



**STUART T. WILSON CPA, PC**  
Fiscal Intermediary

**Barry County CMH**

**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
- W-4
- I-9 (Identification is required. Please refer to page two for all options.)
  - Employee Signature
  - Employer Signature
- Employment Agreement
  - Employer Signature
  - Employee Signature
- 42 CFR 431.107 Agreement
  - Provider Signature (Employee is the provider)
- Employee Wage Information
- Job Description
- 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](mailto: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: \_\_\_\_\_

# 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.**

**2024**

<b>Step 1: Enter Personal Information</b>	<b>(a)</b> First name and middle initial	Last name	<b>(b)</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 <a href="http://www.ssa.gov">www.ssa.gov</a> .
	City or town, state, and ZIP code		
	<b>(c)</b> <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> 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](http://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](http://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.)

<b>Step 3: Claim Dependent and Other Credits</b>	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 . . . . .	<b>3</b>	\$
<b>Step 4 (optional): Other Adjustments</b>	<b>(a) Other income (not from jobs).</b> 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 . . . . .	<b>4(a)</b>	\$
	<b>(b) Deductions.</b> 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 . . . . .	<b>4(b)</b>	\$
	<b>(c) Extra withholding.</b> Enter any additional tax you want withheld each pay period . . . . .	<b>4(c)</b>	\$

<b>Step 5: Sign Here</b>	Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.		
	_____ <b>Employee's signature</b> (This form is not valid unless you sign it.)	_____ <b>Date</b>	

<b>Employers Only</b>	Employer's name and address	First date of employment	Employer identification number (EIN)
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## 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](http://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](http://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](http://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
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
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
c Add the amounts from lines 2a and 2b and enter the result on line 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.
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)

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

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	
<p><b>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.</b></p>		Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):				
		<input type="checkbox"/> 1. A citizen of the United States				
		<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)				
		<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)				
<input type="checkbox"/> 4. A noncitizen (other than <b>Item Numbers 2.</b> and <b>3.</b> above) authorized to work until (exp. date, if any)						
If you check <b>Item Number 4.</b> , 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)	<p><b>Additional Information</b></p>    <p>Check here if you used an alternative procedure authorized by DHS to examine documents.</p>				
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)					

<p><b>Certification:</b> 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.</p>		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

**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
<ol style="list-style-type: none"> <li>1. U.S. Passport or U.S. Passport Card</li> <li>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</li> <li>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</li> <li>4. Employment Authorization Document that contains a photograph (Form I-766)</li> <li>5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole:               <ol style="list-style-type: none"> <li>a. Foreign passport; and</li> <li>b. Form I-94 or Form I-94A that has the following:                   <ol style="list-style-type: none"> <li>(1) The same name as the passport; and</li> <li>(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.</li> </ol> </li> </ol> </li> <li>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</li> </ol>	OR	<ol style="list-style-type: none"> <li>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</li> <li>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</li> <li>3. School ID card with a photograph</li> <li>4. Voter's registration card</li> <li>5. U.S. Military card or draft record</li> <li>6. Military dependent's ID card</li> <li>7. U.S. Coast Guard Merchant Mariner Card</li> <li>8. Native American tribal document</li> <li>9. Driver's license issued by a Canadian government authority</li> <li style="text-align: center;"><b>For persons under age 18 who are unable to present a document listed above:</b></li> <li>10. School record or report card</li> <li>11. Clinic, doctor, or hospital record</li> <li>12. Day-care or nursery school record</li> </ol>	AND	<ol style="list-style-type: none"> <li>1. A Social Security Account Number card, unless the card includes one of the following restrictions:               <ol style="list-style-type: none"> <li>(1) NOT VALID FOR EMPLOYMENT</li> <li>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</li> <li>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</li> </ol> </li> <li>2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)</li> <li>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</li> <li>4. Native American tribal document</li> <li>5. U.S. Citizen ID Card (Form I-197)</li> <li>6. Identification Card for Use of Resident Citizen in the United States (Form I-179)</li> <li>7. Employment authorization document issued by the Department of Homeland Security               <p style="margin-left: 20px;">For examples, see <a href="#">Section 7</a> and <a href="#">Section 13</a> of the M-274 on <a href="https://uscis.gov/i-9-central">uscis.gov/i-9-central</a>.</p> <p style="margin-left: 20px;">The Form I-766, Employment Authorization Document, is a List A, <b>Item Number 4</b>, document, not a List C document.</p> </li> </ol>
<p><b>Acceptable Receipts</b></p> <p>May be presented in lieu of a document listed above for a temporary period.</p> <p>For receipt validity dates, see the M-274.</p>				
<ul style="list-style-type: none"> <li>• Receipt for a replacement of a lost, stolen, or damaged List A document.</li> <li>• Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual.</li> <li>• Form I-94 with "RE" notation or refugee stamp issued to a refugee.</li> </ul>	OR	<p>Receipt for a replacement of a lost, stolen, or damaged List B document.</p>	AND	<p>Receipt for a replacement of a lost, stolen, or damaged List C document.</p>

