Adult over 18

Self-Direction
REQUIRED EMPLOYEE Agreement and PAYROLL FORMS

NOTE: A copy of your employee's social security card and driver's license must be included with this packet. Payroll forms cannot be processed without a copy of these documents.

ALL COMPLETED FORMS ARE TO BE SENT TO:

Nicola Hopkins, BS, QIDP, RSST
Self Determination and Consumer Care Coordinator
Shiawassee Health and Wellness
1555 Industrial Dr.
Owosso, MI 48867

Phone: 989-723-0743
Fax: 989-725-5061
Email: nhopkins@shiabewell.org

SHIAWASSEE HEALTH AND WELLNESS

Self-Direction Employee Agreement

This agreement is made on this date _____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) am aware and agree that my employment is conditioned on my employer's use of self-directed services administered by the Shiawassee Health and Wellness. If my employer stops using self-directed services, 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 to maintain the documentation and records required by my employer or the Shiawassee Health and Wellness. I agree to complete all necessary paperwork to secure mandatory payroll deductions from my pay. All records I may have or assist to maintain 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 my employer.
3. I shall immediately notify _____(for example, it may be an ally) if my employer experiences a medical emergency or illness. I will also notify _____before taking my employer to the physician, except in case of an emergency.
4. I agree to abide by all of my employer's rules (described below) regarding my employment duties to the employer and I acknowledge receipt of the following rules and regulations.
    a. Attachment A Job Description to this Agreement, which outlines the supports that I will provide to my employer.
    b. Insert reporting and documentation requirements for verifying hours worked: Timesheet and Progress note.
5. 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 based on my race, religion, sex, disability, or other protected status under federal or Michigan law. In addition, I agree to give 14 calendar days written notice to my employer if I terminate my employment.
6. I understand and acknowledge that my employer is my sole employer and that I am not an employee of the Shiawassee Health and Wellness, which authorizes the supports I provide, or the financial management service, which is the financial administrator of funds used to pay me.
7. I agree to assist my employer in filing Recipient 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 requested to cooperate with a recipient rights investigation and/or assist my employer with exercising his or her rights.
8. I agree to not to sue the financial management service for its role as the financial administrator of my employer's individual budget and the Shiawassee Health and Wellness for its role in administering self-directed services.
9. I agree to execute a Medicaid Provider Agreement with the Shiawassee Health and Wellness and acknowledge that this agreement does not alter the fact that the Shiawassee Health and Wellness is only the administrator of the funds used through self-direction, and that my employer is _____I understand that my employment is contingent on completing this agreement.

SHIAWASSEE HEALTH AND WELLNESS

Self-Direction Employee Agreement

Article II EMPLOYER RESPONSIBILITIES

I, _____("Employer") agree to the following:

- I will provide my financial management service with the necessary documentation to assure timely compensation of my employee.
- I will maintain all required documentation and provide it to Shiawassee Health and Wellness when requested.
- I will compensate my employee in the following manner: $ _____hourly wage an hour.
- **Information about any benefits the employee shall receive, Check the or add in numbers below.**

_____Holidays (New Year's Day, Good Friday, Easter Sunday, Memorial Day, 4th of July, Labor Day, Thanksgiving, Christmas Day.)

_____ Number of Paid Vacation Hours Per Year.

Vacation Hours cannot be carried forward or "banked" beyond the end of the service plan. If your employment terminates for any reason, all remaining vacation hours are forfeited. There is no provision for "vacation buy out". If the employer has offered vacation hours, the intent is for you to take a break from your job.

_____Mileage Reimbursement: Maximum Annual mileage reimbursement is $600.00 per year. Mileage will be reimbursed at $.25 per mile and tracked on a travel reimbursement form.

- Payroll will be handled by my financial management service Stuart Willson, CPA, PC, which will withhold all necessary tax, unemployment, and other withholdings from the employee's paychecks.
- I will assure my employee receives the required training initially and ongoing.
    a. **Environmental Safety (initially and every three years)**
    b. **Bloodborne Pathogens (Initially)**
    c. **First Aid (initially and every 2 years)**
    d. **Recipient Rights (annually)**
    e. **Individual Plan of Service/Person Centered Plan (every year, and anytime there is any change to the plan) IPOS/PCP training will be documented with a signature by both the employer/trainer, and with a signature by each self-directed staff. IPOS/PCP training must be dated and signed prior to any staff starting to work.**

- I will evaluate the performance of my employee and provide appropriate feedback to assure that I am receiving quality supports.
- I will assure that my employee executes a Medicaid Provider Agreement with Shiawassee Health and Wellness.

_____

Employee Signature Date

_____

Guardian/legal representative (if applicable) Date

_____

Employer Signature Date

Medicaid Fraud, Waste, and Abuse

Fraud, Waste and Abuse uses up valuable Michigan Medicaid funds needed to help children and adults access health care. Everyone can take responsibility by reporting fraud and abuse. Together we can make sure taxpayer money is used for people who really need help.

Examples of Medicaid Fraud

- Billing for medical services not actually performed
- Providing unnecessary services
- Billing for more expensive services
- Billing more than once for the same medical service
- Billing for services without proper documentation
- Falsifying the date or times that services were provided

Responsibilities of a Self-Direction Employer:

- Review documentation to ensure accurate:
  - Date of services
  - Time services were rendered
  - Code for service
  - Staff name
- You must not approve a timecard in which the SD staff claims time while another service is being provided.
  - Example: SD staff may assist in the transportation of an individual to and from an appointment, but they cannot bill for the time during the appointment.
- You must ensure that you are not overutilizing hours. If you feel that your hours need to be increased, you must speak to your Case Coordinator prior to allowing staff to work additional time.

Responsibilities of a Self-Direction Employee:

- Service notes should outline what the individual and staff did throughout the shift
- Review your timecard and mileage sheet thoroughly before submitting it.
  - Ensure all the following elements are accurate:
    - Date
    - Start & Stop Time
    - Code
- SD employees cannot provide services while the individual is receiving another service, including a doctor appointment, therapy, ABA services, etc.

