STUART T. WILSON CPA, PC
CERTIFIED PUBLIC ACCOUNTANT
FISCAL INTERMEDIARY

Macomb

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 (Two forms of identification are required. Please refer to page three for all options.)
  - Employer Signature on Page 2
  - Copy of Driver's License
  - Copy of Social Security Card
- ☐ Employment Agreement
  - Employer Signature
  - Employee Signature
- ☐ Medicaid Provider Agreement
  - Provider Signature (Employee is the provider)
  - Our office obtains the second signature after the paperwork is processed
- ☐ Employee Wage Information
- ☐ Employee Eligibility Checklist
- ☐ Recipient Rights Check Authorization
- ☐ Payroll Procedures (Please read carefully)
  - Employee Signature
- ☐ Copy of Current Auto Insurance Card
- ☐ Direct Deposit Application (Attachment required)
- ☐ IPOS Training
- ☐ Required Training (Training must be submitted with/by your first timesheet)

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

STUART T. WILSON CPA, PC
CERTIFIED PUBLIC ACCOUNTANT
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: _____

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

2020

Step 1: Enter Personal Information

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

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

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

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ► ☐

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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

Step 3: Claim Dependents

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

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

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

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

General Instructions

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.

Exemption from withholding. You may claim exemption from withholding for 2020 if you meet both of the following conditions: you had no federal income tax liability in 2019 **and** you expect to have no federal income tax liability in 2020. You had no federal income tax liability in 2019 if (1) your total tax on line 16 on your 2019 Form 1040 or 1040-SR is zero (or less than the sum of lines 18a, 18b, and 18c), 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 2020 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 16, 2021.

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

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

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

1. Expect to work only part of the year;

2. Have dividend or capital gain income, or are subject to additional taxes, such as the additional Medicare tax;

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

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

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

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

Specific Instructions

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

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

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

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

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

Step 3. Step 3 of Form W-4 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. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. 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 2020 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

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

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

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

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

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

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

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

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

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

1 Enter an estimate of your 2020 itemized deductions (from Schedule A (Form 1040 or 1040-SR)). 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:
- $24,800 if you're married filing jointly or qualifying widow(er)
- $18,650 if you're head of household
- $12,400 if you're single or married filing separately

. . . . . **2** $ _____

3 If line 1 is greater than line 2, subtract line 2 from line 1. 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 or 1040-SR)). See Pub. 505 for more information **4** $ _____

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

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

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

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

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

Married Filing Jointly or Qualifying Widow(er)

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$220	$850	$900	$1,020	$1,020	$1,020	$1,020	$1,020	$1,210	$1,870	$1,870
$10,000 - 19,999	220	1,220	1,900	2,100	2,220	2,220	2,220	2,220	2,410	3,410	4,070	4,070
$20,000 - 29,999	850	1,900	2,730	2,930	3,050	3,050	3,050	3,240	4,240	5,240	5,900	5,900
$30,000 - 39,999	900	2,100	2,930	3,130	3,250	3,250	3,440	4,440	5,440	6,440	7,100	7,100
$40,000 - 49,999	1,020	2,220	3,050	3,250	3,370	3,570	4,570	5,570	6,570	7,570	8,220	8,220
$50,000 - 59,999	1,020	2,220	3,050	3,250	3,570	4,570	5,570	6,570	7,570	8,570	9,220	9,220
$60,000 - 69,999	1,020	2,220	3,050	3,440	4,570	5,570	6,570	7,570	8,570	9,570	10,220	10,220
$70,000 - 79,999	1,020	2,220	3,240	4,440	5,570	6,570	7,570	8,570	9,570	10,570	11,220	11,240
$80,000 - 99,999	1,060	3,260	5,090	6,290	7,420	8,420	9,420	10,420	11,420	12,420	13,260	13,460
$100,000 - 149,999	1,870	4,070	5,900	7,100	8,220	9,320	10,520	11,720	12,920	14,120	14,980	15,180
$150,000 - 239,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,190	16,050	16,250
$240,000 - 259,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,520	17,170	18,170
$260,000 - 279,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	13,120	15,120	17,120	18,770	19,770
$280,000 - 299,999	2,040	4,440	6,470	7,870	9,190	10,720	12,720	14,720	16,720	18,720	20,370	21,370
$300,000 - 319,999	2,040	4,440	6,470	8,200	10,320	12,320	14,320	16,320	18,320	20,320	21,970	22,970
$320,000 - 364,999	2,720	5,920	8,750	10,950	13,070	15,070	17,070	19,070	21,290	23,590	25,540	26,840
$365,000 - 524,999	2,970	6,470	9,600	12,100	14,530	16,830	19,130	21,430	23,730	26,030	27,980	29,280
$525,000 and over	3,140	6,840	10,170	12,870	15,500	18,000	20,500	23,000	25,500	28,000	30,150	31,650

