STUART T. WILSON CPA, PC
Fiscal Intermediary

Genesee

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 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 (Two forms of identification are required. Please refer to page three for all options.)
  - Employer Signature on Page 2
  - Copy of Driver's License
  - Copy of Social Security Card
- ☐ 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
- ☐ Employee Wage Information
- ☐ Job Description
- ☐ Payroll Procedures (Please read carefully)
  - Employee Signature
- ☐ Direct Deposit Application (Attachment required)
- ☐ IPOS Training
- ☐ Provider 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: _____

AUTHORIZATION TO DISCLOSE
EMPLOYEE INFORMATION
AND RELEASE OF LIABILITY

I, _____, authorize Genesee Health System (GHS) and the GHS
(print full name)
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 GHS and the GHS Office of Recipient Rights, its officers, its agents
(print full name)
and its employees from any and all liability, claims, suits, and actions of any nature brought against GHS and the GHS Office of Recipient Rights, its officers, its agents and its employees etc. for disclosing the information requested by me and I shall indemnify and hold them harmless should any claims, suits or actions be filed against them.

PREVIOUS PLACES OF EMPLOYMENT:

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

_____ _____ _____
Applicant's Signature **Date** **Other names used**

_____ _____
Witness Signature **Date**

INFORMATION TO BE SENT TO:

_____Stuart T Wilson CPA CP_____
Provider/Consumer

_____6300 Schade Dr_____
Street Address

_____ Midland MI 48640 _____989-832-5404_____
City **State** **Zip Code** **FAX**

Fax this form to: (810) 257-3790 for processing

RIGHTS OFFICE USE ONLY

An individual with the above name does have a substantiated recipient rights violation(s) according to GHS records.

By: _____ Date: _____
GHS Office of Recipient Rights

Revised: 10/14/08

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

2022

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 widow(er)**
☐ **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, when to use the estimator at *www.irs.gov/W4App*, and privacy.

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); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **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 accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . ► ☐

TIP: To be accurate, submit a 2022 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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 Dependents

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 and 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 2022 if you meet both of the following conditions: you had no federal income tax liability in 2021 **and** you expect to have no federal income tax liability in 2022. You had no federal income tax liability in 2021 if (1) your total tax on line 24 on your 2021 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), 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 2022 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, 2023.

Your privacy. If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

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. Have dividend or capital gain income, or are subject to additional taxes, such as Additional Medicare Tax;

3. Have self-employment income (see below); or

4. 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.

If you (and your spouse) have a total of only two jobs, you may instead 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 roughly 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 2022 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.

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 2022 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:
- $25,900 if you're married filing jointly or qualifying widow(er)
- $19,400 if you're head of household
- $12,950 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 possessions 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 Widow(er)

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	$110	$850	$860	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,770	$1,870
$10,000 - 19,999	110	1,110	1,860	2,060	2,220	2,220	2,220	2,220	2,220	2,970	3,970	4,070
$20,000 - 29,999	850	1,860	2,800	3,000	3,160	3,160	3,160	3,160	3,910	4,910	5,910	6,010
$30,000 - 39,999	860	2,060	3,000	3,200	3,360	3,360	3,360	4,110	5,110	6,110	7,110	7,210
$40,000 - 49,999	1,020	2,220	3,160	3,360	3,520	3,520	4,270	5,270	6,270	7,270	8,270	8,370
$50,000 - 59,999	1,020	2,220	3,160	3,360	3,520	4,270	5,270	6,270	7,270	8,270	9,270	9,370
$60,000 - 69,999	1,020	2,220	3,160	3,360	4,270	5,270	6,270	7,270	8,270	9,270	10,270	10,370
$70,000 - 79,999	1,020	2,220	3,160	4,110	5,270	6,270	7,270	8,270	9,270	10,270	11,270	11,370
$80,000 - 99,999	1,020	2,820	4,760	5,960	7,120	8,120	9,120	10,120	11,120	12,120	13,150	13,450
$100,000 - 149,999	1,870	4,070	6,010	7,210	8,370	9,370	10,510	11,710	12,910	14,110	15,310	15,600
$150,000 - 239,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	15,340	16,540	16,830
$240,000 - 259,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	15,340	16,540	17,590
$260,000 - 279,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	16,100	18,100	19,190
$280,000 - 299,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	13,700	15,700	17,700	19,700	20,790
$300,000 - 319,999	2,040	4,440	6,580	7,980	9,340	11,300	13,300	15,300	17,300	19,300	21,300	22,390
$320,000 - 364,999	2,100	5,300	8,240	10,440	12,600	14,600	16,600	18,600	20,600	22,600	24,870	26,260
$365,000 - 524,999	2,970	6,470	9,710	12,210	14,670	16,970	19,270	21,570	23,870	26,170	28,470	29,870
$525,000 and over	3,140	6,840	10,280	12,980	15,640	18,140	20,640	23,140	25,640	28,140	30,640	32,240

