CONSUMER DIRECT CARE NETWORK

PARTICIPANT DATA FORM

Participant/FEIN Holder Information

Name ______________ ______________ ______________ **Gender** ☐ Male ☐ Female
First *Middle* *Last*

Street Address ______________ *(Physical address where services will be provided, No PO Box)*

City ______________ **State** ______ **Zip** ______ **County** ______________

Phone (____) ________ (____) ________ (____) ________ **Email** ______________
Primary *Secondary* *Fax*

Date of Birth ________ **Social Security #** _____-___-______ **Driver's License** ______________ ______
Number *State*

Medicaid # ______________ **Note:** *A driver's license number is required to complete the Florida Business Tax Application, form DR-1.*

Legal Guardian Information *(if applicable)*

Name ______________ ___ ______________ **Relationship to Participant** ______________
First *MI* *Last*

Street Address ______________

City ______________ **State** ______ **Zip** ______

Phone (____) ________ (____) ________ (____) ________ **Email** ______________
Primary *Secondary* *Fax*

❐ Yes ❐ No - Will legal guardian sign the enclosed Federal and State tax forms on the participant's (FEIN holder's) behalf?

If yes, attach court-appointed guardianship paperwork, and enter social security and driver's license information below.

Social Security # _____-___-______ **Driver's License** ______________ ______
Number *State*

Representative Information *(if applicable)*

Name ______________ **Relationship to Participant** ______________

Street Address ______________

City ______________ **State** ______ **Zip** ______

Phone (____) ________ (____) ________ (____) ________ **Email** ______________
Primary *Secondary* *Fax*

Date of Birth ________ **Social Security #** _____-___-______ **BG Check Clearance Date** ________

Approving Entity Information

Managed Care Plan ______________

External Case Mgr/Care Coordinator Name ______________ **Phone** (____) ________

Address ______________ **Cell** (____) ________

City ______________ **State** ______ **Zip** ______ **Email** ______________

Prior Relationships/Business Accounts

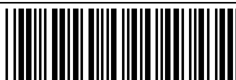
1. ❐ Yes ❐ No - Participant is **Transferring** from another Fiscal Provider? If yes, Provider name: ______________

2. ❐ Yes ❐ No - Are **Prior Business Accounts** established? If yes, enter account information below:

   → ____-__________ ______________ ________
   FEIN **Reemployment Tax Account #** **SUTA Rate**

   → ❐ Yes ❐ No - If previous FEIN, does FEIN holder have employees other than caregivers?

3. **Budget/Auth Start Date** ______________



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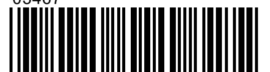


FISCAL EMPLOYER AGENT

PARTICIPANT ORIENTATION AND ENROLLMENT CHECKLIST

Participant (FEIN holder) Name	Representative Name (if applicable)

Review of Participant Guidelines

Participant Enrollment Packet (submit to Consumer Direct) — Check as completed.

- Participant Data Form ☐
- Participant Agreement and Acknowledgement Form ☐
- Participant/Employer and Tax Forms
  1. SS-4 Application for Employer Identification Number (EIN) ☐
  2. 2678 Employer/Payer Appointment of Agent ☐
  3. Guardianship papers (submit photocopy, if applicable) ☐
  4. DR-1 Florida Business Tax Application ☐
  5. DR-835 Power of Attorney ☐
- PDO Consent Form ☐
- Emergency and Backup Plan ☐

Representative Forms (if applicable, submit to Consumer Direct if Participant assigns a Representative to direct services)

- PDO Representative Agreement ☐
- Information Needed for Fingerprinting ☐
- Attestation of Compliance with Background Screening Requirements ☐
- Care Provider Background Screening - Privacy Policy Acknowledgement (Privacy policy statements attached) ☐

Supplemental Forms (Discuss each and keep for future use)

- Payroll Calendar
- Online Time Sheet Instructions
- Paper Time Sheets and Time Sheet Instructions
- Complaint Procedure
- Feedback Form
- Fingerprint Registration Procedure
- List of Barring Offenses
- RT-83 Notice to Employees regarding Florida Reemployment Assistance Program

Direct Service Worker Enrollment Packet (discuss)

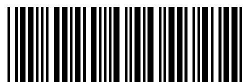
Completed on date: _____/_____/______

Program Coordinator: ______________________________ ______________________________

Name *Signature*

Participant: ______________________________ ______________________________

Name *Signature*



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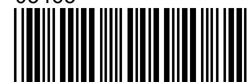


CONSUMER DIRECT CARE NETWORK

ACUERDO DEL PARTICIPANTE Y FORMULARIO DE RECONOCIMIENTO

Nombre del Participante, Imprima ______________________ Nombre del Tutor Legal (si corresponde), Imprima ______________________

INSTRUCCIONES:
1. **Revise cada tema y haga preguntas, si es necesario. Iniciales por cada uno para mostrar su acuerdo (Participante o Tutor Legal) y el entendimiento.**
2. **En este acuerdo, "Yo, Mi, Me" se refiere a los Participantes o el Tutor Legal (LG), según corresponda.**

______ *Yo autorizo a Consumer Direct a inicial por mí porque es difícil para mí escribir*

______ **RECIBO DEL MANUAL DE EMPLEO:** El manual describe las políticas, procedimientos y requisitos para los participantes y trabajadores de servicio directo (DSW) en la opción de dirección del participante (DOP). Voy a leer el manual. Si tengo preguntas, me comunicaré con Consumer Direct. Revisare el manual con mi DSW(s) y les daré una copia. Soy responsable de que mi DSW(s) sigua los requisitos del programa, las políticas y procedimientos contenidos en el manual.

______ **OTROS MATERIALES DE ENTRENAMIENTO:** He recibido y leeré el siguiente material de entrenamiento:

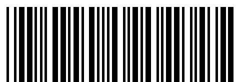
- Directivo para Participantes PDO
- Abuso, Negligencia y Explotación (Suplemento del Manual)
- Fraude de Medicaid (Suplemento del Manual)
- Entrenamiento relacionado con el empleador; completar los documentos fiscales federales y estatales; desarrollando un PDO Plan de Respaldo y Emergencia; entrevistas, formación y evaluación de DSW(s); y completando y presentando las hojas de tiempo.

______ **CONTRATAR TRABAJADORES DE SERVICIO DIRECTO:** Soy responsable en el reclutamiento, entrevista y contratación de DSW(s) trabajadores de servicio directo. El DSW trabajador de servicio directo puede ser un familiar, amigo o alguien de la comunidad. Debo estar cómodo con la persona.

- DSW(s) trabajador de servicio directo no puede ser el representante del participante.
- Antes de que un DSW trabajador de servicio directo pueda comenzar a trabajar y ser pagado en este programa, debo recibir una notificación indicando “aprobado para trabajar" para cada DSW.

______ **PLAN DE ENTRENAMIENTO DEL PARTICIPANTE:** Soy responsable de entrenar y supervisar a mi DSW(s), trabajador de servicio directo. Puedo obtener información sobre cómo hacer esto en el Manual de Empleo. También puedo conseguir información de los empleados de Consumer Direct con los que me comunico regularmente Sé que Consumer Direct responderá preguntas, aclarar y me ayudara a aprender a supervisar y administrar a mi DSW(s).

a. Yo entrenare y programare a mi DSW(s), trabajador de servicio directo para satisfacer mis necesidades de servicio. Mi DSW, trabajador de servicio directo se programará según lo aprobado en mi Care Plan (Plan de Cuidado).
b. Le daré mi opinión a mi DSW, trabajador de servicio directo si él o ella no está haciendo una tarea como fue entrenado o si no está haciendo un buen trabajo. También le daré retroalimentación positiva cuando él o ella está haciendo bien su trabajo.
c. Despediré a un DSW, trabajador de servicio directo si él o ella continúa en hacer un mal trabajo después de recibir retroalimentación y entrenamiento o si él o ella no ha seguido las directrices del programa.
d. He recibido la siguiente información de entrenamiento para mi DSW, trabajador de servicio directo. Sé que soy responsable por el entrenamiento de mi DSW(s), trabajador de servicio directo cuando sea aplicable.