If an employer or employee discover a mistake in billing after services have been paid, the Fiscal Intermediary must be alerted so corrections can be made.

If you think someone is committing fraud, waste or abuse, you are required to report it to SHW's Corporate Compliance Officer (Reports may be submitted anonymously):

Hotline: 989-723-0750

Email: Shia-CorporateCompliance@ShiaBeWell.org

Fax: 989-723-0740

Medicaid Fraud, Waste, and Abuse

I, _____, attest that I have read and understand my responsibilities to identify, correct, prevent, and report potential fraud, waste, and abuse as a employee.

Non-adherence to these requirements can result in the termination of the Self-Direction Agreement and financial takebacks. Furthermore, I understand that continued non-compliance with these requirements is a direct violation of the Federal False Claims Act (FCA) 31 U.S.C. §§ 3729 - 3733 and the Michigan Medicaid False Claims Act. Penalties for violating the FCA include a MINIMUM fine of $13,946 for each false claim, up to 5 years in prison, and exclusion from being able to participate in Federal Healthcare Programs.

_____

Employee Signature Date

_____

Guardian/legal representative (if applicable) Date

_____

Employer Signature Date

Shiawassee Health and Wellness

Self-Direction Payroll Procedures:

1. Procedures for recording time worked:
   a. You will indicate a start and time and a Stop time each time you work.
   b. If a shift runs past midnight, you must record the portion of the shift worked on each day. For example, if you start work at 10 pm on Monday evening until 6am Tuesday morning, you will record your time as follows:

Monday	Start time	10:00 pm
	End Time	12:00 am
Tuesday	Start Time	12:01 am
	End Time	6:00 am.

2. It is your responsibility to turn your timecard in on time to meet the payroll processing deadlines. Your employer will let you know what day and time your timecards are due.
3. If you fail to turn in your timecards by the deadline stated about you will not receive your paycheck on the normal pay day. You will have to wait until the next scheduled pay day to receive the wages owed to you.
4. All time which you put on your timecard must be backed up by the progress note for the day. Which is used as proof of you providing Medicaid Services to your employer.
   a. Only Face to Face services is billable.
   b. Only one staff may provide services at a time. Double up staff, even for training purposes, is not billable and must be recorded on the timecard. You will be paid for non-billable time if you receive prior approval from your employer and it is written in the Person Center Plan.
   c. Approved training time must be recorded on the timecard.
5. Falsifying timecards is not only a violation of this employee agreement, but also a violation of State and Federal Medicaid Laws. Your employer and Shiawassee Health and Wellness will prosecute Medicaid Fraud to the fullest extent of the law.

By signing below all parties acknowledge that they have read and understood the procedure for recording the time worked each week.

_____
Employee Signature Date

_____
Guardian/legal representative (if applicable) Date

_____
Employer Signature Date

Shiawassee Health and Wellness
Self-Direction Staff Job Description

Job Description: Self-Direction Staff

Self-Direction Community Living Support (CLS and or Respite) Staff are responsible for the one-on-one administration of care as dictated by my Person-Centered Plan (PCP). CLS and or Respite staff work alongside me with various needs to assist them maintaining my independence and community involvement.

Job Functions (includes, but not limited to the following):

Provide direct services to me based on my current PCP.
Maintain confidentiality with all my records and information.
Maintain legible up to date records. This includes but is not limited to the following: timesheet, progress note, Occupational Therapy data sheet, Behavioral Data sheet
Demonstrate the ability to receive constructive criticism from me.
Conduct yourself in a professional manner in my home or in the community when with me.
Maintain professional boundaries.
Display effective time management skills.
Maintain a clean, safe, and organized work environment.
Follow Recipient Rights Guidelines

_____
_____
_____
_____
_____
_____

This position requires the following prior to providing any services:

Be at least 18 years of age.
Reliable means of transportation, valid driver's license, and up to date auto insurance if working with me in the community and providing transportation.
Effective oral and written communication skills
Able to communicate expressively & receptively to follow Person Centered Plan (PCP) requirements, emergency procedures, and report on activities performed as well as the other requirements for the job.
staff must complete all required training through Shiawassee Health and Wellness (renewed annually) and Pass background checks.

Scheduling

I offer flexible scheduling. CLS staff typically work with me_____ hours per shift. My CLS staff can expect to be scheduled Monday through Friday and weekends (typically no more than 1-2 weekends/month) depending on my needs. Schedules vary depending on my needs.

_____
Employee Signature Date

_____
Guardian/legal representative (if applicable) Date

_____
Employer Signature Date

SHIAWASSEE Health & Wellness

MEDICAID PROVIDER [42 CFR 431.107] AGREEMENT

The parties to this contract are Shiawassee Health and Wellness "herein referred to as the Host Agency", and _____ "employee herein referred to as the provider".

The purpose of this agreement is to define the roles and responsibilities of the above-named parties and to assure compliance with federal Medicaid requirements. This agreement shall remain in effect until such time it must be terminated or modified. Any party can initiate a termination or modification by providing written notice to the other of the desire to terminate or modify this agreement. This agreement should not be finalized until the provider has met any additional requirements to provide Medicaid Services (i.e. background check, training). Should the provider fail to meet Medicaid requirements, the Host Agency may suspend or terminate 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 which state that I must disclose if I own 5% or more of another provider entity.

4) To comply with the advance directive requirements specified in 42 CFR 489, Subpart I and 42 CFR 417.436 (d), as applicable. This regulation requires that the provider acknowledge the doctrine of informed consent whereby any and all forms of medical treatment, including life-sustaining treatment may be declined by the consumer as specified.

Both parties expressly acknowledge that the sole purpose of this agreement is to assure compliance with 42 USC 1902 (a) 27. (The Social Security Act, that requires an agreement with each provider.)

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 parties with respect to the subject matters, and supersedes any and all other agreements, either oral or in writing between 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 the terms and conditions of this agreement as specified on the foregoing page, and so signify by affixing their signatures below.