\*Refer to the Employment Authorization Extensions page on [I-9 Central](#) for more information.



## Employment Agreement

This contract made this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_, by and between \_\_\_\_\_ (herein referred to as “**Employer**”) and \_\_\_\_\_ on my employer’s participation in the Self-Determination Initiative. If my employer is no longer a participant in the Initiative, I may no longer be employed. In order to acknowledge the terms of my employment, I agree to the following:

1. During the term of this Agreement, I shall assist my employer by performing the duties outlined in this agreement and any attachments to this agreement.
2. I agree to assist my employer in maintaining the necessary documentation and records as required by my employer or their host agency. I agree to complete all the necessary paperwork to secure necessary payroll deductions from my pay. All records I may have or assist in maintaining will be kept confidential and released only upon the consent of my employer. I acknowledge that all records I may have access to be the property of and must be returned to the employer at the time my employment relationship terminates. In addition, illness and incident reports will be filled out at appropriate times, as required by the host Agency or my employer.
3. I shall immediately notify \_\_\_\_\_ (**enter the name of the desired contact person, for example, it may be a family member**) or their designee of any medical emergency or illness. I will also notify designee \_\_\_\_\_ (**if applicable**) before taking my employer to the physician, except in case of an emergency.
4. I agree to participate in any meetings if requested by my employer.
5. I agree to abide by all of my employer’s rules and regulations pertaining to providing support to my employer through the Self-Determination Initiative.
6. I hereby acknowledge receipt of the following rules and regulations:
  - a) Attachment A (if applicable) to this agreement, which outlines the services I shall provide to my employer.
  - b) Attachment B (if applicable) to this agreement, which outlines the household rules of the employer. (Individual can add whatever additional rules they may have regarding phone usage, non-smoking etc., in their home).
  - c) If the Host Agency has any policies and/or procedures for the Self-Determination initiative, or other policies that employee needs to be aware of they should be given to the employee.
  - d) Attachment C to this agreement, which outlines the timesheet, required by the employer and copies of the required payroll tax forms

7. I understand that this is an employment at will relationship, which can be terminated by either party, at any time. However, I agree to give 5 days' written notice to my employer if I need to terminate this Employment Agreement.
8. I understand that, although my pay check will be drafted by the fiscal intermediary, they are only acting as a financial administrator of my employer's budget/funds for the Self-Determination initiative.
9. I agree to hold the fiscal intermediary harmless for their role as the financial administrator of my employer's budget/fund for the Self-Determination Initiative, and acknowledge that I have only one employer.
10. I understand and acknowledge that the host Agency's role in this project is that of project administrator, and that the Host Agency is not my employer.
11. Further, I agree to hold the Host Agency, harmless for their role as a project administrator of the Self-Determination Initiative.
12. I agree to the following compensation for the services I shall perform: (This should be specific.)

\_\_\_\_\_  
\_\_\_\_\_

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

I, \_\_\_\_\_, (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: (This should be specific and agree with line 12 above.)

