,510	4,510	5,510	5,830	5,870	6,070	6,270	6,470	6,600
$40,000 - 59,999	1,390	3,200	4,360	5,360	6,360	7,370	7,890	8,090	8,290	8,490	8,690	8,820
$60,000 - 79,999	1,870	3,680	4,830	5,840	7,040	8,240	8,770	8,970	9,170	9,370	9,570	9,700
$80,000 - 99,999	1,870	3,690	5,040	6,240	7,440	8,640	9,170	9,370	9,570	9,770	9,970	10,810
$100,000 - 124,999	2,040	4,050	5,400	6,600	7,800	9,000	9,530	9,730	10,180	11,180	12,180	13,120
$125,000 - 149,999	2,040	4,050	5,400	6,600	7,800	9,000	10,180	11,180	12,180	13,180	14,180	15,310
$150,000 - 174,999	2,040	4,050	5,400	6,860	8,860	10,860	12,180	13,180	14,230	15,530	16,830	18,060
$175,000 - 199,999	2,040	4,710	6,860	8,860	10,860	12,860	14,380	15,680	16,980	18,280	19,580	20,810
$200,000 - 249,999	2,720	5,610	8,060	10,360	12,660	14,960	16,590	17,890	19,190	20,490	21,790	23,020
$250,000 - 399,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$400,000 - 449,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$450,000 and over	3,140	6,450	9,110	11,610	14,110	16,610	18,430	19,930	21,430	22,930	24,430	25,870

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$510	$850	$1,020	$1,020	$1,020	$1,020	$1,220	$1,870	$1,870	$1,870	$1,960
$10,000 - 19,999	510	1,510	2,020	2,220	2,220	2,220	2,420	3,420	4,070	4,070	4,160	4,360
$20,000 - 29,999	850	2,020	2,560	2,760	2,760	2,960	3,960	4,960	5,610	5,700	5,900	6,100
$30,000 - 39,999	1,020	2,220	2,760	2,960	3,160	4,160	5,160	6,160	6,900	7,100	7,300	7,500
$40,000 - 59,999	1,020	2,220	2,810	4,010	5,010	6,010	7,070	8,270	9,120	9,320	9,520	9,720
$60,000 - 79,999	1,070	3,270	4,810	6,010	7,070	8,270	9,470	10,670	11,520	11,720	11,920	12,120
$80,000 - 99,999	1,870	4,070	5,670	7,070	8,270	9,470	10,670	11,870	12,720	12,920	13,120	13,450
$100,000 - 124,999	2,020	4,420	6,160	7,560	8,760	9,960	11,160	12,360	13,210	13,880	14,880	15,880
$125,000 - 149,999	2,040	4,440	6,180	7,580	8,780	9,980	11,250	13,250	14,900	15,900	16,900	17,900
$150,000 - 174,999	2,040	4,440	6,180	7,580	9,250	11,250	13,250	15,250	16,900	18,030	19,330	20,630
$175,000 - 199,999	2,040	4,510	7,050	9,250	11,250	13,250	15,250	17,530	19,480	20,780	22,080	23,380
$200,000 - 249,999	2,720	5,920	8,620	11,120	13,420	15,720	18,020	20,320	22,270	23,570	24,870	26,170
$250,000 - 449,999	2,970	6,470	9,310	11,810	14,110	16,410	18,710	21,010	22,960	24,260	25,560	26,860
$450,000 and over	3,140	6,840	9,880	12,580	15,080	17,580	20,080	22,580	24,730	26,230	27,730	29,230

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.

Senior Services, Inc.

EMPLOYMENT AGREEMENT

This agreement is made on_____
(Date)

Between waiver participant:_____
(Name)

And employee: _____
(Name)

To describe the supports that the employee will provide to the employer and the terms and conditions of employment.

Article I
Employee Responsibilities

I, the employee:_____am aware and agree that my employment is conditioned on my employer's participation in the Choice Voucher System, administrated by the waiver agent. If my employer ends their participation in the Choice Voucher System, my employment may end. I agree to the following terms of employment:

1. During the term of this Agreement, I shall provide support to my employer by performing the duties outlined in this agreement and any attachments to it.