Print Employee Name _____ Employee Signature _____ Date _____

Self-Direction Coordinator _____ Date _____

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

PAYROLL PROCEDURES

In order to be paid correctly and avoid any delay with payments, 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

- **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

Employee Wage Information

Employee Name: _____

Employee Phone #: (_____) _____

Employee Email: _____

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.

STUART T. WILSON CPA, PC
Fiscal Intermediary

Payment Options

Name: _____ Employer's Name: _____

Email Address (required):_____

(Must choose one)

☐ Direct Deposit	☐ Netspend Skylight ONE Payroll Card
A voided check, a letter from the bank or a copy of a membership card that includes both the account and routing number must be attached. *See information below Account Type: ☐ Checking ☐ Savings	*See attached information

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

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

I have read and understood the terms of my chosen payment option with Stuart T. Wilson CPA, PC.

I understand that if I do not submit my banking information

I will automatically be signed up for the Netspend Skylight ONE Payroll Card.

_____ _____

Signature Date Phone #

Return via Fax: 989-832-5404 Email: payroll@stuartwilsonfi.com

Mail: Stuart T. Wilson CPA, PC Attn: Personnel 6300 Schade Dr. Midland, MI 48640

NETSPEND Skylight ONE® Card

our Skylight Account Info Is With You Wherever You Are

ith the Skylight ONE® Mobile App, you can get updates on your Skylight Account from the alm of your hand.[1]

ard account usage is subject to card activation and identity verification.*

Check your balance at a glance

Log in to your Skylight Account, and see how much money is there, right from your smartphone.

Find the nearest ATM

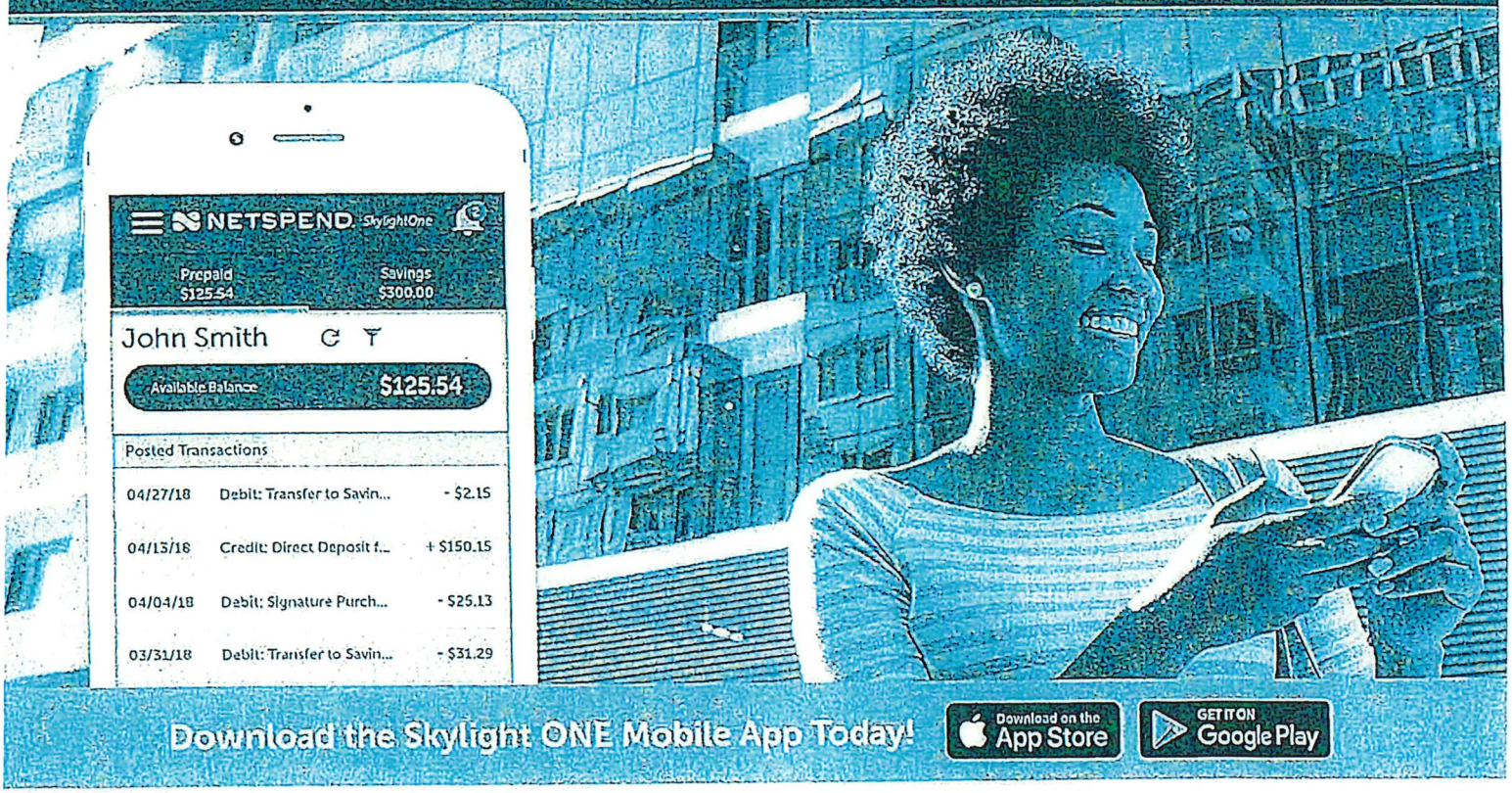
Need some cash? Locate the surcharge-free ATM[2] that is closest to where you are, wherever you are.

See your most recent transactions

See if a payment has posted, or if your paycheck has arrived in just a few taps.

Manage your alerts

Enroll to get a text message[1] or email whenever you get paid, for every transaction, or just periodic balance updates with Anytime Alerts™.



