STUART T. WILSON CPA, PC
Fiscal Intermediary

Region 4

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
- ☐ Employee Wage Information
- ☐ 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.

Employment Agreement

This agreement is made on: _____
(Date)

Between **Participant (Employer)**: _____
(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
(Employee Name)
employment is conditional on my employer's participation in the Self Determination in Long Term Care Program, administered by the waiver agent. If my employer ends their participation in the Self Determination in Long Term Care Program, 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 the waiver agent. 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 the waiver agent or my **employer**:
   _____.
   (Employer Name)

3. **I shall immediately notify my employer's physician and/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 the waiver agent regulations (described below) regarding my employment duties to the employer through the Self Determination in Long Term Care Program and I acknowledge receipt of the following rules and regulations:

   a. I am 18 years old or older, and a US Citizen or Legal Alien.

   b. I am able to demonstrate an ability to perform tasks employer requests.

c. I will complete CPR, blood borne pathogens/universal precautions, and basic first aid training within 30 days of employment. (If the participant is a DNR, this requirement can be waived)

d. I am not a Participant's Representative for the Self Determination Program.

e. I am not a legally responsible relative (spouse/guardian).

f. I will document ***time in*** and ***time out*** for each shift using a standardized form which will be supplied by the employer or Fiscal Intermediary.

g. I will not submit time sheets for time I have not worked or that is not signed by the appropriate person. I understand that to do so constitute **MEDICAID FRAUD** that is punishable by law.

h. I understand that I will not be paid for the time the employer is in the hospital or being care for by someone else.

i. I understand that all changes in the schedule must be approved by the employer.

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 not to sue the fiscal intermediary for its role as the financial administrator of my employer's Self Determination in Long Term Care Program funds and the waiver agent for its role in administering the Self Determination in Long Term Care Program.

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

10. I agree to execute a Medicaid Provider Agreement with the waiver agent and acknowledge that this agreement does not alter the fact that the waiver agent is only the project administrator of the Self Determination in Long Term Care Program, and that:
_____ is my employer. I understand that my employment is
(Employer Name)
contingent upon completing this agreement.

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

12. I understand that if my employer goes into the hospital, other medical care setting, or is cared for by someone else, I cannot be paid for the time I do not provide services.

13. I will not submit timesheets for any hours of work I have not performed. Falsifying timesheets is cause for legal proceedings to be pursued **as this constitutes Medicaid Fraud.**

14. I will contact my employer as soon as I am aware that I am ill or for any other reason I am not able to arrive to provide services.

15. I will treat my employer with respect and dignity at all times.

Article I
Employer Responsibilities

I, the **employer**: _____:
(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: $_____ per **hour**.

3. I understand I am approved for _____ **hours per week** of community living supports **stated in my budget,** and that I will have to consult with my Case Manager/Supports 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 that 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 supportive care.

7. I will assure that my employee executes a Medicaid Provider Agreement with the 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/approve any timesheets for hours that my employee has worked. I **will not** sign/approve any timesheets for hours that my employee **has not worked**. Falsifying timesheets is cause for legal proceedings to be pursued. **I have received and understand information provided regarding Medicaid Fraud.**

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:_____

Medicaid Provider Agreement

THIS AGREEMENT is entered into by and between the Waiver Agent and:

Participant Name: _____

And/or Other Representative: _____

Medicaid Provider: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: (___)_____ **Fax:** (___) _____ **E-mail:** _____

Federal ID#: _____ **Social Security#:** _____ **Birth date:** _____

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 are 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 Waiver/Project Choice.

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.[1]

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:** _____

[1] 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.).