2. I agree to assist my employer in maintaining the documentation and records required by my employer or Senior Services, Inc. I agree to complete all necessary paperwork to secure mandatory payroll deductions from my pay. All records I may have or assist in maintaining are the property of my employer. I will keep these records confidential, release them only with the consent of my employer, and return them to my employer if my employment ends. In addition, I will complete illness and incident reports when necessary as required or requested by Senior Services. Inc. or my employer:

_____

3. **I shall immediately notify my employers physician and/or Or call 9-1-1 if my employer experiences a medical emergency or illness.**

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

5. I agree to abide by all of my employer's rules and Senior Services, Inc. regulations (described below) regarding my employment duties to the employer through the Choice Voucher System and I acknowledge receipt of the following rules and regulations:

a. See Attachment A to this Agreement (job description)
b. I am 18 years old or older, and a US Citizen or Legal Alien
c. I am able to demonstrate an ability to perform tasks employer requests. (Attachment A)
d. I will complete CPR, blood born pathogens/universal precautions, and basic first aid training within 3 months of employment. If Waiver Participant is a DNR this requirement can be waived.
e. I am not a Participant's Representative for the Self-Determination Program
f. I am not a legally responsible relative (spouse/guardian)
g. I will document time in and time out for each shift. Must use a standardized form, which my employer or Fiscal Intermediary will supply.

6. I understand that this is an employment at will relationship, which can be terminated by me or my employer at any time. However, my employer cannot terminate my employment on the basis of my race, religion, sex, disability, or other protected status under Federal or Michigan Law. In addition, I agree to give (Seven) days written notice to my employer if I terminate my employment.

7. I understand and acknowledge that my employer is my sole employer and that I am not an employee of the waiver agent, who authorizes the supports I provide, or the fiscal intermediary, which is the financial administrator of the Choice Voucher System funds used to pay me.

8. I agree to not to sue the fiscal intermediary for its role as the financial administrator of my employer's Choice Voucher System funds and Senior Services, Inc. for its role in administering the Choice Voucher System.

9. I agree to the following compensation for the services I shall perform:
$_____an hour

10. I agree to execute a Medicaid Provider Agreement with Senior Services, Inc. and acknowledge that this agreement does not alter the fact that Senior Services, Inc. is only the project administrator of the Choic e Voucher System, and that (participant) is my employer. I understand that my employment is contingent on completing this agreement.

11. I understand that my employer has been approved for _____ hours of community living supports per month.. I will not work over this amount unless my employer consults with their Support Coordinator and the additional hours are approved.

12. I understand that if my employer goes into the hospital, or other medical care setting, I cannot be paid during their absence.

13. I will not submit timesheets for any hours of work I have not performed, if so, falsifying timesheets will cause for legal proceedings to be pursued

EMPLOYER RESPONSIBILITIES

I, (employer name):

1. Will provide my Fiscal Intermediary with the necessary documentation to assure timely compensation of my employee

2. Will compensate my employee in the following manner: $_____ and hour

3. I understand I am approved for _____ hours of community living supports per month and that I will have to consult with my Support Coordinator before I can allow my employee to work additional hours

4. Payroll will be handled by my Fiscal Intermediary, which will withhold all necessary taxes, unemployment, and other withholdings from the employee's paycheck

5. I will assure my employee receives appropriate training

6. I will evaluate the performance of my employee and provide appropriate feedback to assure that I am receiving quality supports

7. I will assure that my employee executes a Medicaid Provide Agreement with (waiver agent)

8. I understand that if I go into the hospital or other medical care setting, my employee cannot be paid during that time

9. I will sign off/approve any timesheets for hours of work that my employee has/has not worked, falsifying timesheets will cause for legal proceedings to be pursued.