Download the Skylight ONE Mobile App Today! Download on the App Store | GET IT ON Google Play

* **IMPORTANT INFORMATION FOR OPENING A CARD ACCOUNT:** To help the federal government fight the funding of terrorism and money laundering activities, the USA PATRIOT Act requires us to obtain, verify, and record information that identifies each person who opens a Card Account. **WHAT THIS MEANS FOR YOU:** When you open a Card Account, we will ask for your **name, address, date of birth, and your government ID number.** We may also ask to see your driver's license or other identifying information. Card activation and identity verification required before you can use the Card Account. If your identity is partially verified, full use of the Card Account will be restricted, but you may be able to use the Card for in-store purchase transactions. Restrictions include: no ATM withdrawals, international transactions, account-to-account transfers and additional loads. Use of Card Account also subject to fraud prevention restrictions at any time, with or without notice.

[1] No charge for this service, but your wireless carrier may charge for messages or data.

[2] Surcharge free ATM options will vary by card program. Please see your Cardholder Agreement for surcharge free options. An ATM Cash Withdrawal Fee applies at ATMs outside the surcharge free network specified in your Cardholder Agreement. A separate ATM owner fee may also apply.

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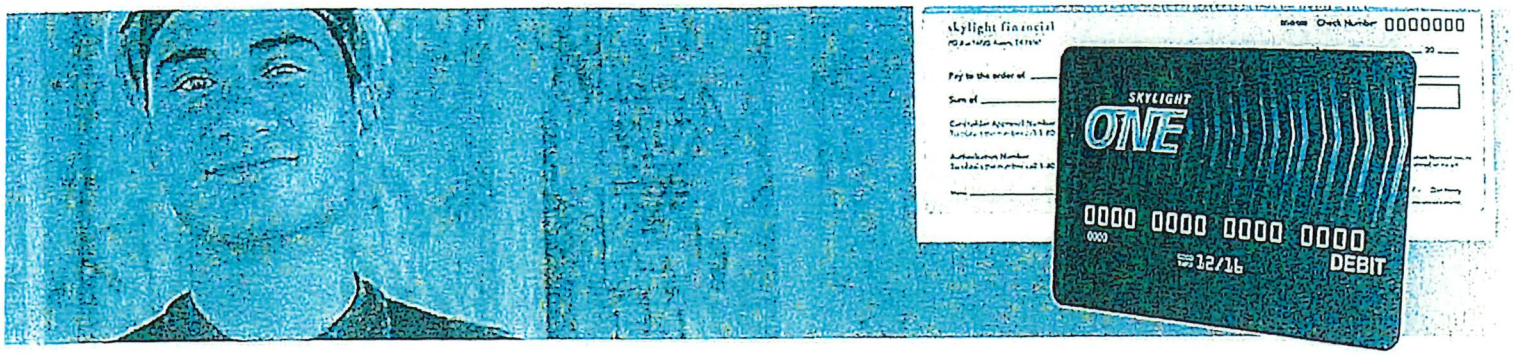
The Skylight ONE® Visa Prepaid Card is issued by Bofl Federal Bank, Republic Bank & Trust Company or SunTrust Bank pursuant to a license from Visa U.S.A. Inc. and may be used everywhere Visa debit cards are accepted. The Skylight ONE® Prepaid Mastercard is issued by Bofl Federal Bank, Republic Bank & Trust Company, or SunTrust Bank pursuant to a license by Mastercard International Incorporated. Please see back of card for Issuing Bank. Bofl Federal Bank, Republic Bank & Trust Company and SunTrust Bank; Members FDIC. Netspend, a TSYS® Company, is a registered agent of Bofl Federal Bank, Republic Bank & Trust Company, and SunTrust Bank. Certain products and services may be licensed under U.S. Patent Nos. 6,000,608 and 6,189,787. Use of the Card Account is subject to activation, ID verification and funds availability. Transaction fees, terms, and conditions apply to the use and reloading of the Card Account. See the Cardholder Agreement for details.

Mastercard is a registered trademark, and the circles design is a trademark of Mastercard International Incorporated.

Card may be used everywhere Debit Mastercard is accepted.



Frequently Asked Questions

The Skylight® PayOptions™ Program

VISA | MasterCard

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 Bofl Federal Bank, Member FDIC, and can be accessed either through your Skylight ONE® Visa® Prepaid Card or Skylight ONE® Prepaid MasterCard®, or by using a Skylight Check to withdraw all of the cash from your Skylight Account.

Where can I use my Skylight ONE Card?

Your Skylight ONE® Card can be used at millions of ATMs to withdraw cash, and anywhere Visa debit cards or Debit MasterCard (based on the logo on the front of your card) are accepted for purchases, such as supermarkets and other retail locations.

What are Skylight Checks and how can I use them?

If you prefer, you can use Skylight Checks to write your own paycheck! Each payday, whether you're at work, at home, or on vacation, you can use a Skylight Check to withdraw all of the cash from your Skylight Account. Skylight Checks can be cashed free of charge at all U.S. Bank branch locations, at participating Walmart locations, and at participating ACE Cash Express locations.[1] You will receive 2 checks in your new account packet. Order additional checks at no cost by calling Customer Service at the number on the back of your card.

What does the Skylight PayOptions Program cost?

There is no cost to sign up and there are many ways to access your wages for free. Some fees may apply based on how you use your Skylight Account. You will receive a fee schedule with your new account packet.

Will I get a new card each payday?

No. Once you are enrolled in the program, you'll automatically receive a personalized Skylight ONE Card. Your pay will be added to the card by 8 a.m. CT each payday. If you accidentally lose the card, just give Skylight a call to request a replacement. Your first replacement card per year is available at no additional cost.[2]

My Skylight ONE Card doesn't have my name on it. Can I still use it to make purchases?

Yes. The first card you receive is a temporary card but it can be used to make signature-based purchases in restaurants, stores, online, and by phone anywhere Visa debit cards or Debit MasterCard are accepted.[3] Once you are enrolled in the program, a card with your name on it will automatically be sent to your mailing address.

Can I request more than one card?

You can add an additional cardholder to your account simply by calling the number on the back of your card.[2,3]

What happens if I lose my card?

When you lose cash, your money is gone. If you lose your card, contact Skylight immediately so your lost card can be cancelled and your money stays safe.[4] When you call, you can ask that a replacement card be sent to you. Your first replacement card per year is available at no additional cost.[2]

How can I check my balance and track my spending?