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	$460	$940	$1,020	$1,020	$1,470	$1,870	$1,870	$1,870	$1,870	$2,040	$2,040	$2,040
$10,000 - 19,999	940	1,530	1,610	2,060	3,060	3,460	3,460	3,460	3,640	3,830	3,830	3,830
$20,000 - 29,999	1,020	1,610	2,130	3,130	4,130	4,540	4,540	4,720	4,920	5,110	5,110	5,110
$30,000 - 39,999	1,020	2,060	3,130	4,130	5,130	5,540	5,720	5,920	6,120	6,310	6,310	6,310
$40,000 - 59,999	1,870	3,460	4,540	5,540	6,690	7,290	7,490	7,690	7,890	8,080	8,080	8,080
$60,000 - 79,999	1,870	3,460	4,690	5,890	7,090	7,690	7,890	8,090	8,290	8,480	9,260	10,060
$80,000 - 99,999	2,020	3,810	5,090	6,290	7,490	8,090	8,290	8,490	9,470	10,460	11,260	12,060
$100,000 - 124,999	2,040	3,830	5,110	6,310	7,510	8,430	9,430	10,430	11,430	12,420	13,520	14,620
$125,000 - 149,999	2,040	3,830	5,110	7,030	9,030	10,430	11,430	12,580	13,880	15,170	16,270	17,370
$150,000 - 174,999	2,360	4,950	7,030	9,030	11,030	12,730	14,030	15,330	16,630	17,920	19,020	20,120
$175,000 - 199,999	2,720	5,310	7,540	9,840	12,140	13,840	15,140	16,440	17,740	19,030	20,130	21,230
$200,000 - 249,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
$250,000 - 399,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
$400,000 - 449,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,450	19,940	21,240	22,540
$450,000 and over	3,140	6,230	8,810	11,310	13,810	15,710	17,210	18,710	20,210	21,700	23,000	24,300

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	$830	$930	$1,020	$1,020	$1,020	$1,480	$1,870	$1,870	$1,930	$2,040	$2,040
$10,000 - 19,999	830	1,920	2,130	2,220	2,220	2,680	3,680	4,070	4,130	4,330	4,440	4,440
$20,000 - 29,999	930	2,130	2,350	2,430	2,900	3,900	4,900	5,340	5,540	5,740	5,850	5,850
$30,000 - 39,999	1,020	2,220	2,430	2,980	3,980	4,980	6,040	6,630	6,830	7,030	7,140	7,140
$40,000 - 59,999	1,020	2,530	3,750	4,830	5,860	7,060	8,260	8,850	9,050	9,250	9,360	9,360
$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,780	10,980	11,180	11,580	12,380
$80,000 - 99,999	1,900	4,300	5,710	7,000	8,200	9,400	10,600	11,180	11,670	12,670	13,580	14,380
$100,000 - 124,999	2,040	4,440	5,850	7,140	8,340	9,540	11,360	12,750	13,750	14,750	15,770	16,870
$125,000 - 149,999	2,040	4,440	5,850	7,360	9,360	11,360	13,360	14,750	16,010	17,310	18,520	19,620
$150,000 - 174,999	2,040	5,060	7,280	9,360	11,360	13,480	15,780	17,460	18,760	20,060	21,270	22,370
$175,000 - 199,999	2,720	5,920	8,130	10,480	12,780	15,080	17,380	19,070	20,370	21,670	22,880	23,980
$200,000 - 249,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
$250,000 - 349,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
$350,000 - 449,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,900	25,200
$450,000 and over	3,140	6,840	9,560	12,140	14,640	17,140	19,640	21,530	23,030	24,530	25,940	27,240

Employment Eligibility Verification

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

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

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

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

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

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

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

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

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

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

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

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

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

Additional Information

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

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

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

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

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

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

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

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

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

Refer to the instructions for more information about acceptable receipts.