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	$400	$930	$1,020	$1,020	$1,250	$1,870	$1,870	$1,870	$1,870	$1,970	$2,040	$2,040
$10,000 - 19,999	930	1,570	1,660	1,890	2,890	3,510	3,510	3,510	3,610	3,810	3,880	3,880
$20,000 - 29,999	1,020	1,660	1,990	2,990	3,990	4,610	4,610	4,710	4,910	5,110	5,180	5,180
$30,000 - 39,999	1,020	1,890	2,990	3,990	4,990	5,610	5,710	5,910	6,110	6,310	6,380	6,380
$40,000 - 59,999	1,870	3,510	4,610	5,610	6,680	7,500	7,700	7,900	8,100	8,300	8,370	8,370
$60,000 - 79,999	1,870	3,510	4,680	5,880	7,080	7,900	8,100	8,300	8,500	8,700	8,970	9,770
$80,000 - 99,999	1,940	3,780	5,080	6,280	7,480	8,300	8,500	8,700	9,100	10,100	10,970	11,770
$100,000 - 124,999	2,040	3,880	5,180	6,380	7,580	8,400	9,140	10,140	11,140	12,140	13,040	14,140
$125,000 - 149,999	2,040	3,880	5,180	6,520	8,520	10,140	11,140	12,140	13,320	14,620	15,790	16,890
$150,000 - 174,999	2,040	4,420	6,520	8,520	10,520	12,170	13,470	14,770	16,070	17,370	18,540	19,640
$175,000 - 199,999	2,720	5,360	7,460	9,630	11,930	13,860	15,160	16,460	17,760	19,060	20,230	21,330
$200,000 - 249,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,310
$250,000 - 399,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,310
$400,000 - 449,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,470
$450,000 and over	3,140	6,290	8,880	11,380	13,880	16,010	17,510	19,010	20,510	22,010	23,380	24,680

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	$760	$910	$1,020	$1,020	$1,020	$1,190	$1,870	$1,870	$1,870	$2,040	$2,040
$10,000 - 19,999	760	1,820	2,110	2,220	2,220	2,390	3,390	4,070	4,070	4,240	4,440	4,440
$20,000 - 29,999	910	2,110	2,400	2,510	2,680	3,680	4,680	5,360	5,530	5,730	5,930	5,930
$30,000 - 39,999	1,020	2,220	2,510	2,790	3,790	4,790	5,790	6,640	6,840	7,040	7,240	7,240
$40,000 - 59,999	1,020	2,240	3,530	4,640	5,640	6,780	7,980	8,860	9,060	9,260	9,460	9,460
$60,000 - 79,999	1,870	4,070	5,360	6,610	7,810	9,010	10,210	11,090	11,290	11,490	11,690	12,170
$80,000 - 99,999	1,870	4,210	5,700	7,010	8,210	9,410	10,610	11,490	11,690	12,380	13,370	14,170
$100,000 - 124,999	2,040	4,440	5,930	7,240	8,440	9,640	10,860	12,540	13,540	14,540	15,540	16,480
$125,000 - 149,999	2,040	4,440	5,930	7,240	8,860	10,860	12,860	14,540	15,540	16,830	18,130	19,230
$150,000 - 174,999	2,040	4,460	6,750	8,860	10,860	12,860	15,000	16,980	18,280	19,580	20,880	21,980
$175,000 - 199,999	2,720	5,920	8,210	10,320	12,600	14,900	17,200	19,180	20,480	21,780	23,080	24,180
$200,000 - 449,999	2,970	6,470	9,060	11,480	13,780	16,080	18,380	20,360	21,660	22,960	24,250	25,360
$450,000 and over	3,140	6,840	9,630	12,250	14,750	17,250	19,750	21,930	23,430	24,930	26,420	27,730