Skylight makes it convenient for you to manage your money. A toll-free automated telephone service provides 24/7 account information. Plus, when you register for online access at skylightpaycard.com, you can visit the Online Account Center anytime to check your balance, review your transactions, and view or print your statements. You can also enroll in Anytime Alerts™ to schedule balance, deposit, or payment updates to be sent directly to your cell phone or email inbox.[5] Or, text us and we'll text your balance back to you!

What if I want to talk to someone about my account?

Skylight's friendly, specially trained Customer Service representatives are available to assist you between 6 a.m. and midnight CT Monday through Friday and on weekends between 8 a.m. and 8 p.m. CT, with bilingual service available. You can reach someone by calling the number on the back of your card.[6]

[1] Skylight Checks can be cashed free of charge at all U.S. Bank branch locations, at participating Walmart locations, and at participating ACE Cash Express locations. Other check cashers set their own policies regarding check acceptance and may charge you a fee to cash Skylight Checks. See the Skylight Checks for step-by-step instructions.
[2] There may be a cost for additional replacement cards. Consult your Cardholder Agreement and fee schedule for details.
[3] There is no application or credit approval process for the Skylight PayOptions Program. IMPORTANT INFORMATION ABOUT PROCEDURES FOR OPENING A NEW CARD ACCOUNT: To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens a Card Account. What this means for you: When you open a Card Account, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents. In accordance with federal regulations, until it is activated and registered, a prepaid card is subject to initial load limitations, may not be used for ATM use, international transactions or account-to-account transfers, or be reloaded.
[4] To minimize losses, Cardholder must notify Skylight promptly of any loss of the card or compromise of the Skylight Account. Other terms apply. See the Cardholder Agreement for details.
[5] Skylight does not charge for this service, but your wireless carrier may charge you for messages or data.
[6] A fee may apply for this call. Consult your Fee Schedule for details.

skylight

MI-W4

(Rev. 12-20)

EMPLOYEE'S MICHIGAN WITHHOLDING EXEMPTION CERTIFICATE
STATE OF MICHIGAN - DEPARTMENT OF TREASURY

This certificate is for Michigan income tax withholding purposes only. ***Read instructions on page 2 before completing this form.***

Issued under P.A. 281 of 1967.

▸ 1. Full Social Security Number	▸ 2. Date of Birth

▸ 3. Name (First, Middle Initial, Last)	4. Driver's License Number or State ID

Home Address (No., Street, P.O. Box or Rural Route)	▸ 5. Are you a new employee? ☐ Yes If Yes, enter date of hire..... (mm/dd/yyyy) ☐ No

City or Town	State	ZIP Code

6. Enter the number of personal and dependent exemptions (see instructions) ..... ▸ 6.	
7. Additional amount you want deducted from each pay (if employer agrees) ..... 7.	$ .00

8. I claim exemption from withholding because (see instructions):

a. ☐ A Michigan income tax liability is not expected this year.

b. ☐ Wages are exempt from withholding. Explain: _____

c. ☐ Permanent home (domicile) is located in the following Renaissance Zone: _____

EMPLOYEE: If you fail or refuse to file this form, your employer must withhold Michigan income tax from your wages without allowance for any exemptions. Keep a copy of this form for your records. See additional instructions on page 2.

Under penalty of perjury, I certify that the number of withholding exemptions claimed on this certificate does not exceed the number I am allowed to claim. If claiming exemption from withholding, I certify that I do not anticipate a Michigan income tax liability this year.

9. Employee's Signature	▸ Date

EMPLOYER: Complete the below section.

10. Employer's Name	▸ 11. Federal Employer Identification Number		
Address (No., Street, P.O. Box or Rural Route)	City or Town	State	ZIP Code
Name of Contact Person	Contact Phone Number		

INSTRUCTIONS TO EMPLOYER: Keep a copy of this certificate with your records. All new hires must be reported to the State of Michigan. See **www.mi-newhire.com** for information.

In addition, a copy of this form must be sent to the Michigan Department of Treasury if the employee claims 10 or more exemptions or claims they are exempt from withholding. Send a copy to:

Michigan Department of Treasury
Tax Technical Section
P.O. Box 30477
Lansing, MI 48909

INSTRUCTIONS TO *EMPLOYEE'S MICHIGAN WITHHOLDING EXEMPTION CERTIFICATE* (Form MI-W4)

You must submit a Michigan withholding exemption certificate (form MI-W4) to your employer on or before the date that employment begins. If you fail or refuse to submit this certificate, your employer must withhold tax from your compensation without allowance for any exemptions. Your employer is required to notify the Michigan Department of Treasury if you have claimed 10 or more personal or dependency exemptions or claimed that you are exempt from withholding.

You MUST provide a new MI-W4 to your employer within 10 days if your residency status changes or if your exemptions decrease because: a) your spouse, for whom you have been claiming an exemption, is divorced or legally separated from you or claims his/her own exemption(s) on a separate certificate, or b) a dependent no longer qualifies under the Internal Revenue Code.

Line 5: If you check "Yes," enter your date of hire.

Line 6: Personal and dependency exemptions. The number of exemptions claimed here may not exceed the number of exemptions you are entitled to claim on a *Michigan Individual Income Tax Return* (Form MI-1040). Dependents include qualifying children and qualifying relatives under the Internal Revenue Code, even if your AGI exceeds the limits to claim federal tax credits for them.

Do not claim the same exemptions more than once or tax will be under-withheld. Specifically, **do not claim:**

- Your personal exemption if someone else will claim you as their dependent.
- Your personal exemption with more than one employer at a time.
- Your spouse's personal exemption if they claim it with their employer.
- Your dependency exemptions if someone else (for example, your spouse) is claiming them with their employer.

Line 7: You may designate additional withholding if you expect to owe more than the amount withheld.