EMPLOYMENT AGREEMENT

This agreement is made on_____
between_____ ("employer") and _____
("employee") to describe the supports that the employee will provide to the employer and the terms and conditions of employment.

Article I
EMPLOYEE RESPONSIBILITIES

I, _____ (employee) acknowledge and agree that employment is conditioned on my employer's participation in the Choice Voucher System administered by Macomb County Community Mental Health Services (MCCMHS). If my employer ends participation in the Choice Voucher System, my employment may end. I agree to the following terms of employment:

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

2. I agree to assist my employer in maintaining the documentation and records required by my employer or MCCMHS. 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 MCCMHS or my employer.

3. I agree that if I become aware of or witness my employer suffer a physical injury, illness, or other adverse event that I will provide immediate comfort and protection, and assure immediate medical treatment for my employer.

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 MCCMHS regulations (described below) regarding my employment duties to the employer through the Choice Voucher System, and I acknowledge receipt of the following rules and regulations:

    a. Attachment A to this Agreement, which outlines the goals and outcomes of my employer's individual plan of service and the services and supports that I will be providing.

    b. Attachment B to this Agreement, Recipient Rights Protection Requirements. I will also receive a copy of the Recipient Rights Booklet, a copy of Chapter 7 of the Michigan Mental Health Code, and a copy of

Chapter 7 of the MDCH Administrative Rules. I agree to complete recipient rights training and all other required training prior to my first day of work. I agree to assist my employer in filing right complaints upon request. I also understand that I have a responsibility to report rights violations of which I am aware or any potential abusive or neglectful situations I observe. I understand that I may be required to cooperate with a recipient rights investigation and/or assist my employer with exercising his or her rights.

c. Attachment C to the Agreement which outlines Employer's House Rules. Additional changes to the House Rules shall be provided to me by my Employer in writing, and a copy shall be attached to the original Employment Agreement.

d. Attachment D, outlining the reporting and documentation requirements for verifying my hours worked. The Fiscal Intermediary will provide this to me.

e. The Chapter 9 policies of the MCCMH MCO Policy Manual (Recipient Rights). These policies may be accessed from the MCCMHS Policy website at the following address: http://www.mccmh.net/MCCMHPolicies/tabid/80/Default.aspx

6. I understand that this is an employment at will relationship, which can be terminated by me or by 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 _____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 MCCMHS, which 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 Choice Voucher System funds and MCCMHS for its role in administering the Choice Voucher System.

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

10. I agree to execute a Medicaid Provider Agreement with MCCMHS and acknowledge that this agreement does not alter the fact that MCCMHS is only the project administrator of the Choice Voucher System, and that my employer

is_____. I understand that my employment is contingent on completing this agreement.

11. My initials below attest to the fact that:

I am not a legally responsible person (e.g. guardian, agent, etc.) for my employer;

I am at least 18 years of age;

I am able to prevent transmission of any communicable disease from self to others in the environment in which I will be providing supports;

I am able to communicate expressively and receptively in order to follow individual plan requirements and participant-specified emergency procedures, and report on activities performed;

I am in good standing with the law (i.e., not a fugitive from justice, a convicted felon, or an illegal alien); and

I am able to perform basic first aid procedures.

_____I understand that my employer will check the truthfulness of my attestation, above, by conducting a background check on me to assure I meet these minimum requirements. I further understand that my employment is conditioned on meeting these minimum requirements.

Article II
EMPLOYER RESPONSIBILITIES

I,_____ (“employer”) agree to the following:

1. I will provide my fiscal intermediary with the necessary documentation to assure timely compensation of my employee.

2. I will compensate my employee in the following manner: $ _____ an hour. Benefits my employee shall receive include: _____ Payroll will be handled by my fiscal intermediary,_____, which will withhold all necessary tax, social security, unemployment and other withholdings from the employee’s paychecks.