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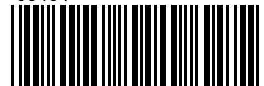

- Control de la infección
- Abuso y Negligencia
- Fraude de Medicaid
- Como levantar y mover pacientes
- HIPAA y Confidencialidad

e. Sé que otros materiales de entrenamiento en otros temas, tales como: bañarse, vestirse, seguridad del hogar y del fuego, transferencias seguras y nutrición, están disponibles con Consumer Direct si yo los pido.

f. Sé que Consumer Direct me ayudara a asegurarse de que mi DSW(s), trabajador de servicio directo sea aprobado para trabajar para mí.

______ Me aseguraré que los **servicios** que yo programe para que el DSW, trabajador de servicio directo realize y el **tiempo que el DSW trabaje** este de acuerdo con mi Plan de Cuidado. Sé que la aprobación de una hoja de tiempo cuando un DSW, trabajador de servicio directo no ha trabajado, o la aprobación de una hoja de tiempo que no está de acuerdo con mi Plan de Cuidado, es un fraude de Medicaid.

- Puedo empezar servicios con Consumer Direct después de que los materiales de inscripción de mi DSW, trabajador de servicio directo sean enviados a Consumer Direct y hasta que reciba una notficacion de “aprobado para trabajar" para cada DSW trabajador directo.
- Yo diseñe un Plan de Emergencia y Remplazo para utilizar cuando mi DSW(s), trabajador de servicio directo regular no esté disponible.
- Sé que soy financieramente responsable del pago de un DSW, trabajador de servicio directo si:
  - No califico o si pierdo mi Medicaid.
  - Dejo que mi DSW(s), trabajador de servicio directo trabaje horas extras.
  - Dejo que mi DSW(s), trabajador de servicio directo trabaje más tiempo del que está aprobado en mi Plan de Cuidado.
  - Dejo que mi DSW(s), trabajador de servicio directo haga tareas que no estén aprobadas en mi Plan de Cuidado.

______ **REPORTAR:** Reportare:

a. Cualquier posible fraude de Medicaid a Consumer Direct inmediatamente y a el MCO.

b. Abuso, negligencia y explotación (descrito en el Manual de Empleo y las Directrices del Participante) para servicios de protección para adultos y Consumer Direct.

c. Cualquier cambio en el estado de salud o situación a Consumer Direct (ejemplos: hospitalización, mejora o disminución en el estado de salud, o cambio de domicilio) dentro de cinco días.

d. Un cambio de nombre o dirección de mi o mi representante dentro de cinco días.

______ **PRIVACIDAD:** He recibido una copia del Aviso de Prácticas de privacidad de Consumer Direct. Describe mis derechos y privilegios bajo las reglas de privacidad de Consumer Direct. Las reglas siguen las regulaciones federales de privacidad (HIPAA).

Daryl Holzer: oficial de cumplimiento, Teléfono gratuito: 1-877-532-8530

______ **DECISION DE SERVIR:** Consumer Direct puede optar por no servirme. Esto sucederá si no quiero seguir pólizas y procedimientos, o si no se pueden satisfacer mis necesidades de salud y seguridad con el programa auto-dirigido. Consumer Direct discutirá sus preocupaciones conmigo y con mi administrador de casos. Mi administrador de casos me ayudará con los servicios de transición de PDO dentro de los treinta (30) días.

______ **FORMULARIO DE CONSENTIMIENTO:** El formulario de consentimiento (forma del estado) describe los derechos y responsabilidades de Consumer Direct y el participante. Entiendo que Consumer Direct está realizando algunas de las responsabilidades de la organización de atención administrada para

la opción participante dirigido. Estos derechos y responsabilidades también se aplican como parte de este acuerdo.

LAS CONDICIONES Y TÉRMINOS DEL CONTRATO

SERVICIO NO EMERGENTE: Yo se que Consumer Direct no proporciona ningún servicio médico de emergencia. Yo reconosco que debo llamar a los servicios de emergencia (911) durante una emergencia médica.

INDEMNICAZION Y EXENCION: Yo reconozco que estaré en una mejor posición para controlar, supervisar y vigilar a mi empleado en el desempeño de sus funciones. Estoy de acuerdo en indemnizar, que significa devolver pago, defender y sostener inofensivo a Consumer Direct de cualquier reclamo, causas de acciones, reclamaciones, demandas alegando cualquier daño o responsabilidad contra Consumer Direct, como resultado de las acciones, omisiones o cualquier conducta de mi DSW, trabajador de servicio directo, mientras trabajaba junto a mí. Este acuerdo de indemnización incluye cualquier reclamo por daños a mi propiedad o mi persona, o la propiedad o las personas de cualquier tercero. Entiendo que esto significa que se deba pagar por los daños causados por mi DSW trabajador de servicio directo, mientras trabajaba junto a mí, que se hacen contra Consumer Direct, incluyendo los costos de que Consumer Direct tenga mientras se defiende contra tales reivindicaciones.

NULIDAD PARCIAL: Si cualquier parte de este acuerdo no le aplica a usted o cambios con el tiempo, las otras partes del acuerdo aún se aplican y son válidos. Si se rompe una parte de este acuerdo, el resto del acuerdo permanece en su lugar.

ARBITRAJE: Estoy de acuerdo que cualquier disputa que Consumer Direct tenga bajo este acuerdo se resolverá mediante arbitraje vinculante, en vez de en los tribunales. En caso de desacuerdo, Consumer Direct puede solicitar arbitraje bajo las reglas y auspicios (apoyo) de la Asociación Americana de Arbitraje. El costo del arbitraje será dividido uniformemente entre Consumer Direct y yo.

LA LEY DEL ESTADO: Si no podemos resolver un problema mediante la negociación o hablando sobre el problema, entonces se aplicará la ley estatal de Florida. Cualquier acción legal relacionada con este acuerdo debe realizarse en la Florida.

DURACION Y MODIFICACION DE CONTRATO: El presente Acuerdo entrará en vigor en la fecha que está firmado por el participante y Consumer Direct. El acuerdo se puede cambiar. Cualquier cambio debe ser por escrito, firmado y fechado por el participante y Consumer Direct . El acuerdo puede interrumpirse inmediatamente por participante o Consumer Direct por decirlo por escrito si está bien hacerlo bajo las reglas del programa y leyes conexas.

NOTIFICACION OPORTUNA: Consumer Direct y el participante aceptan que todo contacto debe ocurrir de manera oportuna. Cualquier aviso se dará inmediatamente, para que el participante o Consumer Direct no sea dañado por un retraso.

ACUERDO COMPLETO: Este acuerdo y otros materiales escritos juntos describen el completo entendimiento entre un participante/Tutor Legal y Consumer Direct . No se aplican los acuerdos verbales. Todos los acuerdos deben ponerse por escrito por el participante/Representante Legal o Consumer Direct .

Soy el empleador directo (Gerente) de el DSW(s), trabajador de servicio directo. Sé que soy responsable de reclutamiento, contratación, capacitación y supervisión de mi DSW(s), trabajador de servicio directo. Acepto toda responsabilidad por cualquier daño personal, médico o relacionado con responsabilidad por los servicios proporcionados bajo este programa. Mi firma indica mi acuerdo.

Firma del Participante o Guardia Legal	_Fecha_	_Representante de Consumer Direct_	_Fecha_

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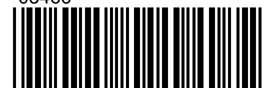

Form **SS-4**
(Rev. December 2019)
Department of the Treasury
Internal Revenue Service

Application for Employer Identification Number

(For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, Indian tribal entities, certain individuals, and others.)
▶ Go to *www.irs.gov/FormSS4* for instructions and the latest information.
▶ See separate instructions for each line. ▶ Keep a copy for your records.

OMB No. 1545-0003

EIN

Type or print clearly.

1 Legal name of entity (or individual) for whom the EIN is being requested

2 Trade name of business (if different from name on line 1)

3 Executor, administrator, trustee, "care of" name

4a Mailing address (room, apt., suite no. and street, or P.O. box)

5a Street address (if different) (Don't enter a P.O. box.)