Employment Eligibility Verification

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

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

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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

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

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

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

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

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

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

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

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

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

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

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

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

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

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

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code

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

A. New Name *(if applicable)*			**B.** Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

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

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

Refer to the instructions for more information about acceptable receipts.

EMPLOYMENT AGREEMENT

This agreement, made this ____ day _____, 20_____, by and between _____, an Individual served in the Self- Determination Initiative and _____. The purpose of this agreement is to outline an (at will) employment contract which designates_____, the Individual as employer of_____, the community living/respite support staff.

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

1. Participate as requested by my employer in planning meetings for services/supports, and fully understand the Person Centered Plan.

2. Assist in maintaining physical conditions of my employer's home within reasonable health and safety standards of the community.

3. Assist my employer with meeting personal care needs, learn the responsibilities and skills necessary to maintain a household, communicating, accessing inclusive opportunities outside of the home, performing work or volunteer obligations, and achieving the desired outcomes, goals and objectives of the Person Centered Plan.

4. Provide guidance and positive support to my employer in considering options, making choices and following through with the consequences of their choices, achieving community connections, negotiating risks, and responding to dangers.

5. Assist in maintaining necessary documentation and records as required by the Self-Determination Initiative, or my employer. All records I 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 are the property of my employer. In addition, illness and incident reports will be filled out at appropriate times, as required or requested by Genesee Health System or my employer.

6. Immediately notify _____family member/guardian of any medical emergency or illness, and before taking my employer to a physician, except in an emergency.

7. Agree to abide by all applicable rules, regulations, and requirements pertaining to providing supports and services and agreed to between my employer, the Individual and Genesee Health System.

8. I hereby acknowledge receipt of the following rules and regulations:
   a) Recipient Rights Training provided by Genesee Health System Office of Recipient Rights will be taken within 30 days of hire.
   b) I agree to accept the jurisdiction of the GHS Office of Recipient Rights and to be subject to the recipient rights investigative process, if necessary.
   c) First Aid and CPR

d) Blood Borne Pathogens and TB testing
e) Any additional DCW training identified in the Individual Plan of Service

9. I understand that this is an employment at will relationship, which can be terminated by either party at anytime. Agree to give 14 days written notice to my employer if I need to terminate this employment agreement.

10. Acknowledge that the employment agreement is an employment at will relationship and which can be terminated at any time without cause, providing for reasonable notice, whenever possible.

11. Understand that although my paychecks will be drafted by:_____ _____ _____a ccording to the Fiscal Intermediary agreement with Genesee Health System. I understand that _____ is acting as a financial administrator of my employer's budget for the Self-Determination Initiative. I authorize _____to make the necessary employment tax payments and understand they are acting only as a financial administrator, and shall in no way be considered my employer.

12. Agree to hold the fiscal intermediary harmless for their role as the financial administration of my employer's budget/fund for the Self-Determination Initiative, and acknowledge that _____ is my only employer.

13. Understand and acknowledge Genesee Health System's role in this initiative, as outlined in the Self-Determination Agreement, and shall in no way be considered my employer.