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: _____

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

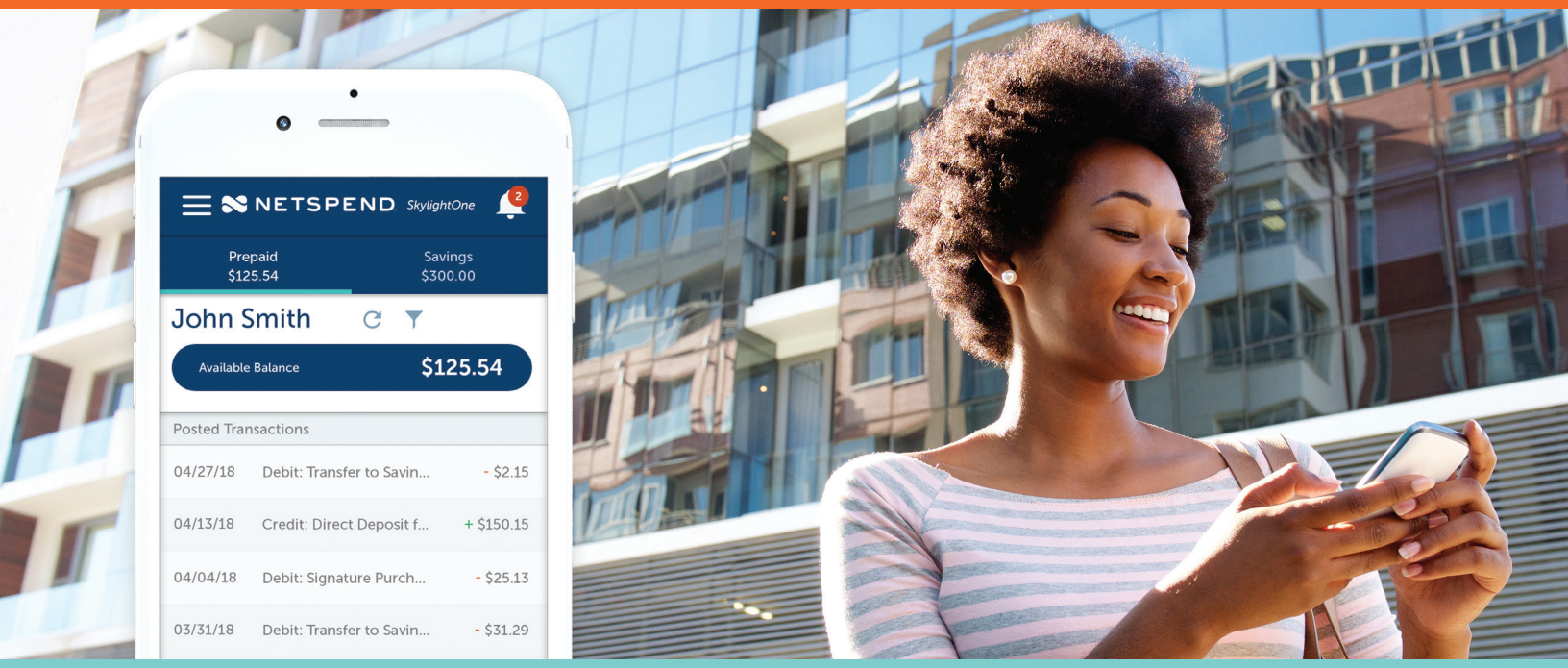
Need some cash? Locate the surcharge-free ATM[2] that is closest to where you are, wherever you are.

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.

Region IV Area Agency on Aging
Self Determination in Long Term Care Program
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. Please return this document to the Region IV Area Agency on Aging Support Coordinator in the self addressed stamped envelope that has been provided for your use.

Employee Initials:

1.) I have completed the CPR training materials and feel I could perform CPR in case of an emergency. _____

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

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

4.) I have read and understand the training on Corporate Compliance, Ethics & Deficit Reduction Act. _____

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

_____ _____
Employee Signature Date

I have further training in the following areas: Completion date:

_____ _____
_____ _____
_____ _____
_____ _____

Comments: _____
_____
_____
_____

Date received at Region IV: _____
WA Agent Staff confirming receipt of document: _____

Michigan Adult Tuberculosis Risk Assessment

Use this tool to identify & prioritize asymptomatic adults for latent TB infection (LTBI) testing
Do not repeat testing unless there are new risk factors since the last test
Do not treat for LTBI until active TB disease has been ruled out‡

Provider Name: _____ Assessment Date: _____

Patient Name: _____ DOB: _____

TB testing is recommended if any of the boxes below are checked

☐ **Birth, travel, or residence** in a country with an **elevated TB rate** for at least 1 month

- Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe
- Prioritize patients with at least one medical risk for progression (see User Guide on page 2 for this list)
- Interferon Gamma Release Assay (IGRA) is preferred over Tuberculin Skin Test (TST) for non-U.S.-born persons ≥2 years old

☐ **Immunosuppression**, current or planned
HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥15 mg/kg/day for ≥1 month) or other immunosuppressive medication

☐ **Close contact** to someone with infectious TB disease during lifetime

Treat for LTBI if TB test result is positive and active TB disease is ruled out‡

☐ **None**; no TB testing is indicated at this time

TB test ordered?	Yes	No	
If YES, type?	TST	IGRA	
Test result	Neg	Pos	If TST, _____ mm
Medical evaluation / CXR recommended	Yes	No	

‡ *For patients with TB symptoms or abnormal CXR consistent with active TB disease, evaluate for active TB disease with a CXR, symptom screen, and if indicated, sputum acid-fast bacilli (AFB) smears, cultures and nucleic acid amplification testing (NAAT).*