4b City, state, and ZIP code (if foreign, see instructions)

5b City, state, and ZIP code (if foreign, see instructions)

6 County and state where principal business is located

7a Name of responsible party

7b SSN, ITIN, or EIN

8a Is this application for a limited liability company (LLC) (or a foreign equivalent)? . . . . ☐ Yes ☐ No

8b If 8a is "Yes," enter the number of LLC members . . . . . . ▶

8c If 8a is "Yes," was the LLC organized in the United States? . . . . ☐ Yes ☐ No

9a **Type of entity** (check only one box). **Caution:** If 8a is "Yes," see the instructions for the correct box to check.

☐ Sole proprietor (SSN) ____________
☐ Partnership
☐ Corporation (enter form number to be filed) ▶ ____________
☐ Personal service corporation
☐ Church or church-controlled organization
☐ Other nonprofit organization (specify) ▶ ____________
☐ Other (specify) ▶
☐ Estate (SSN of decedent) ____________
☐ Plan administrator (TIN) ____________
☐ Trust (TIN of grantor) ____________
☐ Military/National Guard
☐ State/local government
☐ Farmers' cooperative
☐ Federal government
☐ REMIC
☐ Indian tribal governments/enterprises

Group Exemption Number (GEN) if any ▶

9b If a corporation, name the state or foreign country (if applicable) where incorporated | State | Foreign country

10 **Reason for applying** (check only one box)

☐ Started new business (specify type) ▶ ____________
☐ Hired employees (Check the box and see line 13.)
☐ Compliance with IRS withholding regulations
☐ Other (specify) ▶
☐ Banking purpose (specify purpose) ▶ ____________
☐ Changed type of organization (specify new type) ▶ ____________
☐ Purchased going business
☐ Created a trust (specify type) ▶ ____________
☐ Created a pension plan (specify type) ▶ ____________

11 Date business started or acquired (month, day, year). See instructions.

12 Closing month of accounting year

13 Highest number of employees expected in the next 12 months (enter -0- if none). If no employees expected, skip line 14.

Agricultural	Household	Other

14 If you expect your employment tax liability to be $1,000 or less in a full calendar year **and** want to file Form 944 annually instead of Forms 941 quarterly, check here. (Your employment tax liability generally will be $1,000 or less if you expect to pay $5,000 or less in total wages.) If you don't check this box, you must file Form 941 for every quarter. ☐

15 First date wages or annuities were paid (month, day, year). **Note:** If applicant is a withholding agent, enter date income will first be paid to nonresident alien (month, day, year) . . . . ▶

16 Check **one** box that best describes the principal activity of your business.
☐ Health care & social assistance ☐ Wholesale-agent/broker
☐ Construction ☐ Rental & leasing ☐ Transportation & warehousing ☐ Accommodation & food service ☐ Wholesale-other ☐ Retail
☐ Real estate ☐ Manufacturing ☐ Finance & insurance ☐ Other (specify) ▶

17 Indicate principal line of merchandise sold, specific construction work done, products produced, or services provided.

18 Has the applicant entity shown on line 1 ever applied for and received an EIN? ☐ Yes ☐ No
If "Yes," write previous EIN here ▶

Third Party Designee

Complete this section **only** if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form.

Designee's name | Designee's telephone number (include area code)

Address and ZIP code | Designee's fax number (include area code)

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

Applicant's telephone number (include area code)

Name and title (type or print clearly) ▶

Applicant's fax number (include area code)

Signature ▶ Date ▶

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 16055N Form **SS-4** (Rev. 12-2019)

05151

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

(Rev. August 2014) Department of the Treasury — Internal Revenue Service

OMB No. 1545-0748

For IRS use:

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.

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: Complete this part if you want to appoint an agent or revoke an appointment.

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

Foreign country name Foreign province/county Foreign postal 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/payments	For SOME employees/ payees/payments
Form 940, 940-PR (Employer's Annual Federal Unemployment (FUTA) Tax Return)*	☐	☐
Form 941, 941-PR, 941-SS (Employer's QUARTERLY Federal Tax Return)	☐	☐
Form 943, 943-PR (Employer's Annual Federal Tax Return for Agricultural Employees)	☐	☐
Form 944, 944(SP) (Employer's ANNUAL Federal Tax Return)	☐	☐
Form 945 (Annual Return of Withheld Federal Income Tax)	☐	☐
Form CT-1 (Employer's Annual Railroad Retirement Tax Return)	☐	☐
Form CT-2 (Employee Representative's Quarterly Railroad Tax Return)	☐	☐

*Generally you cannot appoint an agent to report, deposit, and pay tax reported on Form 940, Employer's Annual Federal Unemployment (FUTA) Tax Return, unless you are a home care service recipient.

☐ Check here if you are a home care service recipient, and you want to appoint the agent to report, deposit, and pay FUTA tax for you. See the instructions.

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.

✗ Sign your name here

Print your name here

Print your title here

Date / /

Best daytime phone

Now give this form to the agent to complete. ➡

05152

Florida Business Tax Application

Rule 12A-1.097
Florida Administrative Code
Effective XX/XX

Register online at floridarevenue.com It's convenient, free, secure and saves paper, postage, and time.

For DOR Use Only

Please read the *Instructions for Completing the Florida Business Tax Application* **(Form DR-1N)**. Every applicant must complete Sections A and K and must answer the **questions in bold print** at the beginning of every section and subsection. This application will be rejected if the required information is not provided.

Section A – Reason for Applying and Applicant Information

1. Indicate your reason for submitting this application (check only one; provide date and certificate number, if applicable).

☐ a.	New business entity (not previously registered in Florida).	Beginning date of Florida taxable business activity: ☐☐/☐☐/☐☐☐☐
☐ b.	New/additional Florida business location.	Beginning date of business activity at new Florida location: ☐☐/☐☐/☐☐☐☐ ☐ Link new location to existing consolidated filing number: 80-☐☐☐☐☐☐☐☐☐☐-☐
☐ c.	New taxable activity at previously registered business location.	Date of new taxable activity: ☐☐/☐☐/☐☐☐☐ Registered location's certificate number ☐☐-☐☐☐☐☐☐☐☐☐☐-☐
☐ d.	Change of Florida county.	Date of location county change: ☐☐/☐☐/☐☐☐☐ Old location's certificate/account number: ☐☐-☐☐☐☐☐☐☐☐☐☐-☐ ☐ Link new county location to existing consolidated filing number: 80-☐☐☐☐☐☐☐☐☐☐-☐
☐ e.	Change of legal entity/business structure.	Date of legal change: ☐☐/☐☐/☐☐☐☐ Old entity's certificate/account number: ☐☐-☐☐☐☐☐☐☐☐☐☐-☐
☐ f.	Purchase/acquisition of existing business from another person or entity.	Date of purchase/acquisition: ☐☐/☐☐/☐☐☐☐

2. Is this a seasonal business? ☐ Yes ☐ No **If yes**, first month of season: ____________________ last month: ____________________

BUSINESS ENTITY INFORMATION

3a. Legal name of individual owner (for sole proprietor only):	**Last** name:	**First** name:	**Middle** name/initial:	3b. Owner's telephone number: ( )
3c. Legal name of business entity (e.g., corporation, limited liability company, partnership, trust, estate):				
4. Trade, fictitious, or "doing business as" name:				
5a. Physical street address of business location or rental property being registered (see instructions):				5b. Business telephone number: ( )
City/State/ZIP:			County:	5c. Fax number: ( )
6. Mail to the attention of:		Mailing address (if different from # 5a):		
City/State/ZIP:				
7. Email address: Your email address is treated as confidential information [section (s). 213.053, Florida Statutes (F.S.)], and is not subject to disclosure of public records (s. 119.071, F.S.).				
8a. **Business Entity Identification Number** - Provide the Federal Employer Identification Number (FEIN) of the business entity or Social Security Number (SSN)* of the owner/sole proprietor. Sole proprietors employing workers must also have an FEIN.			8b. FEIN:	8c. SSN*:

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9. If you checked Box 1.f. because you purchased or acquired an existing business from another person or entity, provide the following information about the other person or entity:

a. Legal name of person or entity:	b. FEIN:	c. Reemployment tax account number:
d. Address, City, State, ZIP:		e. Sales tax certificate number:
f. Portion of business acquired: ☐ All ☐ Part ☐ Unknown	g. Date of purchase or acquisition: ☐☐/☐☐/☐☐☐☐	
h. Was the business operating at the time of purchase/ acquisition? ☐ Yes ☐ No	i. **If no**, on what date did the business close? ☐☐/☐☐/☐☐☐☐	
j. Did the business have employees at the time of purchase/acquisition? ☐ Yes ☐ No	k. **If yes**, did you acquire the employees? ☐ Yes ☐ No	
l. Did the acquired entity and your entity share any common ownership, management, or control at the time of purchase/acquisition? ☐ Yes ☐ No		

BUSINESS STRUCTURE & OWNERSHIP

10. Check the box next to the structure of your business entity.

☐ a. Sole proprietorship

b. Partnership (check one below)

☐ Married couple ☐ General partnership

☐ Limited partnership ☐ Joint venture

c. Corporation (check one below)

☐ C-corporation ☐ Not-for-profit corporation

☐ S-corporation

d. Limited Liability Company (check one below)

☐ Single member LLC

☐ Elects treatment as C-corporation **

☐ Multi-member LLC

☐ Elects treatment as C-corporation **

**Refers to elections made for federal income tax purposes.

☐ e. Business trust

☐ f. Nonbusiness trust/Fiduciary

☐ g. Estate

Provide date of death: ☐☐/☐☐/☐☐☐☐

☐ h. Government agency

11. Corporations, partnerships, limited liability companies, and trusts must provide the following:

a. Document number issued by the Florida Secretary of State when the entity was chartered or authorized to conduct business in Florida:	Document number: ☐☐☐☐☐☐☐☐☐☐☐☐
b. Date of Florida incorporation, formation or organization, or date of authorization to conduct business in Florida: ☐☐/☐☐/☐☐☐☐	
c. Entity's fiscal year ending date (month/day): ☐☐/☐☐	

12. Identify the owner/sole proprietor, or general partners, officers, managing members, grantors, trustees, or personal representatives of the business entity.
Note: The person signing this application must be listed here.

Name:	Social Security Number *:	Home address:	Percent of ownership/control:
Title:	Driver license number/Issuing state:	City/State/ZIP:	Telephone number: ( )
Name:	Social Security Number*:	Home address:	Percent of ownership/control:
Title:	Driver license number/Issuing state:	City/State/ZIP:	Telephone number: ( )
Name:	Social Security Number *:	Home address:	Percent of ownership/control:
Title	Driver license number/Issuing state:	City/State/ZIP:	Telephone number: ( )

(Attach additional pages, if necessary)

* Social security numbers (SSNs) are used by the Florida Department of Revenue as unique identifiers for the administration of Florida's taxes. SSNs obtained for tax administration purposes are confidential under sections 213.053 and 119.071, Florida Statutes, and not subject to disclosure as public records. Collection of your SSN is authorized under state and federal law. Visit our Internet site at **floridarevenue.com** and select "Privacy Notice" for more information regarding the state and federal law governing the collection, use, or release of SSNs, including authorized exceptions.

BUSINESS BACKGROUND INFORMATION

13. Has this business entity ever been known by another name?	☐ Yes ☐ No	**If yes,** provide previous name:
14. Has this business entity ever been issued a certificate of registration, certificate number or tax account number by the Florida Department of Revenue?		☐ Yes ☐ No
15. Has any owner/proprietor, partner, officer, member, trustee, or the person whose social security number is provided in items 8c or 12 ever been issued a certificate of registration, certificate number or tax account number by the Florida Department of Revenue?		☐ Yes ☐ No
16. If you answered "Yes" to questions 14 or 15, provide the name, address and certificate of registration number for each business, proprietor, owner, partner, officer, member or trustee.	a. Name of person or entity named on certificate of registration:	
	b. Address of person or entity named on certificate of registration:	
	c. Certificate or tax account number:	
17. Has a tax warrant ever been filed by the Florida Department of Revenue against this business entity?		☐ Yes ☐ No
18. Has a tax warrant ever been filed by the Florida Department of Revenue against any owner/proprietor, partner, officer, member, trustee, or the person whose social security number is provided in items 8c or 12?		☐ Yes ☐ No

BUSINESS ACTIVITIES DESCRIPTION

19a. Describe the primary nature of your business and list all activities, products, and services. Include all of your taxable activities if known.	
19b. If known, provide your North American Industry Classification System (NAICS) Code(s). Enter your primary code first. To determine your NAICS code, go to **www.census.gov/eos/www/naics** Primary Code:	

Section B – Activities Subject to Sales & Use Tax (no fee)

General

20. Does your business (check the yes or no box next to each activity with black or blue pen):

Yes	No	
Y	N	a. Sell products or services at retail (to consumers)?
Y	N	b. Sell products or services at wholesale (to registered dealers who will sell to consumers)?
Y	N	c. Purchase or sell secondhand goods (see description in the Sales and Use Tax section of the instructions, Form DR-1N)? If you consign, buy or trade secondary goods, in addition to registering for sales and use tax, complete and submit a *Registration Application for Secondhand Dealers and/or Secondary Metals Recyclers* (Form DR-1S).
Y	N	d. Purchase or sell salvage or scrap metal to be recycled? If you obtain, purchase or convert ferrous or nonferrous metals into raw material products, in addition to registering for sales and use tax, complete and submit a *Registration Application for Secondhand Dealers and/or Secondary Metals Recyclers* (Form DR-1S).
Y	N	e. Sell products or goods from nonpermanent locations (such as flea markets or craft shows)?
Y	N	f. Sell products or goods by mail order using catalogs or the Internet?
Y	N	g. Rent or lease commercial real property to individuals or businesses?
Y	N	h. Rent or lease living or sleeping accommodations to others for periods of six months or less?
Y	N	i. Manage the rental or leasing of living or sleeping accommodations belonging to others?
Y	N	j. Rent equipment or other property or goods to individuals or businesses?
Y	N	k. Repair or alter consumer products or equipment?
Y	N	l. Charge admission or membership fees?
Y	N	m. Place and operate coin-operated amusement machines at business locations belonging to others?
Y	N	n. Place and operate food or beverage vending machines at business locations belonging to others?
Y	N	o. Place and operate nonfood or nonbeverage vending machines at business locations belonging to others?
Y	N	p. Operate vending machines at your business location(s)?
Y	N	q. Purchase items that you will include in a finished product assembled or manufactured for sale?

Item 20 continues on Page 4

20. Does your business (check the yes or no box next to each activity with black or blue pen):

Y N r. Purchase items for use in your business that were not taxed by the seller when purchased (includes purchases through catalogs, the Internet, or from out-of-state vendors)?

Y N s. Use dyed diesel fuel for off-road purposes?

Y N t. Provide any of the following services? If yes, check the box next to each service you provide.

☐ (1) Pest control services for nonresidential buildings
☐ (2) Interior cleaning services for nonresidential buildings
☐ (3) Detective services
☐ (4) Protection services
☐ (5) Security alarm system monitoring services

Coin-Operated Amusement Machines

21. Are coin-operated amusement machines operated at your business location? .... Y N
If yes, answer question a. **If no**, skip to question 22.

a. Do you have a written agreement designating a party other than the applicant entity as the operator of the amusement machines at your location? .... Y N
If yes, provide name, address, and telephone number of machine operator: **If no**, also complete an *Application for Amusement Machine Certificate* (Form DR-18).

Name:	Telephone number: ( )
Mailing address:	City/State/ZIP:

Real Property Contractors

22. Do you improve real property as a contractor? .... Y N
If yes, answer questions a–d. **If no**, skip to question 23.

a. Indicate your industry category(s) (check all that apply): ☐ residential ☐ commercial ☐ industrial ☐ utility ☐ bridge/road

b. Do you sell products at retail? .... Y N

c. Do you purchase materials/supplies from out-of-state vendors for use in your Florida projects? .... Y N

d. Do you construct or assemble building components away from your project sites? .... Y N

Motor Fuel Sales

23. Do you sell gasoline, diesel fuel, or aviation fuel at posted retail prices? .... Y N
If yes, complete item a. **If no**, skip to question 24.

a. Check the box next to the description that best describes your fuel sales activities.
☐ Gas station only ☐ Gas station/convenience store ☐ Truck stop ☐ Marine fueling ☐ Aircraft fueling

Section C – Activities Subject to Sales Tax and the Prepaid Wireless E911 Fee

24. Do you sell prepaid phones, phone cards or calling arrangements? .... Y N
If yes, check the box next to each activity below that describes your sales.