\_\_\_\_\_  
\_\_\_\_\_

3. Assure appropriate training to my employee. Further, I will assure that my providers meet the five minimum requirements of Chapter Three of the State Medicaid Manual:
  - a) At least 18 years of age;
  - b) Able to prevent transmission of any communicable disease from self to others in the environment in which they providing supports;

- c) Able to communicate expressively and receptively with me in order to follow individual plan requirements and participant-specific emergency procedures, and report on activities performed;
- d) In good standing with the law (i.e. not a fugitive from justice, a convicted felon, or an illegal alien);
- e) Able to perform basic first aid procedures.

Further, the Host Agency shall assure all other providers of services (i.e., clinical services, supports coordination, personal agents); meet the required standards of Chapter Three of the State Medicaid Manual.

- 4. Evaluate the performance of my employees or contractors, and provide appropriate feedback to assure I am purchasing quality of services.
- 5. Assure that my employee executes a 42CFR 431.107 agreement with the specified Waiver Agency Organization.**

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employer Signature

\_\_\_\_\_  
Date

Employer: \_\_\_\_\_

### **42 CFR 431.107 Agreements**

The parties of this contract are the mental health agency (“herein referred to as the Host Agency”), and \_\_\_\_\_ (“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 is 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 furnishing services under the person-centered plan 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(b), 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 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.

\_\_\_\_\_  
Executive Director or Self Determination Coordinator

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider Agency/Employee

\_\_\_\_\_  
Date



### Employee Wage Information

Employee Name: \_\_\_\_\_

Employee Phone #: (\_\_\_\_\_) \_\_\_\_\_

Employee Email: \_\_\_\_\_

Is your address the same as your employer?  yes  no

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

**This portion to be completed by the employer/representative.**

*Employers, please review your budget to ensure accuracy.*

Hourly Rate: \_\_\_\_\_

**Benefits:** (If applicable)

Holiday Pay

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

Vacation/PTO  \_\_\_\_\_ hours per calendar year

*Vacation time is calculated January-December. If left unused, it does not roll over. If employment is terminated or participant leaves the program, any unused vacation is forfeited.*

***Benefits are subject to budget allocation.***

## JOB DESCRIPTION & REQUIREMENTS

Employer Name:

Employee Name:

Supervisor:

Job Title: **Direct Support Professional**

Start/Updated Date:

Personal Representative (ex., family, friend, community member, lead staff, etc.) who will assist the Employer with their Self-Determined Arrangement:

### JOB REQUIREMENTS & QUALIFICATIONS

1. Employee must be at least 18 years of age.
2. Employee must provide proof of their eligibility to work in the United States.
3. Employee must attend all required training.
4. Employee must follow employers' Person-Centered Plan.
5. Employee must read and understand the job description and be able to perform the Specific Responsibilities (listed below) both for themselves, where applicable, and for their employer.
6. Employee must communicate effectively.
7. Employee must be in good standing with the law.
8. If the employee is the stand-by guardian and assumes powers and duties of the initially appointed guardian, the employee will no longer be eligible to receive reimbursement for Medicaid specialty mental health services.
9. Employee must consent to a criminal background check, driving record check and check of the Abuse and Neglect Registry.
10. If transportation of employer is a job requirement, employee must maintain a current Michigan Operator License (driver's license). Failure to maintain a current license may lead to the employee's inability to transport their employer and/or dismissal.
11. If transportation of employer is a job requirement, employee must provide proof of a current motor vehicle insurance policy. The policy must be maintained for the duration of employment. If changes are made to the policy, the employer must be notified, and new proof of insurance must be given to ISK.

### REQUIRED TRAININGS

Recipient Rights – updated annually; Bloodborne Pathogens – updated annually; Basic Knowledge of First Aid – updated annually; any additional training required by the Person-Centered Plan; Behavior Plan and/or requested by the employer.