3. I will assure my employee receives appropriate training, including but not limited to recipient rights training according to the provisions of Attachment B to this agreement.

4. I will evaluate the performance of my employee and provide appropriate feedback to assure that I am receiving quality supports. My employee shall be evaluated on an annual basis. Continuation of the Agreement is conditioned upon the employee's satisfactory performance under this Agreement.

5. I will assure that my employee executes a Medicaid Provider Agreement with MCCMHS, and I shall forward said executed agreement to MCCMHS prior to my employee's start of employment.

_____ _____

Employee Signature Date

_____ _____

Employer Signature Date

Employer Name: _____ CW _____ SEDW _____ (check as applicable)

MEDICAID PROVIDER AGREEMENT

.

This agreement is made on _____ between Macomb County Community Mental Health Services (MCCMHS) and _____ ("Medicaid Provider"). The purpose of this agreement is to define the roles and responsibilities of the above named parties. This agreement shall remain in effect until such time as it is 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, MCCMHS will certify the Medicaid Provider as available to provide services to individuals who receive services and/or supports in accordance with their individual plans of services and supports developed in a person-centered planning process, authorized by MCCMHS or one of its contractors, and financed through Michigan's Medicaid Specialty Pre-paid Mental Health Plan.

The Medicaid Provider stipulates that it agrees to the following:

1. To keep any records required by the participant or MCCMHS regarding the services provided to participants and to provide such information and any related invoices or billings, upon request, to the participant, MCCMHS, 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.

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 MCCMHS 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.

_____ _____

MCCMHS Executive Director Date

_____ _____

Medicaid Provider Agency/Individual Date

STUART T. WILSON CPA, PC
CERTIFIED PUBLIC ACCOUNTANT
FISCAL INTERMEDIARY

Employee Wage Information

Employee Name: _____

Employee Phone #: (_____) _____

Employee Email: _____

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

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

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

Hourly Rate: _____

Benefits: (If applicable)

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

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

Benefits are subject to budget allocation.

Employee Eligibility Checklist

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

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

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

Are you:

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

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

Are you:

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

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

Are you:

___ Any of the persons listed above in sections 1 or 2

___ Living in the same home as the employer

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

_____ _____

Employee Signature **Date**

Please note: If at a later date MCCMH should become aware that a conflict of interest exists between the employee and the employer, the employee will be liable to MCCMH **to pay back ALL amounts** received under the employment arrangement while a conflict of interest was in existence. Also, if at any time of the above mentioned conditions should change, it is the responsibility of the employee to notify the supports coordinator/case manager.

COMMUNITY MENTAL HEALTH
OFFICE OF RECIPIENT RIGHTS
22550 Hall Road, Clinton Township, MI 48036
586-469-6528 FAX 586-466-4131
www.mccmh.net

AUTHORIZATION TO RELEASE RECIPIENT RIGHTS INFORMATION

I _____ hereby authorize Macomb County Community Mental Health Services, Office of Recipient Rights, to release to the following corporation or provider Stuart T. Wilson CPA PC at the following ~~address~~ Fax 989 832 5404 any written reports or records regarding substantiated violations of recipient rights against me.

I release the Macomb County Community Mental Health Services, Office of Recipient Rights, from any and all claims, liability and damages that may result from the release of these reports or records. I also understand that because of the nature of my job and licensing requirements, the information provided pursuant to this authorization may be provided to representatives of the Department of Consumer and Industry Services and/or other community health agencies. I hereby consent to the release of this information to these agencies.

_____
Applicant's Name (please print clearly)

_____
Applicant's Signature Date

_____
Applicant's Maiden Name (print clearly)

Last 4 digits of
Social Security Number _____

_____ _____
Witness's Signature Date

Note** If an applicant disagrees with our findings, please contact this office prior to any dismissal to ensure we have the correct person and prevent a possible mix up in identities.

PLEASE PROVIDE COMPLETE MAILING ADDRESS AND/OR FAX NUMBER ON ALL RELEASE FORMS!

