



Dear Prospective In Home Care Employer,

Here are the necessary forms to get you started with the registration process. When the packet is returned to us, we will process your paperwork and send you a registration letter with additional information. If you have any questions, feel free to call us 608/630-8402.

The following documents are included in this packet:

- General Application
- Form 2678
- Form 8821
- Forms SS-4
- Form 56 (*complete only if applicable*)

**RETURN COMPLETED PACKET TO:
WISCONSIN QUALITY HOME CARE COMMISSION
701 E. WASHINGTON AVE. LL3
MADISON, WI 53703**

Notes to Employer:

- *WQHCC does not supply/receive timesheets. You can get timesheets from your case manager, and you (or your workers) should continue to send completed timesheets to your case management agency. Your case management agency (such as CLA, FSRC, AAA, South Madison Coalition, Dane County Long-Term Support, etc.) will have its own deadlines for when timesheets are due each month.*
- *Service Employees International Union (SEIU), Healthcare, Local 150-WI is the union that exclusively covers In Home Care Providers in the WQHCC registry. In 2007, Homecare Providers voted in a union election in favor of having a union. Their first bargaining agreement, signed in 2009, provides a registry and more training opportunities for Homecare Providers. Under this agreement, providers who work more than four hours per month are either SEIU member or fair share payers and are covered by the articles in the collective bargaining agreement. Those providers who work fewer than four hours per month are not covered by the union contract. Information about the contract provision is available to workers through SEIU: 608/255-5211.*



WI QUALITY HOME CARE COMMISSION
GENERAL INFORMATION FORM

NAME OF EMPLOYER OR PRIMARY CONTACT PERSON:

Name(s) _____

Home Phone _____ Secondary Phone _____

Primary email: _____ Alternate email _____

TYPE OF CARE Home Chore Personal care Supportive Home Care Respite
 Back Up Care Live In Transportation Other

INDIVIDUAL RECEIVING CARE: (possibly same as employer)

Name _____
(Last) (First) (Middle)

Address _____
(Street) (City) (State) (Zip)

Phone _____ Age _____ DOB: ____/____/____ Ht. _____ Wt. _____

Social Security Number: _____

Case Management Agency: _____

Funding Service/ Contact Persons _____

Emergency Contact _____
(name) (relationship) (phone)

Primary Physician _____
(name) (hospital) (clinic)

How are you currently meeting your in home care ? _____

What could be better ? _____

Direct Care Registry Profile Data Form – Employer

This data form provides information for employers to search the direct care registry

General Match Requirements:

1. How would you describe the person in need of care:
 Elderly Physically disabled Developmentally disabled
2. How would you describe the care environment:
 Structured Free flowing Quiet Lively
3. Would you consider receiving care in the provider's home? Yes No
4. Are there pets in the home environment? Yes No
5. What are the hours of care you are seeking?
 Full time Part time Emergency backup Respite
6. Do you require the provider to have a car? Yes No
7. Will the provider be required to drive a car other than his/her own? Yes No
8. Is there smoking in the care environment? Yes No
9. Mark other required tasks
Cooking Basic house cleaning tasks laundry
grocery-shopping medical appointments?
10. Is a language other than English required? Yes
If Yes, circle language;
(Spanish/Hmong/Chinese/Dutch/French/German/Italian/Portuguese/Russian/Japanese /Other)

Care Provider Experience Requirements:

Behavioral supports? . Dementia? . Developmental disabilities? . Vision issues?
Hard of hearing/use of hearing aids? Adaptive communication (i.e Dynavox)?
Mental health diagnosis? . Traumatic brain injury? Frail. Elderly?
Alzheimer's? Alcohol and Other Drug Abuse (AODA)?

Personal Care Task Requirements:

. Dressing/Undressing? . Hair care? . Oral hygiene? . Nail care?
. Incontinence care? . Toilet assistance? . Bladder/bowel care (colostomy)?
. Feminine care? . Shaving (face/legs/arms)? . Bathing/showering assistance?
. Bed bath? . Medication administration/assistance? . Food prep/eating?
G-tube experience? . Mobility . Assistance prosthetics or orthotics?
Repositioning? . Use of Lift? Exercise programs/range of motion?
Repeatedly lift more than: 10 lbs 20 lbs 40 lbs 50 lbs +55 lbs

Availability Requirements:

1. PLACE AN X IN THE TIME PERIODS YOU ARE SEEKING CARE

DAY OF WEEK	MORNING 6:00 -12:00	AFTERNOON 12:00 – 5:00	EVENING 5:00 -8:00	OVERNIGHT 8:00 – 6:00 AM
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