*Employee will receive training in the employer's IPOS (Individual Plan of Service) at the time of hire, and updated annually, or as IPOS is updated. By signing this Job Description, I, employer, acknowledge that a designated individual (CMH staff or my designated staff) has trained my employee in my current IPOS. By signing this Job Description, I, employee, acknowledge that I have received training in my employer's current IPOS.*

IPOS Training completed on \_\_\_\_\_ trained by \_\_\_\_\_ / \_\_\_\_\_  
(date) (Trainer staff name) (date)

**GENERAL & SPECIFIC RESPONSIBILITIES**

*The general and specific responsibilities listed below are directly tied to goals in the employer's current IPOS. By signing this Job Description, I, employer, acknowledge that I have ensured my employee has received training in my current IPOS. By signing this Job Description, I, employee, acknowledge that I have received training in my employer's current IPOS.*

1.

2.

3.

4.

5.

6.

7.



**HOUSEHOLD RULES**

These rules may include dress code, smoking policy, phone usage, visitors at work, conduct during personal care, etc.

- 1.

**PROCEDURES FOR CALLING-IN**

These are procedures on who to call if the employee is sick or experiencing an emergency and cannot report to work. Medicaid requires that an “emergency back-up plan” be developed by your employer and in place in order to maintain your employer’s health and safety.

1. .

**PROCEDURES FOR ARRANGING TIME OFF**

These are procedures for arranging, in advance, coverage for time off.

- 1.

**MEDICATION**

**EMERGENCY CONTACT INFORMATION**

Phone numbers are listed in specific call order. In the event of an emergency, the employee should begin by calling individuals who appear at the top of the list then move down the list in order until an emergency contact is reached.

Name	Relationship	Phone Number #1	Phone Number #2

**SIGNATURES**

---

EMPLOYER / DATE

---

EMPLOYEE\* / DATE

---

GUARDIAN / DATE

---

SELF-DETERMINATION STAFF / DATE

---

OTHER / DATE

## **CMH PAYROLL PROCEDURES**

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

### **Turning in Timesheets for Payment:**

- **Please refer to the payroll calendar for scheduled pay days.**
  - All time worked must be reported within 14 days of the end of the pay period.
- **Timesheets received late and/or separate may not be paid on time.**
  - All timesheets for a Participant are to be faxed/e-mailed together by noon on Monday each week.
- **Only correct timesheets will be processed.**
  - If a timesheet contains omissions or errors, it will be returned to the employer and payment may be delayed.
    - Overlapping time with another provider will not be processed
    - Only authorized hours will be paid
- **Mileage logs must be turned in weekly with the corresponding timesheet.**
- **No Photocopied signatures will be accepted.**
  - A new timesheet must be used each week. Duplicated timesheets are not accepted.

### **Payment Methods:**

- **Direct Deposit or Netspend Skylight ONE Payroll Card**
  - Check stubs are sent via email.
- **Changes in payment method must be submitted in writing and may take 2-3 weeks to become effective.**
  - Do not close your bank account without providing our office with enough notification; otherwise your payment will be delayed.
  - Address changes must be submitted in writing.

Name: \_\_\_\_\_ Employer's Name: \_\_\_\_\_

Email Address (required): \_\_\_\_\_

**(Must choose one)**

<p><input type="checkbox"/> <b>Direct Deposit</b> A voided check, a letter from the bank or a copy of a membership card that includes both the account and routing number <b>must</b> be attached. *See information below</p> <p>Account Type:   <input type="checkbox"/> Checking   <input type="checkbox"/> Savings</p>	<p><input type="checkbox"/> <b>Netspend Skylight ONE Payroll Card</b> *See attached information</p>
---	---

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](mailto: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](mailto: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.<sup>1</sup>

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<sup>2</sup> that is closest to where you are, wherever you are.