Line 8a: You may claim exemption from Michigan income tax withholding if all of the following conditions are met:

i) Your employment is intermittent, temporary, or less than full time;

ii) Your personal and dependency exemptions exceed your annual taxable compensation;

iii) You claimed exemption from federal withholding; and

iv) You did not incur a Michigan income tax liability for the previous year.

Line 8b: Reasons wages might be exempt from withholding include:

- You are a nonresident spouse of military personnel stationed in Michigan.
- You are a resident of one of the following reciprocal states while working in Michigan: Illinois, Indiana, Kentucky, Minnesota, Ohio, or Wisconsin.
- You are a member of a Native American tribe that has a tax agreement with the State of Michigan and whose principal place of residence is within the designated agreement area.
- You are an enrolled member of a federally-recognized tribe that does not have a tax agreement with the State of Michigan, you reside within that tribe's Indian Country (as defined in 18 USC 1151), and compensation from this job will be earned within that Indian Country.

Line 8c: For questions about Renaissance Zones, contact your local assessor's office.

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2024

Step 1: Enter Personal Information

(a) First name and middle initial | Last name | (b) Social security number

Address

City or town, state, and ZIP code

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*.

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

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

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

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

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

Step 3: Claim Dependent and Other Credits

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

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

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

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . 3 $

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2024 if you meet both of the following conditions: you had no federal income tax liability in 2023 **and** you expect to have no federal income tax liability in 2024. You had no federal income tax liability in 2023 if (1) your total tax on line 24 on your 2023 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2024 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2025.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

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

1. Expect to work only part of the year;

2. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

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

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

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

Specific Instructions

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

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

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

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

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

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2024 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

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

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

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

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

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

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

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

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

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

1 Enter an estimate of your 2024 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . 1 $

2 Enter:
- $29,200 if you're married filing jointly or a qualifying surviving spouse
- $21,900 if you're head of household
- $14,600 if you're single or married filing separately

. . . . . 2 $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . 3 $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . 4 $

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

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$780	$850	$940	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,370
$10,000 - 19,999	0	780	1,780	1,940	2,140	2,220	2,220	2,220	2,220	2,220	2,570	3,570
$20,000 - 29,999	780	1,780	2,870	3,140	3,340	3,420	3,420	3,420	3,420	3,770	4,770	5,770
$30,000 - 39,999	850	1,940	3,140	3,410	3,610	3,690	3,690	3,690	4,040	5,040	6,040	7,040
$40,000 - 49,999	940	2,140	3,340	3,610	3,810	3,890	3,890	4,240	5,240	6,240	7,240	8,240
$50,000 - 59,999	1,020	2,220	3,420	3,690	3,890	3,970	4,320	5,320	6,320	7,320	8,320	9,320
$60,000 - 69,999	1,020	2,220	3,420	3,690	3,890	4,320	5,320	6,320	7,320	8,320	9,320	10,320
$70,000 - 79,999	1,020	2,220	3,420	3,690	4,240	5,320	6,320	7,320	8,320	9,320	10,320	11,320
$80,000 - 99,999	1,020	2,220	3,620	4,890	6,090	7,170	8,170	9,170	10,170	11,170	12,170	13,170
$100,000 - 149,999	1,870	4,070	6,270	7,540	8,740	9,820	10,820	11,820	12,830	14,030	15,230	16,430
$150,000 - 239,999	1,960	4,360	6,760	8,230	9,630	10,910	12,110	13,310	14,510	15,710	16,910	18,110
$240,000 - 259,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$260,000 - 279,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$280,000 - 299,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,380
$300,000 - 319,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,980	17,980	19,980
$320,000 - 364,999	2,040	4,440	6,840	8,310	9,710	11,280	13,280	15,280	17,280	19,280	21,280	23,280
$365,000 - 524,999	2,720	6,010	9,510	12,080	14,580	16,950	19,250	21,550	23,850	26,150	28,450	30,750
$525,000 and over	3,140	6,840	10,540	13,310	16,010	18,590	21,090	23,590	26,090	28,590	31,090	33,590

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$240	$870	$1,020	$1,020	$1,020	$1,540	$1,870	$1,870	$1,870	$1,870	$1,910	$2,040
$10,000 - 19,999	870	1,680	1,830	1,830	2,350	3,350	3,680	3,680	3,680	3,720	3,920	4,050
$20,000 - 29,999	1,020	1,830	1,980	2,510	3,510	4,510	4,830	4,830	4,870	5,070	5,270	5,400
$30,000 - 39,999	1,020	1,830	2,510	3,510	4,510	5,510	5,830	5,870	6,070	6,270	6,470	6,600
$40,000 - 59,999	1,390	3,200	4,360	5,360	6,360	7,370	7,890	8,090	8,290	8,490	8,690	8,820
$60,000 - 79,999	1,870	3,680	4,830	5,840	7,040	8,240	8,770	8,970	9,170	9,370	9,570	9,700
$80,000 - 99,999	1,870	3,690	5,040	6,240	7,440	8,640	9,170	9,370	9,570	9,770	9,970	10,810
$100,000 - 124,999	2,040	4,050	5,400	6,600	7,800	9,000	9,530	9,730	10,180	11,180	12,180	13,120
$125,000 - 149,999	2,040	4,050	5,400	6,600	7,800	9,000	10,180	11,180	12,180	13,180	14,180	15,310
$150,000 - 174,999	2,040	4,050	5,400	6,860	8,860	10,860	12,180	13,180	14,230	15,530	16,830	18,060
$175,000 - 199,999	2,040	4,710	6,860	8,860	10,860	12,860	14,380	15,680	16,980	18,280	19,580	20,810
$200,000 - 249,999	2,720	5,610	8,060	10,360	12,660	14,960	16,590	17,890	19,190	20,490	21,790	23,020
$250,000 - 399,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$400,000 - 449,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$450,000 and over	3,140	6,450	9,110	11,610	14,110	16,610	18,430	19,930	21,430	22,930	24,430	25,870