OFFICE USE ONLY

The individual named above **DOES** ____ **DOES NOT** ____ have any written reports or records regarding substantiated violations of recipient rights.

_____ _____
Authorized Signature of Office of Recipient Rights Date

STUART T. WILSON CPA, PC
CERTIFIED PUBLIC ACCOUNTANT
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 attached payroll calendar for scheduled pay days.**
  - All time worked must be reported within 14 days of the end of the pay period.

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

- **Only correct timesheets will be processed.**
  - If a timesheet contains omissions or errors, it will be returned to the employer and payment may be delayed.
    - Overlapping time with another provider will not be processed
    - Only authorized hours will be paid
    - Insufficient documentation or progress notes will result in unpaid shifts
    - If a shift is paid that the funding agency deems ineligible due to insufficient documentation, funds will be recouped.

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

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

Payment Methods:

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

- **Direct deposit**
  - Check stubs are sent via email.

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

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

_____ _____

Employee Signature Date

STUART T. WILSON CPA, PC
CERTIFIED PUBLIC ACCOUNTANT
FISCAL INTERMEDIARY

Direct Deposit Application

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

Employer's Name: _____ Organization: _____

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

- Direct deposit may take 2-3 weeks for initial set-up. Likewise, it **may take 2-3 weeks to cancel.**
- All cancellations must be submitted in writing.
- **Do not close your bank account without providing our office with sufficient notification; otherwise your payment will be delayed.**
- On payday you will receive your check stub **via email**. This also serves as your notice of deposit. The email comes from no_reply@stuartwilsonfi.com. Please check your spam folder if you do not receive your notice.
- Stuart T. Wilson CPA, PC is not held accountable for any overdraft fees that you may incur for using funds prior to their **actual confirmed deposit.**
- Stuart T. Wilson CPA, PC is authorized to correct errors that may occur. This authority remains in effect until we are notified in writing that you no longer want direct deposit.

I have read and understood the terms of direct deposit with Stuart T. Wilson CPA, PC.

_____ _____

Signature Date Phone #

Bank Account Information:

Account Type: ☐Checking ☐Savings

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

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

STUART T. WILSON CPA, PC
CERTIFIED PUBLIC ACCOUNTANT
FISCAL INTERMEDIARY

Training Resources for Macomb County Providers

Training information is now posted on the MCCMH training website, www.mccmh.net, under "Provider Links," then "Training." On the Training webpage, under "Links," click where it states, "To view the Training Calendar click here." Once you are on that page scroll down to find:

1) Self-Determination Training Requirements Guide
   Includes links to required on-line, free training resources and other information on how to access required face-to-face training. Where more than one training resource is noted, the title of the approved course is included for each source.

2) Self-Determination Training Tracking Sheet
   Use this resource to help you keep track of timeframes for training due dates based on your hire date.

3) Self-Determination Individual Plan of Service Training Form
   "IPOS" training is required prior to your first date of service.

A signed Employment Agreement is a "ticket" into free in-class training at MCCMH.

Providers need to complete the following trainings, depending on the program in which the consumer participates.

Child Waiver/Choice Voucher *Proof of training must be submitted to our office*	**Self-Determination** *Proof of training must be submitted to our office*
IPOS (Individual Plan of Service)- Prior to Working	IPOS (Individual Plan of Service)- Prior to Working
CPR/First Aid- Prior to Working	CPR/First Aid- Within 30 days
Recipient Rights- Prior to Working	Recipient Rights- Within 30 days
TB Test-Prior to Working	Emergency Preparedness- Within 30 days
Bloodborne Pathogens- Prior to Working	Limited English Proficiency- Within 30 days
Emergency Preparedness- Within 30 days	Bloodborne Pathogens- Within 90 days
Limited English Proficiency- Within 30 days	Cultural Competency- Within 90 days
Cultural Competency- Within 90 days	Corporate Compliance- Within 90 days
Corporate Compliance- Within 90 days	Grievance & Appeals- Within 90 days
Grievance & Appeals- Within 90 days	Trauma Informed Care- Within 90 days
Trauma Informed Care- Within 90 days	

Training must be completed annually in order to provide services and be paid with Medicaid dollars.