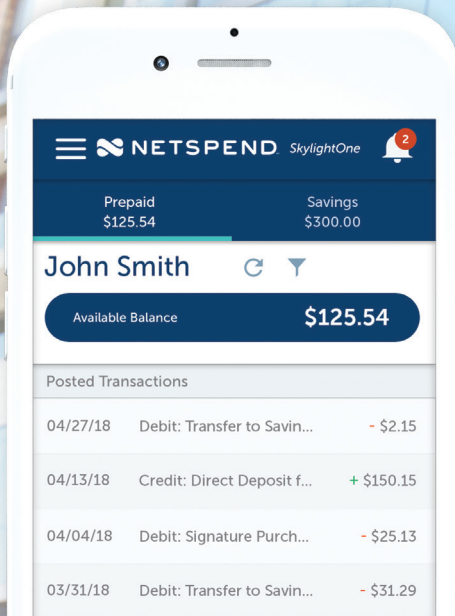
## See your most recent transactions

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<sup>1</sup> or email whenever you get paid, for every transaction, or just periodic balance updates with Anytime Alerts™.



Download the Skylight ONE Mobile App Today!



**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.

<sup>1</sup> No charge for this service, but your wireless carrier may charge for messages or data.

<sup>2</sup> 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 BofI 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 BofI 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. BofI Federal Bank, Republic Bank & Trust Company and SunTrust Bank; Members FDIC. Netspend, a TSYS® Company, is a registered agent of BofI 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.

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# 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.<sup>1</sup> 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.<sup>2</sup>

### 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.<sup>3</sup> 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.<sup>2,3</sup>

### 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.<sup>4</sup> 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.<sup>2</sup>

### 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](http://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.<sup>5</sup> 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.<sup>6</sup>

<sup>1</sup> 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.

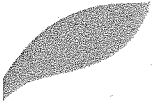
<sup>2</sup> There may be a cost for additional replacement cards. Consult your Cardholder Agreement and fee schedule for details.

<sup>3</sup> 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.

<sup>4</sup> 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.

<sup>5</sup> Skylight does not charge for this service, but your wireless carrier may charge you for messages or data.

<sup>6</sup> A fee may apply for this call. Consult your Fee Schedule for details.



# Barry County Community Mental Health Authority

## Mental Health and Substance Abuse Services

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Linda Maupin, Board Chair  
Richard Thiemkey, Executive Director

Dear Providers,

Included you will find documentation for Respite services and CLS services. Many of you are familiar with at least one of these services, but maybe not both. This letter and following documentation serves as a general refresher of services and how to make sure that documentation is filled out correctly. While we appreciate all of the work that you do for our clients (tireless and thankless work!), it cannot be understated the amount of audits that go into service note documentation, as well as the paramount importance of correct documentation. Upon finding errors in documentation, the federal government will often recoup money from the CMH, who then needs to recoup money from the Fiscal Intermediary, who may then recoup money from you-the provider. Therefore, it is imperative that we go over how to correctly document services. If you have any questions, please never hesitate to reach out to the case manager assigned to the client's case, or myself.

First, I would like to clarify the difference between CLS and Respite. A reminder, you may only bill for a service that is authorized by the treatment plan. If you work with the client to build their skills by promoting independence in personal care and their daily life, or working on community integration, you are likely billing for CLS. While you can do those things with Respite, there is no skill-building involved with Respite. Respite is strictly an intermitted break for the primary caregiver.

For respite documentation and CLS documentation, it is important that these notes are unique, and do not repeat. While we understand that many people have established routines, these catch eyes of government auditors. It is also important that each field is filled out. While it may seem like a lot, we have to document those same fields when we provide services internally, including describing client's overall satisfaction. On the CLS documentation, there may be multiple goals worked on during your shift and each goal needs have the description of what the client did, the intervention provided by the provider, and the progress toward that objective.

We know you all do a great job making sure that the client's needs are met, and we truly appreciate the work you do. Please keep this letter as a periodic reminder, which we all benefit from, to make sure standards are met, and decrease the chances of recoupment due to audits ☺

Thank you,

Cody Davis  
Supports Coordinator/Self-Determination Coordinator  
Barry County Community Mental Health Authority

An Affiliate of Southwest Michigan Behavioral Health  
Accredited by Commission of Accreditation of Rehabilitation Facilities

## Self-Determination Service Documentation “Cheat Sheet”

(Please refer to corresponding numbers on service note)