Michigan Adult Tuberculosis Risk Assessment User Guide

Prioritize persons with risks for progression

If health system resources do not allow for testing of all non-US-born persons from a country with an elevated TB rate, prioritize patients with at least one of the following medical risks for progression:

- diabetes mellitus
- smoker within past year
- end-stage renal disease
- leukemia or lymphoma
- silicosis
- cancer of head or neck
- intestinal bypass/gastrectomy
- chronic malabsorption
- body mass index ≤20
- history of CXR findings suggestive of previous or inactive TB (no prior treatment). Includes fibrosis or noncalcified nodules but does not include solitary calcified nodule or isolated pleural thickening. In addition to LTBI testing, evaluate for active TB disease.

Avoid testing persons at low risk

Routine testing of persons without risk factors is not recommended and may result in unnecessary evaluations and treatment because of false-positive test results.

When to repeat a risk assessment & test

The risk assessment should be administered at least once. Persons can be screened for new risk factors at subsequent preventive health visits. Re-testing should only be done in persons who previously tested negative and have new risk factors since the last assessment.

IGRA preference in BCG vaccinated

Because IGRA has increased specificity for TB infection in persons vaccinated with BCG, IGRA is preferred over the TST in these persons. Most persons born outside the US have been vaccinated with BCG.

Mandated testing

Certain populations may be mandated for testing by state regulation (e.g., healthcare workers, residents or employees of correctional institutions, substance abuse treatment facilities, homeless shelters, etc.) This risk assessment was created to focus testing on patients at highest risk and does not supersede mandated testing. Please refer to the Michigan Department of Licensing and Regulatory Affairs (LARA) for more information about TB screening regulation in Michigan.

Foreign travel or residence

Travel to countries with an elevated TB rate may be a risk for TB exposure in certain circumstances (e.g., extended duration, likely contact with persons with infectious TB, high prevalence of TB in travel location, non-tourist travel). The duration of at least 1 consecutive month to trigger testing is intended to identify travel most likely to involve TB exposure. TB screening tests can be falsely negative within the 8 weeks after exposure, so are best obtained 8 weeks after return from travel.

A negative TB test does not rule out active TB disease

A negative TST or IGRA result does not rule out active TB disease. In fact, a negative TST or IGRA in a patient with active TB disease can be a sign of extensive disease and poor outcome.

Evaluation for active TB disease

Patients with any of the following symptoms that are otherwise unexplained should be evaluated for active TB disease: cough for more than 2-3 weeks, fevers, night sweats, weight loss and hemoptysis. Evaluate for active TB disease with a CXR, symptom screen and if indicated, sputum AFB smears, cultures and NAAT. A negative TB test does not rule out active TB disease.

Michigan Adult Tuberculosis Risk Assessment User Guide

Age as a factor

This risk assessment tool is intended for adults. A risk assessment tool created for children is available on our website.

Age (among adults) is not considered in this risk assessment. However, younger adults have more years of expected life during which progression from latent infection to active TB disease could develop. Some programs or clinicians may additionally prioritize testing of younger non-US-born persons when all non-US-born are not tested.

LTBI treatment

Persons with LTBI and risk factors for progression to active TB disease should be offered treatment, once active TB disease has been ruled out.

Shorter regimens for treating LTBI have been shown to be as effective as 9 months of isoniazid and are more likely to be completed. Use of these shorter regimens is preferred in most patients. Drug-drug interactions and contact to drug resistant TB are typical reasons these regimens cannot be used.

CDC Recommended LTBI treatment regimens

Medication	Frequency	Duration	Doses
Isoniazid & Rifapentine	Weekly	12 weeks	12*
Rifampin	Daily	4 months	120
Isoniazid	Daily or 2x weekly	6–9 months	52-270

**11-12 doses in 16 weeks required for completion*

Refusal of recommended LTBI treatment

Refusal should be documented. Recommendations for treatment should be made at future encounters with medical services. If treatment is later accepted, TB disease should be excluded, and CXR repeated if it has been more than 6 months from the initial evaluation; or more than 3 months if there is immunosuppression.