10. I understand I must treat my employee(s) with respect and that I cannot solicit them for anything or harass them in any way (sexually or verbally)

_____

Employee Signature Date

_____

Employer Signature Date

Senior Services, Inc.
MEDICAID PROVIDER AGREEMENT

THIS AGREEMENT is entered into by and between Senior Services, Inc. herein referred to as Waiver Agent, and:

Medicaid Provider:

Address:

City: **State:** MI **Zip:**

Phone: ( ) **Fax:** ( ) **E-Mail:**

Federal ID#:

Social Security#: **Birthdate:**

The purpose of this agreement is to define the roles and responsibilities of the above named parties. It is understood by and between the Medicaid Provider and Waiver Agent that a binding agreement shall commence on the date of acceptance as indicated by signatures on behalf of the Waiver Agent. 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, the Waiver Agent will certify the Medicaid Provider as available to provide services to individuals who receiving services and/or supports in accordance with their service plans developed through the person-centered planning process, authorized by the Waiver Agent or one of its subcontractors, and funded through the MI-Choice Waiver/Project Choices.

The Medicaid Provider stipulates that it agrees to the following:

1. To keep any records required by the Participant or the Waiver Agent regarding the services provided to Participants and to provide such information and any related invoices or billings, upon request, to the Participant, Waiver Agent, the State Medicaid Agency, the Secretary of the Department of Health and Human Services or the State Medicaid fraud control unit.

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

3. To comply with intent of the advance directive requirements specified in 42 CFR 489, Subpart I and 42 CFR 417.436 (d), as applicable, by finding out if a Participant has an advance directive to refuse life-sustaining medical treatment, and informing the Participant, before the Provider starts work, whether or not the Provider will carry out that advance directive so the Participant can make an informed choice during the hiring process.

This requirement applies to home health agencies and providers of home health care and personal care services as well as health care institutions. However, under Michigan law, certain health professionals cannot refuse to honor a Do Not Resuscitate order (MCL 333.1051 et. seq.).

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 the Waiver Agent is not the employer of the Medicaid Provider, and that the Participant is the sole employer of the Medicaid Provider.

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. No change or modification of the terms of this agreement is valid unless it is in writing and signed by the parties.

_____ _____

Medicaid Provider Agency/Individual Date

_____ _____

Executive Director, Waiver Agent Date

Copy to Fiscal Intermediary:
Date: **Name:**

Job Description for Self Determination

COMMUNITY LIVING SUPPORTS

Service Definition:

Community Living Supports facilitate an individual's independence and promote reasonable participation in the community. Community Living Supports can be provided in the participant's residence or in community settings as necessary in order to meet support and service needs sufficient to address nursing facility level of care need.

Community Living Supports includes:

A. Assisting* (see note below), reminding, cueing, observing, guiding and/or training in the following activities:
   a. Meal preparation
   b. Laundry
   c. Routine, seasonal, and heavy household care maintenance
   d. Activities of daily living such as bathing, eating, dressing, personal hygiene
   e. Shopping for food and other necessities of daily living

B. Assistance, support and/or guidance with such activities as:
   a. Money management
   b. Non-medical care (not requiring nurse of physician intervention)
   c. Social participation, relationship maintenance and building community connections to reduce personal isolation
   d. Transportation (excluding to and from medical appointments) from the participant's residence to community activities, among community activities, and from the community activities back to the participant's residence
   e. Participation in regular community activities incidental to meeting the individual's community living preferences
   f. Attendance at medical appointments
   g. Acquiring or procuring good and services necessary for home and community living

C. Reminding, cueing, observing and/or monitoring of medication administration

D. Staff assistance with preserving the health and safety of the individual in order that he/she may reside and be supported in the most integrated independent community setting
When transportation incidental to the provision of community living supports is included, it shall not also be authorized as a separate wavier service for the beneficiary. Transportation to medical appointments is covered by Medicaid through the Department of Human Services (DHS). Community Living Supports do not include the cost associated with room and board. This service is authorized when necessary to prevent the institutionalization of the person service.