14. Agree to hold Genesee Health System harmless for their role in this Self-Determination Initiative.

15. Understand that in consideration for the above stated agreement, I shall be compensated every two weeks. I have received time sheet instructions. The rate of pay is _____ per hour.

16. I agree to execute a Medicaid Provider Agreement with Genesee Health System and acknowledge that this agreement does not alter the fact that Genesee Health System is only the project administrator of the Self-Determination Initiative, and that my employer is _____. I understand that my employment is contingent on completion of this agreement.

I _____ (Employer) agree to the following:

1. Provide my fiscal intermediary with the necessary documentation to assure timely compensation of my employee.
2. Compensate my employee in the following manner: _____an hour (This should include a description of benefits or exclude benefits, whichever is agreed to) _____
3. Assure appropriate training to my employee. Further, I will assure that my providers meet the five minimum requirements of Chapter Three of the 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 participate in specific emergency procedures, and report on activities performed; 4) in good standing with law (i.e. not a fugitive from justice, a convicted felon, or an illegal alien); 5) able to perform basic first aid procedures. Further, Genesee Health System shall assure all other providers of services (i.e., clinical services, supports coordination, case management, personal agents), meet the required standards of Chapter Three of the State Medicaid Manual.

4. Evaluate the performance of my employee or contractors, and provide appropriate feedback to assure I am purchasing quality of services.
5. Assure that my employee executes a Medicaid Provider Agreement with Genesee Health System.

_____
Employee

_____
Employer/Individual

_____
Guardian

Original: *Employer/Individual*
Copy: *Employee, Fiscal Intermediary*

USE OF MEDICAID FUNDS AND THE 42CFR431.107 AGREEMENT

Medicaid is the primary financing source for most services and supports through the public mental health system in Michigan. In Michigan, GHS is a Medicaid specialty prepaid health plans, and function as managed care organizations. Since Medicaid funds are being used, there must be a separate agreement in place between each provider, including individuals employed by the person served as personal assistants, furnishing services and the GHS acting as a Pre-Paid health Plan (PHP). This agreement, called a 42CFR431.107 AGREEMENT, contains a set of stipulations that must be made to the GHS. The Provider agrees to: 1.) Keep records of its delivery of services; 2.) Make those records available for review at the request of the GHS; 3.) Disclose financial ownership interest in related Medicaid-financed provider entities; and 4.) Provide for ways to assure person served of services of its policies related to the person served's right to refuse treatment. These stipulations are described in federal Regulations at 42CFR431.107 and other sections of the Code of Federal Regulations as referenced therein. This agreement does not substitute for either the self-determination agreement, or employment agreements and purchase of service agreements, nor does it involve the same sorts of obligations that exist between the individual and their providers of service. It likewise. Does not obligate the GHS as a party to the agreements for receiving services and supports between the individual and chosen providers.

GENESEE HEALTH SYSTEM
42 CFR 431.107 AGREEMENT

The parties to this contract are Genesee Health System (GHS) "herein referred to as the Host Agency", _____ "herein referred to as "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.

The Host Agency Agrees to the following:

1) Upon receipt of this agreement, to certify the Provider as available to provide services to individuals who receive services and supports through arrangements authorized by the Host Agency or one of its subcontractors, and financed through Michigan's Medicaid Specialty Pre-paid Mental Health Plan where the individual is seeking or requesting services and/or supports in accordance with their person-centered-plan.

The Provider agrees to the following

1) To keep any records necessary to disclose the extent of services the provider furnishes to recipients of services.
2) On request, to furnish any information maintained under paragraph (1) of this section and any information regarding payments claimed by the Provider for furnished services under the person-centered plan of to the Host Agency, 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 1 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 the Host Agency is not the employer of the Provider of Services and that the Participant is the sole employer of the Provider of the 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. No 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 as specified on the foregoing pages, and so signify by affixing their signatures below.