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$510	$850	$1,020	$1,020	$1,020	$1,020	$1,220	$1,870	$1,870	$1,870	$1,960
$10,000 - 19,999	510	1,510	2,020	2,220	2,220	2,220	2,420	3,420	4,070	4,070	4,160	4,360
$20,000 - 29,999	850	2,020	2,560	2,760	2,760	2,960	3,960	4,960	5,610	5,700	5,900	6,100
$30,000 - 39,999	1,020	2,220	2,760	2,960	3,160	4,160	5,160	6,160	6,900	7,100	7,300	7,500
$40,000 - 59,999	1,020	2,220	2,810	4,010	5,010	6,010	7,070	8,270	9,120	9,320	9,520	9,720
$60,000 - 79,999	1,070	3,270	4,810	6,010	7,070	8,270	9,470	10,670	11,520	11,720	11,920	12,120
$80,000 - 99,999	1,870	4,070	5,670	7,070	8,270	9,470	10,670	11,870	12,720	12,920	13,120	13,450
$100,000 - 124,999	2,020	4,420	6,160	7,560	8,760	9,960	11,160	12,360	13,210	13,880	14,880	15,880
$125,000 - 149,999	2,040	4,440	6,180	7,580	8,780	9,980	11,250	13,250	14,900	15,900	16,900	17,900
$150,000 - 174,999	2,040	4,440	6,180	7,580	9,250	11,250	13,250	15,250	16,900	18,030	19,330	20,630
$175,000 - 199,999	2,040	4,510	7,050	9,250	11,250	13,250	15,250	17,530	19,480	20,780	22,080	23,380
$200,000 - 249,999	2,720	5,920	8,620	11,120	13,420	15,720	18,020	20,320	22,270	23,570	24,870	26,170
$250,000 - 449,999	2,970	6,470	9,310	11,810	14,110	16,410	18,710	21,010	22,960	24,260	25,560	26,860
$450,000 and over	3,140	6,840	9,880	12,580	15,080	17,580	20,080	22,580	24,730	26,230	27,730	29,230

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No.1615-0047
Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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

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

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

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

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

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)			**Additional Information**		
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)					

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.	First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
	6300 Schade Dr., Midland, MI 48640

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		7. Employment authorization document issued by the Department of Homeland Security For examples, see Section 7 and Section 13 of the M-274 on uscis.gov/i-9-central. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	OR	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on I-9 Central for more information.

DHS-1929, CENTRAL REGISTRY CLEARANCE REQUEST

Michigan Department of Health and Human Services
(Revised 5-23)

COPY PHOTO ID HERE

OR

ATTACH A SEPARATE PAGE

SECTION 1 – INFORMATION ON PERSON BEING CLEARED

Name, (First, Middle, Last)

Maiden Name, Aliases, also known as (A.K.A) | Social Security Number | Date of Birth

Address | City | State | Zip Code

Phone Number | Email

☐ I would like to pick up my results in County (For Michigan Residents Only).

Signature Required for Individual Being Cleared | Date

X

SECTION 2 – REQUESTER INFORMATION

Check Appropriate Box

☒ Employer
☐ Volunteer Agency
☐ Out-of-State Child Caring Institution
☐ Out-of-State Adoption/Foster Care Home Screening
☐ Michigan Court/Law Enforcement/Department of Corrections/Prosecuting Attorney
☐ Individual Self-Request

Name of Agency or Organization: Stuart Wilson, CPA | Name of Requester

Address: 6300 Schade Drive | City: Midland | State: MI | Zip Code: 48642

Email | Fax: 989-832-5404 | Phone Number: 989-832-5400

Effective November 1, 2022, only confirmed cases of methamphetamine production, confirmed serious abuse or neglect, confirmed sexual abuse, or confirmed sexual exploitation will be classified as a central registry case in Michigan. Individuals may have child welfare history that previously resulted in central registry placement, but that would no longer meet the criteria. In addition, select criminal convictions involving children will result in placement on central registry.

This clearance does not identify individuals with child abuse/neglect history who did not meet the new central registry requirements as noted above or history in other states, territories, or tribal trust land.

With your signature, you are authorizing agencies to receive notice of all placements on central registry as allowable by Child Protection Law (MCL 722.627-722.627j).

The confidentiality of central registry information is protected by Sections 7 through 7j of the Michigan Child Protection Law (MCL 722.627-722.627j). Anyone who violates this protection is guilty of a misdemeanor and is civilly liable for damages.

INSTRUCTIONS FOR DHS-1929

REQUIREMENTS

All submitted requests must include a completed form with signature and a copy of the individual of the inquiry's legal photo ID.

With this signed written request, the department may provide confirmation of central registry placement to an individual, office, agency, and/or entity authorized by law to receive it. Results of placement on central registry will be indicated on a DHS-1910, Central Registry Check, response letter and mailed to the address on the individual's legal photo ID within ten (10) business days, via certified mail or marked restricted (to be delivered to addressee only), OR via encrypted email to the requestor, if authorized to receive the results.

If the individual of the inquiry is not listed on central registry, results indicating the person is not listed on central registry as of the date the clearance was performed will be marked on a DHS-1910, Central Registry Check, response letter and issued via standard mail, fax, or by encrypted email to the email address provided on this form within ten (10) business days. If Section 2 is completed, the clearance results will be sent to the listed agency lead.

INSTRUCTIONS

Employer and/or Volunteer Agency
Includes all agencies, organizations and companies employing staff or seeking volunteers. Includes school and university coursework programs, hospitals, medical centers, and third-party companies. Excludes camp organizations, children camp organizations, and Michigan-based child caring institutions.

Michigan-Based Agencies: Michigan employers and volunteer agencies requesting a central registry clearance on an employee/volunteer or potential employee/volunteer must complete both Sections 1 and 2. Submit the completed DHS-1929 form, along with legal photo ID, to the MDHHS office in the county where the employer or volunteer agency is located. See the attached list for MDHHS county office locations and contact numbers.

NOTE: If the Michigan-based agency is requesting a central registry clearance on an employee/volunteer or potential employee/volunteer who **resides out-of-state**, submit the DHS-1929 form, along with a legal ID, to the Out-of-State Central Registry mailbox at MDHHS-Outofstate-Central-Registry@michigan.gov or by fax. See the attached list for Out-of-State location and contact information.