Resources & References

- Treatment regimens for LTBI available on the CDC LTBI Resources website (www.cdc.gov/tb/topic/treatment/ltbi.htm)
- US Preventive Services Task Force Latent TB Infection Screening Recommendations are available on the US Preventive Services Task Force website (www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/latent-tuberculosis-infection-screening)
- This pamphlet was adapted from the California Adult Tuberculosis Risk Assessment and User Guide, created by the California TB Controllers Association, the California Department of Public Health, and the Curry International Tuberculosis Center (www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/TBCB-CA-TB-Risk-Assessment-and-Fact-Sheet.pdf)

Abbreviations

AFB, acid-fast bacilli; BCG, Bacillus Calmette-Guérin; CXR, chest x-ray; IGRA, interferon gamma release assay; LARA, Licensing and Regulatory Affairs; LTBI, latent TB infection; NAAT, nucleic acid amplification testing; TST, tuberculin skin test

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CORPORATE COMPLIANCE, ETHICS, & DEFICIT REDUCTION ACT TRAINING
CODE OF PROFESSIONAL ETHICS

All Providers shall conduct their professional relationships in accordance with the following code of professional ethics:

1. Shall not discriminate against or refuse professional services to anyone on the basis of race, color, age, sex, religion, national affiliation, marital status, height, weight, arrest record, disability, medical condition or sexual orientation.
2. Shall regard as their primary objective the welfare of the individual or group served.
3. Shall not without proper credentials provide care, treatment or services that require a license, registration or certification under applicable law or regulation.
4. Shall not use professional relationships to further their own interests, shall remain sensitive to any potential conflict of interest, or appearance of conflict of interest, and shall discuss such situations with CMH.
5. Shall maintain responsibility for providing quality services, only so long as there is a clear benefit to the person, and shall assist with obtaining other needed services when their services are no longer appropriate.
6. Shall not provide services in the employee's home or families home.
7. Shall not engage in sexual relationships with persons they serve in a professional capacity and shall not engage in sexual relationships with the significant others of the persons they serve in a professional capacity.
8. Shall recognize and advocate for the rights afforded consumers of mental health services.
9. Shall respect the privacy of service consumers and hold in confidence all information obtained in the course of professional service, disclosing confidences only when mandated or permitted by law. This applies both during and after the CMH contractual relationship.
10. Shall display a professional attitude toward applicants, consumers, colleagues and any sensitive situations arising within CMH.
11. Shall respect the rights, findings, views and actions of colleagues, shall treat them with fairness, courtesy and good faith, and shall use appropriate channels to express judgment.
12. Shall be aware of their potential influence on consumers and shall not exploit their trust.
13. Shall not engage in nor condone any form of harassment or discrimination.
14. Shall accept the responsibility to help protect the community against unethical practice by any individual or organization engaged in mental health services.

15. Shall accurately represent themselves and CMH to the public, distinguishing clearly between statements and actions made as individuals or as representatives of CMH , and refraining from any public activity, which could harm CMH or its consumers.
16. Shall bill only for services actually provided using a detailed timesheet or invoice.
17. Shall not bill for goods and services that were never delivered or rendered.
18. Shall not submit false service records or samples in order to show better than actual performance.
19. Shall not falsify time sheets or other documents.
20. Shall not pre-date or post-date documents.
21. Shall document support services delivered.
22. Shall not forge a signature- signing for someone else even if they ask you to sign.
23. Shall not provide services before all mandatory trainings are complete.
24. Shall not perform inappropriate or unnecessary services that are not medically necessary or does not meet the definition of the service in the Medicaid Provider Manual.
25. Documenting one-on-one service for each consumer when multiple consumers were served at the same time.
26. Using the same medical documentation for multiple services/shifts (for example, copying the same documentation and using it other dates instead of writing a specific document for each time period)
27. Shall understand that violation of this Code of Ethics may be considered a material breach of contract and could result in provider agreement termination.

False Claims Act

The False Claims Act (FCA) is a Federal law that establishes criminal and civil liability when any covered person or entity improperly receives reimbursement from or avoids payment to the Federal government.

In particular, the Federal FCA prohibits:

- Knowingly presenting, or causing to be presented, a false or fraudulent claim for payment;
- Knowingly making, using or causing to be made or used, a false record of statement to get a false claim paid or approved;
- Conspiring to defraud by getting a false claim allowed or paid;
- Certifying recipient of property from an unauthorized officer of the government, and;
- Knowingly making, using or causing to be made or used a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the government.

TIME PERIOD FOR A CLAIM TO BE BROUGHT

The statute of limitations for suits under the False Claims Act is the later of:

a) Within six years of the illegal conduct, or

b) Within three years after the Government knows or should have known about the illegal conduct, but in no event later than ten years after the illegal activity.

WHAT MONEY CAN BE RECOVERED

A person who brings a False Claims Act case is entitled to a proportional share of the funds that are recovered for the government. As a part of the process, the individual must provide the government with all of his or her information.