_____ _____
Chief Executive Officer Date

_____ _____
Provider Agency/Individual Date

Original: Contract Manager
Copy: Fiscal Intermediary

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

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

Hourly Rate: _____

<u>Benefits:</u> (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**.*

Direct Care & Respite Responsibilities

Job Title: Community Living Support & Respite Staff

Reports to: Employer (assisted by Fiscal Intermediary)

Community Living Supports (CLS):

The supports include assistance, support (including reminding, observing, and/or guiding) and/or training in activities such as meal planning/preparation, laundry, routine household care and maintenance, activities of daily living such as bathing, eating , dressing, personal hygiene, shopping and money management, monitoring of medications, non-medical care (not requiring a nurse), socializations and relationship building, transportation, leisure choice and participation in regular community activities, and attendance to medical appointments. *REQUIREMENTS FOR DOCUMENTATION* A log with entries of the supports which are consistent with the supports indentified in the consumer's individual plan of service and signed by the consumer and care giver.

Respite Care:

Services provided on a short-term basis because of the absence or need for relief of the primary care giver. *REQUIRED DOCUMENTATION* A schedule of planned respite activities and completed log detailing the units of respite provided and signed by both the consumer and service provider.

Signed: _____ Date _____

Witnessed by: _____ Date _____

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 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
  - Insufficient documentation or progress notes will result in unpaid shifts
  - If a shift is paid that the funding agency deems ineligible due to insufficient documentation, funds will be recouped.
- **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:

- **Mail-out checks**
  - Paychecks will be received within 2-4 days of the pay date.
  - Missing checks may be reissued 10 business days from the date of the check. We do not reissue checks prior to that time.
- **Direct deposit**
  - 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.

_____ _____

Employee Signature Date

I have read and understand Stuart T. Wilson CPA, PC payroll procedures. Additionally, I understand that I am responsible for any information and/or notifications that are included with my paycheck/paystub.

STUART T. WILSON CPA, PC
Fiscal Intermediary

Direct Deposit Application

Name: _____ Email Address (**required**):_____

Employer's Name: _____ Organization: _____

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

- Direct deposit may take 2-3 weeks for initial set-up. Likewise, it **may take 2-3 weeks to cancel.**
- All cancellations must be submitted in writing.
- **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 direct deposit with Stuart T. Wilson CPA, PC.

_____ _____

Signature Date Phone #

Bank Account Information:

Account Type: ☐ Checking ☐ Savings

- **You must provide a voided check, membership card or a letter from your bank. The document must include your routing and account number. This ensures account accuracy. Deposit slips or your personal bank statements are not accepted.**

- **Handwritten information on this page will not be accepted.**

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

Genesee HEALTH SYSTEM
420 W. Fifth Avenue
Flint, MI 48503

TRAINING DOCUMENTATION FORM FOR PARAPROFESSIONAL STAFF / FAMILY

Date: _____ **Start Time:** _____ **Stop Time:** _____

Consumer Name: _____ **Case Number:** _____

Corporation / Home Name: _____

Trainer Signature and Credentials: _____

Topic / Issues Discussed: (Please list)		
Attendee Signature	**Printed Name**	**Title**

Routing:

Original to consumer record (via scanning by HID)

Copy to Provider Agency to maintain Training Records

Client Name: _____

DOB: _____

Staff Name: _____

Case Number: _____

STUART T. WILSON CPA, PC
Fiscal Intermediary

Genesee Health Systems
Training Information

Self-Determination Provider Requirements

- ☐ CPR & First Aid (Prior to providing services)
- ☐ Blood Borne Pathogens (Includes a TB test. A return reading of the test is required– Prior to providing services)
- ☐ Recipient Rights (Must be completed within 30 days of hire)
- ☐ IPOS (Prior to providing services)

For registration, please call the training center at (810) 762-5280.
Indicate that you are working for a self-determination participant.