Self-Determination
Individual Plan of Service (IPOS) Training/Verification

Name of Person Served: _____

- **My employees will be required to understand my goals and provide support for me to achieve those goals by assisting with goal objectives I have chosen.**
- **Service Progress Notes should clearly state the date, time, duration of service activity and service code (CLS or Respite)**
- **Service Progress Notes shall contain statement(s) regarding services provided that reflects the goals from the IPOS.**
- **Service Progress Notes must reasonably describe all activities/events that occurred during each shift.**
- **Service Progress Notes must reasonably account for all time billed**.
- **Service Progress Notes shall be written in a non-judgmental style, which does not reflect the employee's personal opinions, feelings or attitudes**.
- **All Service Notes shall be completed using blue or black ink. Writing must be neat and legible.**

By signing this document, I, _____ (employee**) have reviewed a copy of the IPOS**, understand Medicaid documentation requirements, have had all my questions and concerns addressed, and have been trained on how to implement the IPOS for the person served.

IPOS Date: _____

_____ _____
Employee Signature Date

_____ _____
(Managing) Employer Signature Date

_____
Fiscal Intermediary Name

_____ _____
Trainer's Name (If Primary Case Holder answer question below) Date

Primary Case Holder was authorized to train staff on behalf of the participant ☐ Yes ☐ No

Send original to Fiscal Intermediary for filing

First Aid & CPR

Effective March 1, 2019, the MCCMH Training Department will no longer provide First Aid and CPR to the MCCMH Provider Network. Therefore providers will need to obtain their training from other appropriate sources.

In person (hands on) skills demonstration monitored by a certified instructor for certification in First Aid and CPR is required. Examples of entities that fulfill this requirement within their established fidelity are American Heart Association, American Red Cross, EMS Safety, and American Safety & Health Institute. Training opportunities can be found on these entities websites. Blended training options that incorporate online content training along with in person skills demonstration in front of a certified trainer for certification will be accepted. Any training option that does not include in person skills demonstrations will not be accepted.

American Red Cross CPR/FA training formats that can be utilized are:

1) **In Person:** Led by knowledgeable instructors, our in-person courses combine lecture with hands-on skills sessions. Perfect for those who learn best in a traditional classroom setting, our in-person classes give you ample time to ask questions and become comfortable with the latest techniques.
2) **Simulation Learning:** Using a combination of self-paced, interactive online CPR classes and in-class skill sessions, our groundbreaking Simulation Learning courses give you the ability to train on your schedule, and demonstrate your skills to a certified instructor.

American Heart Association formats that can be utilized are:

1) **100% Classroom Training**: Live in person training provided within a classroom setting. This includes in person skills demonstration for certification in front of a certified AHA First Aid and CPR instructor.
2) **Blended Learning**: Which combines online learning with hands on session and in person skills demonstration for certification in front of a certified AHA First Aid and CPR instructor.

Please see the links below for a list of preferred (trainings with in person competency skills demonstration) training opportunities with the American Red Cross or American Heart Association

American Heart Association Link:
http://ahainstructornetwork.americanheart.org/AHAECC/classConnector.jsp?pid=ahaecc.classconnector.home

American Red Cross Link:
https://www.redcross.org/take-a-class/cpr/cpr-training/cpr-classes

American Safety & Health Institute:
https://emergencycare.hsi.com/

Staff members must provide their employers with a valid certificate of completion to be stored in their personnel file.

STUART T. WILSON CPA, PC
CERTIFIED PUBLIC ACCOUNTANT
FISCAL INTERMEDIARY

Please keep a copy of the employment agreement. You will need to present it to MCCMH when you attend trainings. It will be your "ticket" to receive the trainings at no cost.

EMPLOYMENT AGREEMENT

This agreement is made on_____
between_____ ("employer") and _____
("employee") to describe the supports that the employee will provide to the employer and the terms and conditions of employment.