☐ a. Domestic or international long distance calling/phone cards (non-wireless)

☐ b. Prepaid wireless services (cards, plans, devices) that provide access to wireless networks and interaction with 911 emergency services.

Section D – Activities Subject to Solid Waste Fees & Surcharge (no fee)

25. Do you sell tires or batteries, or rent or lease motor vehicles to others? .... Y N
If yes, answer questions a–c. **If no**, skip to question 26.

a. Do you sell (at retail) new tires for motorized vehicles that are sold separately or as part of a vehicle? .... Y N

b. Do you sell (at retail) new or remanufactured lead-acid batteries that are sold separately or as a component part of another product such as new automobiles, golf carts, or boats? .... Y N

c. Do you rent, lease, or sell car-sharing membership services for the use of, motor vehicles that transport fewer than nine passengers? .... Y N

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26. Do you own or operate a dry-cleaning plant or dry drop-off facility in Florida? .... Y N

27. Do you produce or import perchloroethylene? .... Y N
If yes, also complete a Florida Fuel or Pollutants Tax Application (Form DR-156). **If no**, continue to question 28.

Section E - Activities Subject to Reemployment Tax (formerly Unemployment Tax) (no fee)

NOTE: In addition to registering for Reemployment Tax:

- New Florida employers must register with the Florida New Hire Reporting Center to report newly hired and re-hired employees in Florida, visit **https://newhire.state.fl.us**
- Florida employers are required to obtain appropriate workers' compensation insurance coverage for their employees, visit **http://www.myfloridacfo.com/division/WC/**

28. Have you employed or will you employ workers in the state of Florida? ** .... Y N
If no, skip Section E (questions 29-39).

** **Officers performing services for the corporation and receiving payment for such services (salary or distributions) are considered employees of the corporation for purposes of reemployment tax (RT).**

29. Is your business already registered and actively paying Florida reemployment tax? .... Y N
If yes, provide your RT Account Number and skip questions 30-39. **RT Account Number** ☐☐☐☐☐☐☐

30. Are you reactivating your reemployment tax account? .... Y N
If yes, provide your RT Account Number. **RT Account Number** ☐☐☐☐☐☐☐

31. Employment type (check all that apply):

- ☐ Regular employer (employee leasing companies attach a copy of Department of Business & Professional Regulation [DBPR] license)
- ☐ Nonprofit organization (attach a copy of your 501(c)(3) determination letter from the IRS)
- ☐ Domestic employer (household & personal care)
- ☐ Indian tribe or Tribal unit
- ☐ Governmental entity
  FL State agencies provide first six digits of FLAIR Org Code ☐☐☐☐☐☐
- ☐ Agricultural (noncitrus) employer
- ☐ Agricultural (citrus) employer
- ☐ Agricultural crew chief

32. On what date did you, or will you first employ workers in Florida? ** .... ☐☐/☐☐/☐☐☐☐

33. If your employment type is:

a. **Regular, Indian tribe/Tribal unit, or Governmental employer**

Have you or will you pay gross wages of at least $1,500 within a calendar quarter? ** .... Y N

If yes, provide the date you reached or will reach $1,500 gross wages: .... ☐☐/☐☐/☐☐☐☐

Have you or will you employ one or more workers for 20 or more weeks within a calendar year? ** .... Y N

If yes, provide the date of the 20th week: .... ☐☐/☐☐/☐☐☐☐

b. **Nonprofit organization**

Have you or will you employ four or more workers for 20 or more weeks within a calendar year? ** .... Y N

If yes, provide the date of the 20th week: .... ☐☐/☐☐/☐☐☐☐

c. **Domestic employer**

Have you or will you pay gross wages of at least $1,000 within a calendar quarter? ** .... Y N

If yes, provide the date you reached or will reach $1,000 gross wages: .... ☐☐/☐☐/☐☐☐☐

d. **Agricultural (non-citrus, citrus, or crew chief) employer**

Have you or will you pay gross wages of at least $10,000 within a calendar quarter? ** .... Y N

If yes, provide the date you reached or will reach $10,000 gross wages: .... __ __ / __ __ / __ __ __ __

Have you or will you employ five or more workers for 20 or more weeks within a calendar year? ** .... Y N

If yes, provide the date of the 20th week: .... __ __ / __ __ / __ __ __ __

34. Have you paid federal unemployment tax in another state this year or last year? .... Y N

If yes, in which state: ____________________ in which year: .... __ __ __ __

35. Do you use the services of persons in Florida whom you consider to be self-employed, independent contractors? .... Y N

If yes, also complete an *Independent Contractor Analysis* (RTS-6061)

36. Do you lease workers from an employee leasing company? .... Y N

If yes, complete items a–f about the leasing company and your leasing arrangement.

a. Leasing company's name:		
b. FEIN:	c. DBPR License Number:	d. RT Account Number:
e. Portion of workforce that is leased: ☐ All ☐ Part	f. Date of leasing arrangement: __ __ / __ __ / __ __ __ __	

37. List the locations where you employ workers in Florida.

Address:	City:	County:	Number of employees:
Principal products or services:	If services, indicate if ☐ Administrative ☐ Research ☐ Other: ________		
Address:	City:	County:	Number of employees:
Principal products or services:	If services, indicate if ☐ Administrative ☐ Research ☐ Other: ________		
Address:	City:	County:	Number of employees:
Principal products or services:	If services, indicate if ☐ Administrative ☐ Research ☐ Other: ________		

38. If another party (accountant, bookkeeper, agent) will maintain your payroll, provide the following information about the other party:

Individual or firm name:	Federal ID number (FEIN, PTIN):
Mailing address:	City/State/ZIP:
Email address:	Telephone number: ( )

39. Mailing addresses for reemployment tax – All correspondence about your reemployment tax account, returns, statements, rate notices, and claims and benefits information, will be mailed to the address you provided in item 6. If you wish to have these documents mailed elsewhere, provide other addresses below.

a. **Reporting** – Mail Employer's Quarterly Reports, certifications, and correspondence related to reporting to (check one): ☐ Payroll address (item 38) ☐ Other, below

Name:	Telephone number: ( )
Mailing address:	City/State/ZIP:
Email address:	

b. **Tax Rate** – Mail tax rate notices and rate-related correspondence to (check one): ☐ Payroll address (item 38) ☐ Other, below

Name:	Telephone number: ( )
Mailing address:	City/State/ZIP:
Email address:	

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c. **Claims** – Mail notices of benefits paid and other correspondence about claims and benefits to (check one): ☐ Payroll address (item 38) ☐ Other, below

Name:		Telephone number: ( )
Mailing address:	City/State/ZIP:	
Email address:		

Section F - Activities Subject to Communications Services Tax (no fee)

40. Do you sell communications services; purchase communications services to integrate into prepaid calling arrangements; or are you applying for a direct pay permit for communications services tax? .... Y N
If yes, check the box next to each service you sell, and answer questions 41-44. **If no**, skip Section F (questions 41-44).

☐ Telephone service (i.e., local, long distance, wireless or VOIP)
☐ Paging service
☐ Facsimile (fax) service (not in the course of advertising or professional services)
☐ Reseller (only sales for resale; no sales to retail customers)
☐ Other services; please describe: ____________________
☐ Video service (e.g., television programming)
☐ Direct-to-home satellite service
☐ Pay telephone service
☐ Purchase services to integrate into prepaid calling arrangements

41. Are you applying for a direct pay permit for communications services tax? .... Y N
If yes, also complete an *Application for Self-Accrual Authority/Direct Pay Permit* (Form DR-700030).

42. In order to charge the correct amount of tax, you must know the taxing jurisdiction in which your customers are located. How will you verify the correct assignment of customer location to taxing jurisdiction? If you use multiple databases, **check all that apply**. If you sell only pay telephone or direct-to-home satellite services, provide prepaid calling arrangements, are a reseller, or are applying for a direct pay permit, skip to item 44.