### CLS Documentation:

- 1- Name of individual you are providing services for
- 2- Date the service is being provided
- 3- And 4- Start time and stop time of service being provided. Please do not round. If you choose to end service at 4:56 pm, do not put down 5pm, please continue to provide services until 5pm.
- 4- See 3
- 5- This is the assigned case number from CMH. This can be found on the client treatment plan
- 6- The assigned case worker/supports coordinator for the client
- 7- The objectives come from the treatment plan-please state the CLS objective worked on during your service. It will be helpful to have the treatment plan to refer to. Please obtain this from the guardian or the case manager.
- 8- Please refer to the Level of Support section near the top of the documentation sheet and fill out appropriately.
- 9- The location: at home, in the community, at the library, etc
- 10- This ties into the level of support required. If you needed to do a full physical assist, what did you do to help the person complete the objective? If it was a partial physical, what did you versus what did the client do? How many verbal prompts did it take to complete the objective
- 11- Did the client make good progress toward their objective? How did they participate in completing their objective?
- 12- Please describe, in their own words, client satisfaction with the service today. If this was not discussed, or client is non-verbal, please put “Not discussed,” or if client seemed happy/upset, please describe.
- 13- PLEASE SIGN YOUR NAME FOR EACH SERVICE
- 14- Please make sure the date matches the date of service. We have seen where providers wait to sign their documentation all at once, and the signature date does not match with service date. They do need to match.

7-11 are repeated on this sheet, as multiple objectives are likely to be worked on during a service. Each objective addressed needs this information.

Respite Documentation follows similar pattern as above. Please make sure each field is filled out, following the above guideline.



## Barry Mental Health Authority - Independent CLS Staff Documentation

Consumer Name 1 Start Time 3 Case Number 5  
 Date of Service 2 Stop Time 4 CSM/SC 6

**Level of Support** (Choose at least one for each Goal / Objective area below):

**4** – Full Physical Assist **3** – Light/Partial Physical Assist **2** – Guiding-Verbal/Gesture **1** – Monitoring/Observing/Reminding **0** – Independent **R** - Refused

*Please write in the Objective above in the space provided below:*

Objective 7			
Level of Support Required	<b>8</b>	Location	<b>9</b>
Staff Intervention:			
10			
Progress towards achieving the Objective:			
11			
Objective 7			
Level of Support Required	<b>8</b>	Location	<b>9</b>
Staff Intervention:			
10			
Progress towards achieving the Objective:			
11			
Objective <b>7</b>			
Level of Support Required	<b>8</b>	Location	<b>9</b>
Staff Intervention:			
10			
Progress towards achieving the Objective:			
11			
<b>Overall Satisfaction</b> - 'In their own words'			
<b>12</b>			

Staff Signature \_\_\_\_\_ 13 \_\_\_\_\_ Date \_\_\_\_\_ 14 \_\_\_\_\_

**Barry County Community Mental Health Authority  
Independent Respite Staff Documentation  
DATE**

Consumer Name 1 \_\_\_\_\_ Start Time 3 \_\_\_\_\_ Case Number 5 \_\_\_\_\_  
Date of Service 2 \_\_\_\_\_ Stop Time 4 \_\_\_\_\_ CSM/SC 6 \_\_\_\_\_

Respite Goal: <u>7</u>
Please provide a brief summary of what occurred or was provided:  <u>8</u>

**Staff Signature** 9 \_\_\_\_\_ **Date** 10 \_\_\_\_\_

Consumer Name \_\_\_\_\_ Start Time \_\_\_\_\_ Case Number \_\_\_\_\_  
Date of Service \_\_\_\_\_ Stop Time \_\_\_\_\_ CSM/SC \_\_\_\_\_

Respite Goal:
Please provide a brief summary of what occurred or was provided:

**Staff Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Consumer Name \_\_\_\_\_ Start Time \_\_\_\_\_ Case Number \_\_\_\_\_  
Date of Service \_\_\_\_\_ Stop Time \_\_\_\_\_ CSM/SC \_\_\_\_\_

Respite Goal:
Please provide a brief summary of what occurred or was provided:

**Staff Signature** \_\_\_\_\_ **Date** \_\_\_\_\_