Out-of-State Agencies: Out-of-state employers and volunteer agencies requesting a central registry clearance on an employee/volunteer or potential employee/volunteer must complete both Sections 1 and 2. Submit the completed DHS-1929 form, along with legal photo ID, to the Out-of-State Central Registry mailbox at MDHHS-Outofstate-Central-Registry@michigan.gov or by fax. See the attached list for Out-of-State location and contact information.

Out-of-State Child Caring Institutions: Out-of-state child caring centers, child placing agencies, and residential centers requesting a central registry clearance on an employee/volunteer or potential employee/volunteer must complete both Sections 1 and 2. Submit the completed DHS-1929 form, along with legal photo ID, to the Out-of-State Central Registry mailbox at MDHHS-Outofstate-Central-Registry@michigan.gov or by fax. See the attached list for Out-of-State location and contact information.

NOTE: Out-of-State Child Placing Agencies requesting investigation case record history **do not complete this form**. Agencies outside of Michigan who are investigating a report of known or suspected child abuse or neglect, may request records by *emailing a request on letterhead to

MDHHS-OutofStateAgencyCPSRecordsRequest@michigan.gov.

Out-of-State Adoption and Foster Home Screening: The Division of Child Welfare Licensing (DCWL) will conduct central registry clearances for out-of-state agencies for the following purposes:

1. Licensing foster homes.
2. Adoption screening.

All requests must come from the child placing agency working with the foster or adoptive applicant. The request must be in writing on the requester's letterhead stating the reason for the request (example: foster home licensing, adoptive placement, etc.) and must include all the following and submit by *email to: MDHHS-DCWL-OSCR@michigan.gov

1. Name and title of individual requesting the information.
2. Contact information (phone, fax numbers, email address, etc.)
3. Name(s) of the individual(s) requested to be cleared.
4. The individual being cleared must complete the DHS-1929, Central Registry Clearance Request form that provides authorization for MDHHS to complete the requested clearance. All submissions must include the applicant's legal photo ID.
5. The DHS-1929 form must accompany the agency's request.

Michigan Court/Law Enforcement/Department of Corrections/Prosecuting Attorney
Any Michigan court, law enforcement agency, Department of Corrections or prosecuting attorney requesting a central registry clearance must complete both Sections 1 and 2. Submit the completed DHS-1929 form, along with legal photo ID, to the MDHHS office in the county where the agency is located. See the attached list for MDHHS county office locations and contact numbers.

INDIVIDUAL SELF-REQUEST

Michigan Residents: Michigan residents who are requesting a central registry clearance on themselves must complete Section 1 and check the "Individual Self-Request" box in Section 2. Submit the completed DHS-1929 form, along with legal photo ID, to your local MDHHS office. Results will be sent to your listed address. If you need to retrieve your results in person at your local MDHHS office, you must provide your legal photo ID to receive the results. See the attached list for MDHHS county office locations and contact numbers.

Out-of-State Residents: Individuals who are not residents of Michigan who are requesting a central registry clearance on themselves must complete Section 1 and check the "Individual Self-Request" box in Section 2. Submit the completed DHS-1929 form, along with legal photo ID, to the Out-of-State Central Registry mailbox at MDHHS-Outofstate-Central-Registry@michigan.gov or by fax. See the attached list for Out-of-State location and contact information.

Other Agencies/Organizations Not Listed
If your agency is not listed within the instructions, visit the Michigan Central Registry website for instructions to obtain the information needed by your agency to request or obtain a central registry clearance. www.michigan.gov/mdhhs/adult-child-serv/abuse-neglect

*MDHHS strives to protect client confidentiality. If using email to communicate with MDHHS, please encrypt the email to protect the client's information. If encryption is not available, please mail or fax the request.

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: Shiawassee Health and Wellness

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 to my employer, to be run ongoing, and to the "Host Agency" which acts as project administrator; and to the "Fiscal Intermediary" which serves as my employer's financial administrator.

Furthermore, I acknowledge that I am required to notify Stuart T. Wilson CPA, PC as soon as possible, but no later than the next business day, if I have been convicted of any crime.

_____
Signature Date

Results are released to the participant/guardian or case manager.

For results contact:

Participant/Guardian Name: _____

Phone #: _____ Email: _____

or

Case Manager: _____

Phone #: _____ Email: _____

AUTHORIZATION TO DISCLOSE
EMPLOYEE INFORMATION AND RELEASE OF LIABILITY
OFFICE OF RECIPIENT RIGHTS CHECK

I, _____, authorize Shiawassee Health and Wellness (SHW) and the SHW Office of
(Print full name)
Recipient Rights to disclose to the Provider/Consumer listed below any and all information in your possession regarding any violation of recipients' rights committed by me. I recognize that any disclosure cannot include confidential client information protected by any Federal, State, or common law.

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

PREVIOUS PLACES OF EMPLOYMENT

1._____ Dates employed _____ to _____
2._____ Dates employed _____ to _____
3._____ Dates employed _____ to _____

Please check the appropriate box below

☐ I acknowledge that I have worked in the Mental Health field prior to my application for employment. I have worked in the following counties and give my permission for you to check with their county's Office of Recipient Rights: _____.

☐ I have not worked in the Mental Health field prior to my application for employment.

_____	_____	_____
Applicant's Signature	**Date**	**Previous/Maiden Names Used (Print)**
_____	_____	_____
Witness Signature	**Date**	**Title**

INFORMATION TO BE SENT TO:

Nicola Hopkins
Provider/Consumer
1555 Industrial Drive
Street Address

Owosso	MI	48867	989-725-5061
City	State	Zip Code	FAX #

RIGHTS OFFICE USE ONLY

The above applicant has the following Recipient rights history:
Violation(s) of Abuse or Neglect:
☐ YES ☐ No _____

The above applicant has the following Recipient Rights History:
Violation(s) of other Recipient rights categories
☐ Yes ☐ No _____

By: _____ Date _____
SHW Office of Recipient Rights Fax# (989)723-0888