☐ 1. An electronic database provided by the Department.
☐ 2. Your own database that will be certified by the Department; to apply for certification, you must complete an Application for Certification of Communications Services Database (Form DR-700012).
☐ 3. A database supplied by a vendor. Provide the vendor name and product: Vendor:____________________ Product:____________________
☐ 4. ZIP+4 and a methodology for assignment when ZIP codes overlap jurisdictions.
☐ 5. ZIP+4 that does not overlap jurisdictions (e.g., a hotel located in one jurisdiction).
☐ 6. None of the above.

43. If you use multiple databases, you may be eligible for both collection allowances. If you will file separate returns for each type of database, check the box below. See instructions for explanation.

☐ I will file two separate communications services tax returns, one for each type of database.

44. Name and contact information of the managerial representative who can answer questions about filed tax returns:

Name:		Telephone number: ( )
Mailing address:	City/State/ZIP:	
Email address:		

Section G - Activities Subject to Documentary Stamp Tax (no fee)

45. Do you make sales, finalized by written financing agreements, that are not recorded by the Clerk of the Court, but do require documentary stamp tax to be paid? .... Y N
If yes, complete items a-b. **If no**, skip to question 46.

a. Do you anticipate five or more transactions subject to documentary stamp tax per month? .... Y N

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b. Will books and records be kept at locations in addition to the location provided for item 5? Y N
If yes, provide location information:

Address:	City/State/ZIP:
Address:	City/State/ZIP:
Address:	City/State/ZIP:
Address:	City/State/ZIP:

Section H - Activities Subject to Gross Receipts Tax on Electrical Power and Gas (no fee)

46. Do you own or operate a local electric or natural or manufactured gas (excluding LP gas) utility distribution facility in Florida? Y N
If yes, check the items below that apply and answer question b. **If no**, skip to question 47.

a. ☐ Electricity ☐ Natural or manufactured gas

b. Do you import into Florida natural or manufactured gas (excluding LP gas) for your own use instead of purchasing taxable utility or transportation services? Y N

Section I - Activities Subject to Severance Taxes & Miami-Dade County Lake Belt Fees (no fee)

47. Do you extract oil, gas, sulfur, solid minerals, phosphate rock or heavy minerals from the soils or waters of Florida? Y N
If yes, check the box next to each activity you are engaged in. **If no**, skip to question 48.

☐ a. Extracting oil for sale, transport, storage, profit, or commercial use.
☐ b. Extracting gas for sale, transport, profit, or commercial use.
☐ c. Extracting sulfur for sale, transport, storage, profit, or commercial use.
☐ d. Extracting solid minerals, phosphate rock, or heavy minerals from the soil or water for commercial use.
☐ e. Extracting lime rock or sand from within the Miami-Dade County Lake Belt Area (see s. 373.4149, F.S., for boundary description).

Section J – Enrollment to File and Pay Taxes and Fees Electronically (no fee)

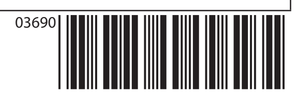
48. Do you wish to enroll to file and pay taxes, fees, and surcharges electronically? Y N
Complete this section if you wish to electronically file and pay all taxes, fees and surcharges resulting from this registration, if an electronic option exists. Each will have the same filing and paying contacts, banking information and method of payment. If you wish to enroll each tax/fee/surcharge separately (e.g., different contacts, banking information, methods of payment) you may do so online after you have received all certificate and account numbers following this registration. For detailed information about the e-Services program, see the instructions (Form DR-1N) or go to **floridarevenue.com** and select Enroll for tax e-Services.

49. Contact Person for Electronic Payments

Name:	Telephone number: ( )	Fax number: ( )
Mailing address:	City/State/ZIP:	
Email address:		
☐ a company employee ☐ a non-related tax preparer ☐ the party named in item 38	Federal PTIN (if tax preparer):	

50. Contact Person for Electronic Return Filing ☐ Check if same as contact person for electronic payments.

Name:	Telephone number: ( )	Fax number: ( )
Mailing address:	City/State/ZIP:	
Email address:		
☐ a company employee ☐ a non-related tax preparer ☐ the party named in item 38	Federal PTIN (if tax preparer):	



51. Choose your filing/payment method:
☐ File Electronically   Pay Electronically (select one):   ☐ ACH-Debit (e-check)   ☐ ACH-Credit

ACH-Debit (e-check) is the action taken when the Department's bank withdraws a tax payment from the taxpayer's bank account upon the taxpayer's authorization; the taxpayer's bank account is debited.

ACH-Credit is the action taken when the taxpayer's bank transfers a tax payment to the Department's bank account; the Department's account is credited. This is not a credit card payment.

52. Banking Information (not required for ACH-Credit payment method):

a. Bank/financial institution name:	b. **Account type:** ☐ Business, **or** ☐ Personal **and** ☐ Checking, **or** ☐ Savings
c. Bank account number:	d. Bank Routing Number: |: ☐☐☐☐☐☐☐☐☐ :|

Note: Due to federal security requirements, we cannot process international ACH transactions. If any funding for payments comes from financial institutions located outside the US or its territories, please contact us to make other payment arrangements. If you are unsure, please contact your financial institution.

53. Enrollee Authorization and Agreement

This is an Agreement between the Florida Department of Revenue, hereinafter "the Department," and the business entity named herein, hereinafter "the Enrollee," entered into according to the provisions of the Florida Statutes and the Florida Administrative Code.

By completing this agreement and submitting this enrollment request, the Enrollee applies and is hereby authorized by the Department to file tax returns and reports, make tax and fee payments, and transmit remittances to the Department electronically. This agreement represents the entire understanding of the parties in relation to the electronic filing of returns, reports, and remittances.

The same statute and rule provisions that pertain to all paper documents filed or payments made by the Enrollee also govern an electronic return, or payment initiated electronically according to this agreement.

I certify that I am authorized to sign on behalf of the business entity identified herein, and that all information provided in this document has been personally reviewed by me and the facts stated in it are true. According to the payment method selected above, I hereby authorize the Department to present debit entries into the bank account referenced above at the depository designated herein (ACH-Debit), or I am authorized to register for the ACH-Credit payment privilege and accept all responsibility for the filing of payments through the ACH-Credit method.

Signature:________________________ Title:____________________ Date:______________

Printed name:____

Second Signature: ________________________ Title:____________________ Date:______________
(If account requires two signatures)

Printed name:____

Section K - Applicant Acknowledgement, Declaration and Signature

Registrant's Responsibilities – You must initial next to each responsibility listed below to indicate that you have read, acknowledge, and understand each one. Your application will be rejected if any part of this section is left blank.

______ I understand it is my responsibility to notify the Department of Revenue of any changes of business structure, activities, location, mailing address or contact information.

______ I understand that any person who is required to collect, truthfully account for, and pay any tax, surcharge, or fee, and willfully fails to do so shall be personally liable for penalties and twice the amount of tax, under the provisions of s. 213.29, F.S.

In addition to any other penalties provided by law, including civil penalties, I understand it is a criminal offense to:

______ Fail or refuse to register (a late registration fee or penalty may also be imposed).

______ Not timely file a tax return or report.

______ Underreport a tax, surcharge or fee liability on a return or report filed.

______ Fail or refuse to collect a required tax, surcharge or fee.

______ Not remit a collected tax, surcharge or fee.

______ Make a worthless check, draft, debit card payment, or electronic funds transfer to the Department.

Authorized Signature – **Depending on your business structure, only the following principal persons may sign this application:**

- If the applicant is a sole proprietor, the individual owner must sign.
- If the applicant is a partnership, a general partner must sign.
- If the applicant is a corporation, an incorporator or officer must sign.
- If the applicant is a limited liability company, a member or manager (if authorized by the members) must sign.
- If the applicant is a trust, the grantor or a trustee must sign.
- If the applicant is an estate, the personal representative, executor or executrix must sign.
- If the applicant is a government agency, an official authorized to sign on behalf of the agency must sign.

Note: The person signing the application must be listed under item 12 in the Business Structure & Ownership section.

Applicant Attestation, Declaration, and Signature

Under penalties of perjury, I attest that I am the applicant, or that I am an authorized principal of the applicant entity identified herein, and also declare that I have read the information provided on this application and that the facts stated in it are true.