Article I
EMPLOYEE RESPONSIBILITIES

I, _____ (employee) acknowledge and agree that employment is conditioned on my employer's participation in the Choice Voucher System administered by Macomb County Community Mental Health Services (MCCMHS). If my employer ends participation in the Choice Voucher System, my employment may end. I agree to the following terms of employment:

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

2. I agree to assist my employer in maintaining the documentation and records required by my employer or MCCMHS. 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 MCCMHS or my employer.

3. I agree that if I become aware of or witness my employer suffer a physical injury, illness, or other adverse event that I will provide immediate comfort and protection, and assure immediate medical treatment for my employer.

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 MCCMHS regulations (described below) regarding my employment duties to the employer through the Choice Voucher System, and I acknowledge receipt of the following rules and regulations:

    a. Attachment A to this Agreement, which outlines the goals and outcomes of my employer's individual plan of service and the services and supports that I will be providing.

    b. Attachment B to this Agreement, Recipient Rights Protection Requirements. I will also receive a copy of the Recipient Rights Booklet, a copy of Chapter 7 of the Michigan Mental Health Code, and a copy of

Chapter 7 of the MDCH Administrative Rules. I agree to complete recipient rights training and all other required training prior to my first day of work. I agree to assist my employer in filing right complaints upon request. I also understand that I have a responsibility to report rights violations of which I am aware or any potential abusive or neglectful situations I observe. I understand that I may be required to cooperate with a recipient rights investigation and/or assist my employer with exercising his or her rights.

c. Attachment C to the Agreement which outlines Employer's House Rules. Additional changes to the House Rules shall be provided to me by my Employer in writing, and a copy shall be attached to the original Employment Agreement.

d. Attachment D, outlining the reporting and documentation requirements for verifying my hours worked. The Fiscal Intermediary will provide this to me.

e. The Chapter 9 policies of the MCCMH MCO Policy Manual (Recipient Rights). These policies may be accessed from the MCCMHS Policy website at the following address: http://www.mccmh.net/MCCMHPolicies/tabid/80/Default.aspx

6. I understand that this is an employment at will relationship, which can be terminated by me or by 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 _____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 MCCMHS, which 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 Choice Voucher System funds and MCCMHS for its role in administering the Choice Voucher System.

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

10. I agree to execute a Medicaid Provider Agreement with MCCMHS and acknowledge that this agreement does not alter the fact that MCCMHS is only the project administrator of the Choice Voucher System, and that my employer

is_____. I understand that my employment is contingent on completing this agreement.

11. My initials below attest to the fact that:

I am not a legally responsible person (e.g. guardian, agent, etc.) for my employer;

I am at least 18 years of age;

I am able to prevent transmission of any communicable disease from self to others in the environment in which I will be providing supports;

I am able to communicate expressively and receptively in order to follow individual plan requirements and participant-specified emergency procedures, and report on activities performed;

I am in good standing with the law (i.e., not a fugitive from justice, a convicted felon, or an illegal alien); and

I am able to perform basic first aid procedures.

_____I understand that my employer will check the truthfulness of my attestation, above, by conducting a background check on me to assure I meet these minimum requirements. I further understand that my employment is conditioned on meeting these minimum requirements.

Article II
EMPLOYER RESPONSIBILITIES

I,_____ (“employer”) agree to the following:

1. I will provide my fiscal intermediary with the necessary documentation to assure timely compensation of my employee.

2. I will compensate my employee in the following manner: $ _____ an hour. Benefits my employee shall receive include: _____ Payroll will be handled by my fiscal intermediary,_____, which will withhold all necessary tax, social security, unemployment and other withholdings from the employee’s paychecks.

3. I will assure my employee receives appropriate training, including but not limited to recipient rights training according to the provisions of Attachment B to this agreement.

4. I will evaluate the performance of my employee and provide appropriate feedback to assure that I am receiving quality supports. My employee shall be evaluated on an annual basis. Continuation of the Agreement is conditioned upon the employee's satisfactory performance under this Agreement.

5. I will assure that my employee executes a Medicaid Provider Agreement with MCCMHS, and I shall forward said executed agreement to MCCMHS prior to my employee's start of employment.

_____ _____

Employee Signature Date

_____ _____

Employer Signature Date