Personal Interests of the Care Recipient:

1. Animals? _____ 2. Antiques? _____ 3. Baking? _____
 4. Children? _____ 5. Cooking? _____ 6. Crafts? _____
 7. Gardening? _____ 8. Movies? _____ 9. Politics? _____
 10. Music? _____ 11. Religion? _____ 12. Sports? _____
 13. Travel? _____ 14. Other? _____

Information to be completed by WQHCC Staff:

Password _____

Approval Status: _____ Approved _____ Denied _____ Pending

Registry Acceptance Date _____

Registry Close Date _____

Other comments for WQHCC: _____

Form **2678** **Employer/Payer Appointment of Agent**

(Rev. October 2007) Department of the Treasury — Internal Revenue Service

OMB No. 1545-0748

Use this form if you want to request approval to have an agent file returns and make deposits or payments of employment or other withholding taxes or if you want to revoke an existing appointment.

- If you are an employer or payer who wants to request approval, complete Parts 1 and 2 and sign Part 2. Then give it to the agent. Have the agent complete Part 3 and sign it.

Note. This appointment is not effective until we approve your request. See the instructions for filing Form 2678 on page 3.

- If you are an employer, payer, or agent who wants to revoke an existing appointment, complete all three parts. In this case, only one signature is required.

For IRS use:

Part 1: Why you are filing this form...

(Check one)

- You want to **appoint** an agent for tax reporting, depositing, and paying.
- You want to **revoke** an existing appointment.

Part 2: Employer or Payer Information: If you want to appoint an agent or revoke an appointment, complete this part.

1 Employer identification number (EIN) -

2 Employer's or payer's name
(not your trade name)

3 Trade name (if any)

4 Address

Number Street Suite or room number

 City State ZIP code

5 Forms for which you want to appoint an agent or revoke the agent's appointment to file.
(Check all that apply.)

	For ALL employees/ payees	For SOME employees/ payees
Form 941, 941-PR, 941-SS (Employer's QUARTERLY Federal Tax Return)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Form 943, 943-PR (Employer's Annual Federal Tax Return for Agricultural Employees)	<input type="checkbox"/>	<input type="checkbox"/>
Form 944, 944-PR, 944-SS, 944(SP) (Employer's ANNUAL Federal Tax Return)	<input type="checkbox"/>	<input type="checkbox"/>
Form 945 (Annual Return of Withheld Federal Income Tax)	<input type="checkbox"/>	<input type="checkbox"/>
Form CT-1 (Employer's Annual Railroad Retirement Tax Return)	<input type="checkbox"/>	<input type="checkbox"/>
Form CT-2 (Employee Representative's Quarterly Railroad Tax Return)	<input type="checkbox"/>	<input type="checkbox"/>

Note: You may NOT appoint an agent to report, deposit, and pay taxes reported on Form 940, Employer's Annual Federal Unemployment (FUTA) Tax Return.

I am authorizing the IRS to disclose otherwise confidential tax information to the agent relating to the authority granted under this appointment, including disclosures required to process Form 2678. The agent may contract with a third party, such as a reporting agent or certified public accountant, to prepare or file the returns covered by this appointment, or to make any required deposits and payments. Such contract may authorize the IRS to disclose confidential tax information of the employer/payer and agent to such third party. If a third party fails to file the returns or make the deposits and payments, the agent and employer/payer remain liable.

X Sign your name here

Print your name here

Print your title here

 OWNER

Date

 / /

Best daytime phone

 () -

Now give this form to the agent to complete. →

Part 3: Agent Information: If you will be an agent for an employer or payer, or want to revoke an appointment, complete this part.

6 Agent's employer identification number (EIN) 0 2 - 0 7 3 2 6 6 6

7 Agent's name (not trade name) MELISSA GOKE - CAF 0305-04554R

8 Trade name (if any) FISCAL ASSISTANCE EMPLOYER AGENT

9 Address 124 W HOLUM STREET

Number	Street	State	Suite or room number
DEFOREST		WI	53532
City		State	ZIP code

Check here if the employer is a disabled individual or other welfare recipient receiving home-care services through a state or local program.

Under penalties of perjury, I declare that I have examined this form and any attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

X Sign your name here

Print your name here

Melissa Goke

Print your title here

Assistant Director

Date

/ /

Best daytime phone

(608) 846 - 7058