Signature: ______________________________ Title: ______________________

Printed name: ______________________________ Date: ______________________

USE THIS CHECKLIST TO ENSURE FAST PROCESSING OF YOUR APPLICATION.

- ✔ Complete all required sections of this application.
- ✔ Make sure that you have provided your FEIN or SSN.
- ✔ Sign and date the application.
- ✔ Attach required documentation or additional applications, if applicable.
- ✔ Mail to: **Account Management MS 1-5730**
  Florida Department of Revenue
  5050 W Tennessee St
  Tallahassee FL 32399-0160

You may also mail or deliver your application to any Department of Revenue taxpayer service center. Visit the Department's website at **floridarevenue.com**

FOR DOR USE ONLY

PM/Delivery	☐☐/☐☐/☐☐☐☐	**Contract Object (MO)**	☐☐☐☐☐☐☐☐☐
B.P. No.	☐☐☐☐☐☐☐☐☐	**Certificate No.**	☐☐-☐☐☐☐☐☐☐☐☐☐-☐
RT Acct. No.	☐☐☐☐☐☐☐	**Contract Object (other)**	☐☐☐☐☐☐☐☐☐
NAICS Code(s):			

03692

Florida Department of Revenue
POWER OF ATTORNEY
and Declaration of Representative

DR-835
R. 10/11
TC

Rule 12-6.0015
Florida Administrative Code
Effective 01/12

See Instructions for additional information

PART I - POWER OF ATTORNEY

Section 1. Taxpayer Information. Taxpayer(s) must sign and date this form on Page 2, Part I, Section 8.

Taxpayer name(s) and address(es)	Federal ID no(s). (SSN*, FEIN, etc.)	Florida Tax Registration Number(s) (Business Part. No., Sales Tax No., R.T. Acct No., etc.)
	Contact person	Telephone number ( )
		Fax number ( )

The Taxpayer(s) hereby appoint(s) the following representative(s) as attorney(s)-in-fact:

Section 2. Representative(s). Each representative must be listed individually, and must sign and date this form on Page 2, Part II.

Name and address (include name of firm if applicable)	Telephone number ( )
	Fax number ( )
E-mail address:	Cell phone number ( )
Name and address (include name of firm if applicable)	Telephone number ( )
	Fax number ( )
E-mail address:	Cell phone number ( )
Name and address (include name of firm if applicable)	Telephone number ( )
	Fax number ( )
E-mail address:	Cell phone number ( )

To represent the taxpayer(s) before the Florida Department of Revenue in the following tax matters:

Section 3. Tax Matters. Do not complete this section if completing Section 4.

Type of Tax (Corporate, Sales, Reemployment, formerly Unemployment, etc.)	Year(s) / Period(s)	Tax Matter(s) (Tax Audits, Protests, Refunds, etc.)

Section 4. To Appoint a Reemployment Tax (formerly Unemployment Tax) Agent Only. Do not complete Sections 3 and 6 if completing Section 4.

By completing this section, an employer (taxpayer) appoints a representative to act as its Florida reemployment tax agent before the Florida Department of Revenue on a continuing basis and to receive confidential information with respect to mailings, filings, and other tax matters related to the Florida reemployment assistance program law. All other sections of this form (except Sections 3 and 6) must also be completed.

Do not complete Section 4 unless you wish to appoint a reemployment tax agent on a continuing basis.

Agent name	Agent number (required)
Firm name	Federal I.D. No. (required)
Address (if different from above)	Telephone number ( )

Mail Type: See Instructions for explanations. Check one box only. 1 (Primary) 2 (Reporting) 3 (Rate) 4 (Claim)

Section 5. Acts Authorized.

The representative(s) are authorized to receive and inspect confidential tax information and to perform any and all acts that I (we) can perform with respect to the tax matters described in Section 3 and Section 4 (for example, the authority to sign any agreements, consents, or other documents). Except as otherwise provided, the authority specifically includes the power to execute waivers of restrictions on assessment or collection of deficiencies in tax, to execute consents extending the statutory period for assessment or claims for refund of taxes, and to execute closing agreements under section 213.21, Florida Statutes. This authority does not include the power to endorse or cash warrants, or the power to sign certain returns.

If you want to authorize a representative named in Section 2 to receive (but not to endorse or cash) refund warrants, write the name of the representative on this line and check the box ....▶ ______________________________

List any specific limitations or deletions to the acts otherwise authorized in this Power of Attorney.

____

____

03502

Florida Tax Registration Number:
Taxpayer Name(s): Federal Identification Number:

- Taxpayer(s) must complete Page 1 of this Power of Attorney or it will not be processed.

Section 6. Notices and Communication. Do not complete Section 6 if completing Section 4.

- Notices and other written communications will be sent to the first representative listed in Part I, Section 2, unless the taxpayer selects one of the options below. Receipt by either the representative or the taxpayer will be considered receipt by both.
  a. If you want notices and communications sent to both you and your representative, check this box .... ▶
  b. If you want notices or communications sent to you and not your representative, check this box.................................. ▶

Certain computer-generated notices and other written communications cannot be issued in duplicate due to current system constraints. Therefore, we will send these communications to only the taxpayer at his or her tax registration address.

Section 7. Retention / Nonrevocation of Prior Power(s) of Attorney.

The filing of this Power of Attorney will not revoke earlier Power(s) of Attorney on file with the Florida Department of Revenue, even for the same tax matters and years or periods covered by this document. If you want to revoke a prior Power of Attorney, check this box.. ▶

You must attach a copy of any Power of Attorney you wish to revoke.

Section 8. Signature of Taxpayer(s).

If a tax matter concerns a joint return, both husband and wife must sign if joint representation is requested. If signed by a corporate officer, partner, member/managing member, guardian, tax matters partner/person, executor, receiver, administrator, trustee, or fiduciary on behalf of the taxpayer, I declare under penalties of perjury that I have the authority to execute this form on behalf of the taxpayer.

Under penalties of perjury, I (we) declare that I (we) have read the foregoing document, and the facts stated in it are true.

If this Power of Attorney is not signed and dated, it will be returned.

Signature _______________ Date _______________ Title (if applicable) _______________

Print name _______________

Signature _______________ Date _______________ Title (if applicable) _______________

Print name _______________

PART II - DECLARATION OF REPRESENTATIVE

Under penalties of perjury, I declare that:

- I am familiar with the mandatory standards of conduct governing representation before the Department of Revenue, including Rules 12-6.006 and 28-106.107 of the Florida Administrative Code, as amended.
- I am familiar with the law and facts related to this matter and am qualified to represent the taxpayer(s) in this matter.
- I am authorized to represent the taxpayer(s) identified in Part I for the tax matter(s) specified therein, and to receive and inspect confidential taxpayer information.
- I am one of the following:
  a. Attorney - a member in good standing of the bar of the highest court of the jurisdiction shown below.
  b. Certified Public Accountant - duly qualified to practice as a certified public accountant in the jurisdiction shown below.
  c. Enrolled Agent – enrolled as an agent pursuant to the requirements of Treasury Department Circular Number 230.
  d. Former Department of Revenue Employee. As a representative, I cannot accept representation in a matter upon which I had direct involvement while I was a public employee.
  e. Reemployment Tax Agent authorized in Section 4 of this form.
  f. Other Qualified Representative
- **I have read the foregoing Declaration of Representative and the facts stated in it are true.**

If this Declaration of Representative is not signed and dated, it will not be processed.

Designation – Insert Letter from Above (a -f)	Jurisdiction (State) and Enrollment Card No. (if any)	Signature	Date

03503

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Formulario de Consentimiento Opción de Dirección del Participante (PDO)

Yo, ___________________________________, elegí el participar en la Opción de Dirección del Participante (PDO). Entiendo que seré responsable de lo siguiente:

Por favor escriba sus iniciales en cada línea que aparece abajo para indicar que usted ha leído y que comprende cada asunto.

________1. Tengo la Guía del Participante PDO. La guía me indica el funcionamiento del PDO y mis responsabilidades. Leeré la guía. Soy responsable de seguir la guía.

________2. Me comunicaré con el administrador de mi caso si necesito asistencia.

________3. Le informaré a mi administrador de caso si deseo seleccionar a un representante.

________4. Estoy de acuerdo de que es mi responsabilidad el entrevistar, emplear, entrenar, supervisar, y despedir (si fuese necesario) a mi(s) trabajador(es) de servicio directo.