*Tasks that address personal care needs differ in scope, nature, supervision arrangements or provider type (including provider training and qualifications) from personal care services in the State Plan, The differences between the waiver coverage and the State Plan are that the provider qualifications and training requirements are more stringent for community living supports tasks as provided under the waiver than the requirements for these types of services under the State Plan.

Community Living Supports services cannot be provided in circumstances where they would be a duplication of services available under the State Plan or elsewhere available. The distinction must be apparent by unique hours and units in the approved care plan.

Provider Qualifications: *INDIVIDUAL*

1. Providers must be at least 18 years of age, have the ability to communicate effectively both orally and in writing and follow instructions, be trained in first and cardiopulmonary resuscitation, be trained in universal precautions and blood-born pathogens and be in good standing with the law as validated by a criminal background check conducted by the OHCDS. Training in cardiopulmonary resuscitation can be waived if providing services for a participant who has a " Do Not Resuscitate' (DNR) order. If providing transportation incidental to this service, the provider must possess a valid Michigan driver's license.

2. Individuals providing Community Living Supports must have previous relevant experience or training and skills in housekeeping, household management, good health practices, observation, reporting, and recording information. Additionally, skills, knowledge and/or experience with food preparation, safe food handling procedures, and reporting and identifying abuse and neglect are highly desirable.

3. Previous relevant experience/training to meet MDCH operating standards.

4. Must be deemed capable of performing the required tasks by the OHCDS.

PROVIDER QUALIFICATIONS: *AGENCY*

1. Providers must be at least 18 years of age, have the ability to communicate effectively both orally and in writing and follow instructions, be trained in first and cardiopulmonary resuscitation, be trained in universal precautions and blood-born pathogens and be in good standing with the law as validated by a criminal background check conducted by the OHCDS.
2. A registered nurse licensed to practice nursing in the State shall furnish supervision of Community Living Support providers. At the State's discretion, other qualified providers may supervise personal care providers. The direct care worker's supervisor shall be available to the worker at all times the worker is furnishing Community Living Support services.
3. The OHCDS and/or provider agency must train worker to properly perform each task required for each participant the worker serves before delivering the service to that participant. The supervisor must assure that each worker can competently and confidently perform every task assigned for each participant served. MDCH strongly recommends each worker delivering Community Living Support services complete a certified nursing assistance training course.

4. Community Living Support providers may perform higher-level, non-invasive tasks such as maintenance of catheters and feeding tubes, minor dressing changes, and wound care if the direct care worker has been individual trained and supervised by an RN for each participant who requires such care. The supervising RN must assure each worker's confidence and competence in the performance of each task required.
5. Individuals providing Community Living Supports services must have relevant experience or training and skills in housekeeping, household management, good health practices, observation, reporting, and recording information. Additionally, skills knowledge, and/or experience with food preparation, safe food handling procedures, and reporting and identifying abuse and neglect are highly desirable.

Print Employee Name: _____

Employee 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: _____

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
___ 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**

Please note: If at a later date Senior Services should become aware that a conflict of interest exists between the employee and the employer, the employee will be liable to Senior Services **to pay back ALL amounts** received under the employment arrangement while a conflict of interest was in existence. Also, if at any time of 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

PAYROLL PROCEDURES

In order to be paid correctly, avoid any delay, or forfeit the ability to be paid with Medicaid funds, the following 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 **on the 1st & 16th**

- **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.

- **Mileage logs must be turned in on the 1st & 16th with the corresponding timesheet.**

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

- **Do not include unauthorized hours on your timesheet.**
  - Unauthorized hours will not be paid.