PROTECTIONS FOR PEOPLE WHO BRING FCA CASES

Anyone who lawfully acts to bring suit is protected from:

a) Discharge, demotion, suspension, threats, harassment, and discrimination.

b) If violated, an employee is entitled to reinstatement with seniority, double back pay, interest on back pay, compensation for discriminatory treatment, and attorney's fees.

MICHIGAN FALSE CLAIMS ACT

An Act to prohibit fraud in the obtaining of benefits or payments in connection with the medical assistance program; to prohibit kickbacks or bribes in connection with the program; to prohibit conspiracies in obtaining benefits or payments; to authorize the Attorney General to investigate alleged violations of this act;...to provide for civil actions to recover money received by reason of fraudulent conduct;...to prohibit retaliation; to provide for certain civil fines; and to prescribe remedies and penalties.

Any person may bring a civil action in the name of the State to recover losses.

At the time of filing, the person shall disclose, in writing, substantially all material evidence and information supporting the complaint.

The Attorney General may proceed, or if not, the individual may proceed with action.

If a person other than the Attorney General prevails in an action that the person initiates, the court shall award that person: Costs, reasonable attorney's fees, and based on effort, a percentage of monetary proceeds.

If the court finds an action under this section based primarily on information from other than the person bringing the action, the court shall award costs, reasonable attorney's fees, and not more than 10% of monetary recovery. If court finds that the person bringing the action planned, initiated, or participated in the conduct upon which the action is brought, then court may reduce or eliminate the share of proceeds.

A person other than the Attorney General shall not bring an action that is already the subject of a civil suit, criminal investigation, prosecution, or administrative investigation.

Frivolous Actions:

If a person proceeds with an action after the Attorney General declines, and the court finds it to be frivolous, the court shall award prevailing defendant actual and reasonable attorney's fees and expenses and impose a civil fine of not more than $10,000.

No Retaliation:

An employer shall not discharge, demote, suspend, threaten, harass, or otherwise discriminate against an employee who initiates, assists, or participates in a proceeding or court action.

An employer who violates this is liable to the employee for all of the following:

- Reinstatement to position without loss of seniority
- 2x back pay
- Interest on back pay
- Compensatory damages
- Other relief as necessary to make employee whole

WHISTLEBLOWERS' PROTECTION ACT

An Act to provide protection to employees who report a violation or suspected violation of state, local or federal law; to provide protection to employees who participate in hearings, investigations, legislative inquiries, or court actions; and to prescribe remedies and penalties.

An employer shall not discharge, threaten or otherwise discriminate against an employee regarding compensation, terms, conditions, location, or privileges of employment because the employee reports or is about to report a violation.

A person who alleges a violation of this act may bring a civil action for appropriate injunctive relief, or actual damages, within 90 days after the occurrence of the alleged violation.

An employer is not required to compensate an employee for participation in an investigation, hearing or inquiry held by a public body in accordance with this Act.

WHAT SHOULD I DO IF I RECOGNIZE A PROBLEM EXISTS?

You play a critical role in upholding the public trust by bringing compliance and ethics questions, issues and suggestions for correcting them to the attention of the following appropriate person(s). If you

recognize a problem similar to those mentioned in this training, please inform any one of the following, as applicable:

CONTACT INFORMATION FOR SUSPECTED COMPLIANCE VIOLATIONS

Please report suspected compliance violations to:

Stuart T. Wilson CPA, PC
6300 Schade Dr.
Midland, MI 48640 989-832-5400

Reports can also be made to the Mid-State Health Network (MSHN) Compliance Officer:

Kim Zimmerman
530 W. Ionia Street, Suite F
Lansing, MI 48933
P: 517.253.7525 C: 616.648.0485
kim.zimmerman@midstatehealthnetwork.org

MSHN COMPLIANCE LINE 1-844-793-1288

Complaints can also be made to:
MDCH Medicaid Fraud Hotline: 1.855.MI.FRAUD (643.7283)
HHS/OIG Hotline: 1.800.HHS.TIPS (447.8477)

The complexity of our operations demands a constant vigilance on everyone's part to assure a strong future in mental health service delivery.

All employees are responsible for reporting suspected fraud and ethical violations, and should do so without fear of retaliation.

Concerns may be reported via email, can be verbal or on an anonymous basis through U.S. mail.

Thank YOU for your commitment to fiscal integrity and ethical practices to uphold the public trust and support quality service.

You have finished reviewing the Corporate Compliance, Ethics and Deficit Reduction Act training.

Remember, this course is **NOT complete** until you sign, date, and submit the form documenting completion.