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

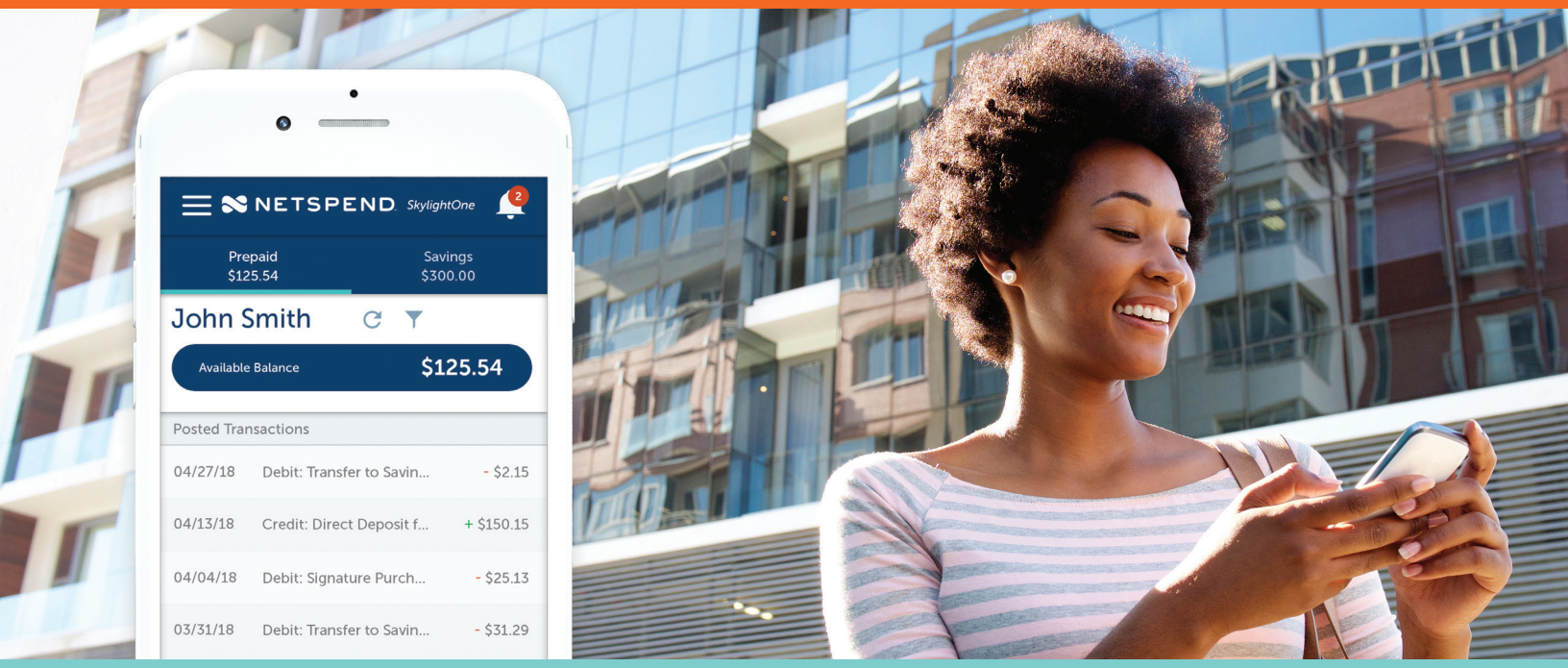
Need some cash? Locate the surcharge-free ATM[2] that is closest to where you are, wherever you are.

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.

Senior Services, Inc.

TRAINING RECORD

EMPLOYEE Name:

Employer Name:

Please initial each training requirement as you complete them and sign the bottom of the form when you have all three requirements completed. Then return this document to the Support Coordinator in the self-addressed stamped envelope.

1) I have completed the CPR training materials. I feel I could perform CPR in case of an emergency. (Not required if a DNR is in place)
_____(employee initials)

2) I have read the material on bloodborne pathogens and the use of universal precautions. I feel I am well informed about bloodborne pathogens and the use of universal precautions.
_____(employee initials)

3) I have read the First aid reference guide on basic first aide. I feel I could perform basic first aid if needed.
_____(employee initials)

I attest that all the above information is true and that I have completed all three training requirements.

_____ _____
Signature Date

I have additional training in the following areas/comments: Completion date:

_____

_____

_____

_____