________5. Emplearé a un(os) trabajador(es) de servicio directo cualificado(s). Las cualificaciones para el(los) trabajador(es) de servicio directo se encuentran en la Guía del Participante PDO. Debo emplear un(os) trabajador(es) de servicio directo que sean entrenados en las precauciones universales y en las normas de privacidad HIPAA.

________6. Crearé un listado de las labores del trabajo y un horario de trabajo para mi(s) trabajador(es) de servicio directo. El listado de las labores del trabajo y el horario de trabajo tienen que estar escritos en el Acuerdo del Participante/Trabajador(es) de Servicio Directo.

________7. Aseguraré que el(los) trabajador(es) de servicio directo no trabaje(n) mas horas que las que estén aprobadas en el Acuerdo del Participante/Trabajador(es) de Servicio Directo.

________8. Comprendo que puedo recibir más entrenamiento si lo necesito. Me comunicare con el administrador de mi caso si deseo más entrenamiento.

________9. Comprendo que la hoja de jornales devengados de mi(s) trabajador(es) de servicio directo deben estar correctos.

________10. Le entregaré las hojas de jornales devengados de mi(s) trabajador(es) de servicio directo a mi Plan. Las hojas de jornales devengados deben ser enviadas para la fecha programada según la nomina de pago.

________11. Le informaré a mi administrador del caso si decido despedir a mi(s) trabajador(es) de servicio directo.

________12. Crearé un Plan de Emergencia Alterno para saber que hacer en dado caso que mi(s) trabajador(es) de servicio directo no se presente(n) a proveerme mis servicios.

________13. Le informaré a mi administrador del caso si estoy teniendo problemas con mi(s) trabajador(es) de servicio directo.

________14. Comprendo que puedo parar de participar en el PDO en cualquier momento. Le informaré a mi administrador del caso si deseo parar de participar en el PDO. Mi administrador de caso se asegurará de que se me sigan proveyendo los servicios. Si paro de participar en el PDO mis servicios serán proveídos por un proveedor de la red de proveedores de mi Plan.

________15. Yo seguiré los requisitos en este Formulario de Consentimiento, en mi(s) Acuerdo(s) del Participante/Trabajador(es) de Servicio Directo, mi Acuerdo del Participante y las Guías del Participante PDO. Si yo no sigo los requisitos, mi Plan pudiese parar mi participación en el PDO. Si mi Plan para mi participación en el PDO, mi administrador del caso se asegurará de que mis servicios continúen siendo proveídos por un proveedor de la red de proveedores de mi Plan.

He leído y comprendo este Formulario de Consentimiento PDO. Comprendo que mi participación en le PDO es voluntario.

____
Nombre en letra de molde del Participante   Firma   Fecha

____
Nombre en letra de molde del Representante (si aplica)   Firma   Fecha

Yo le he explicado toda la información requerida para que este participante pudiese tomar una decisión informada sobre la participación en el PDO.

____
Nombre en letra de molde del Administrador del Caso   Firma   Fecha

CONSUMER DIRECT CARE NETWORK

PLAN DE EMERGENCIA Y DE REPUESTO PARA EL PARTICIPANTE

Nombre del Participante	**Representante o Tutor Legal (si corresponde)**

Entiendo que:

1. Consumer Direct ayudará al participante o representante con el desarrollo de un plan de emergencia que se utilizará si un trabajador establecido de servicio directo (DSW) no puede proporcionar servicios.
2. Es responsabilidad del participante o representante usar, modificar, actualizar o decidir si el plan de emergencia es efectivo.
3. Es responsabilidad del participante o representante de reportar cualquier falta de servicio inmediatamente a Consumer Direct.
4. En el caso de emergencia llame al 911.

Plan de Acción

A. Trabajadores de Respaldo

Por favor indique abajo a quién llamará si su trabajador de servicio directo DSW(s) actual no se reporta a su turno (puede incluir voluntarios, miembros de la iglesia, amigos, familia, o trabajadores directos DSWs anteriores):

Nombre	Dirección (Ciudad y Zip)	Días/horas no disponible	Teléfono

B. Otro Respaldo:
Más allá de llamar a las personas mencionadas o el personal de emergencia para ver si pueden proporcionar asistencia, me pondré en contacto los siguientes para obtener servicios:

Otros proveedores de MCO

Nombre	Dirección	Ciudad	Zip	Teléfono

C. Voy a hablar con los trabajadores de respaldo antes de que surja una emergencia acerca de empleo, seguridad, salario, su disponibilidad y también acerca de mis necesidades. Sé que mi trabajador (es) de respaldo debe ser elegibles para el trabajo y entrenados para ser pagados.

D. Entiendo que Consumer Direct mantiene una tabla de trabajo a la que yo puedo hacer referencia al reclutar trabajadores de respaldo.

E. S*é que PDO no proporciona servicios de emergencia. Por lo tanto, en caso de emergencia, yo:*

☐ **Activare mi línea de vida** ☐ **Contactare 911**

F. Si creo estar en riesgo de daño por abuso, negligencia o explotación, sé que debo contactar a Servicios Protectores de Adultos o de Abuso de menores al **1-800-962-2873**.

G. Si ha ocurrido una emergencia, me pondré en contacto:

Familiar

Nombre	Dirección	Ciudad	Zip	Teléfono

Manejador de caso

Nombre	Dirección	Ciudad	Zip	Teléfono

Médico

Nombre	Dirección	Ciudad	Zip	Teléfono

Otros

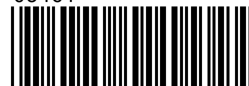
Nombre	Dirección	Ciudad	Zip	Teléfono

* Este formulario es enviado al administrador de casos y revisado trimestralmente.

_________________________________ _____________
Firma Participante o Representante *Fecha*

_________________________________ _____________
Firma de Representante de Consumer Direct *Fecha*

_________________________________ _____________
Especialista PDO/Manejador de Caso *Fecha*



Formulario de Inscripción Acuerdo del Representante Opción de Dirección del Participante (PDO)

Yo, ____, estoy de acuerdo con ser el(la) representante para __________________________________, quien esta participando en la Opción de Dirección del Participante (PDO). Entiendo que seré responsable de lo siguiente:

Por favor escriba sus iniciales en cada línea que aparece abajo para indicar que usted ha leído y que comprende cada asunto.

________1. Tengo la Guía del Participante PDO. La guía me indica el funcionamiento del PDO y mis responsabilidades. Leeré la guía. Soy responsable de seguir la guía.

________2. Me comunicaré con el administrador del caso del participante si necesito asistencia.

________3. Yo involucraré al participante tanto como desee estar involucrado(a) en las decisiones a tomar.

________4. Estoy de acuerdo de que es mi responsabilidad el entrevistar, emplear, entrenar, supervisar, y despedir (si fuese necesario) al(los) trabajador(es) de servicio directo del participante.

________5. Emplearé a un(os) trabajador(es) de servicio directo cualificado(s). Las cualificaciones para el(los) trabajador(es) de servicio directo se encuentran en la Guía del Participante PDO. Debo emplear un(os) trabajador(es) de servicio directo que sean entrenados en las precauciones universales y en las normas de privacidad HIPAA.

________6. Crearé un listado de las labores del trabajo y un horario de trabajo para el(los) trabajador(es) de servicio directo del participante. El listado de las labores del trabajo y el horario de trabajo tienen que estar escritos en el Acuerdo del Participante/Trabajador(es) de Servicio Directo.

________7. Aseguraré que el(los) trabajador(es) de servicio directo del participante no trabaje(n) mas horas que las que estén aprobadas en el Acuerdo del Participante/Trabajador(es) de Servicio Directo.

________8. Comprendo que puedo recibir más entrenamiento si lo necesito. Me comunicaré con el administrador de caso del participante si deseo más entrenamiento.

________9. Comprendo que la hoja de jornales devengados del(los) trabajador(es) de servicio directo deben estar correctos.

________10. Le entregaré las hojas de jornales devengados de del(los) trabajador(es) de servicio directo al Plan del participante. Las hojas de jornales devengados deben ser enviadas para la fecha programada según la nomina de pago.

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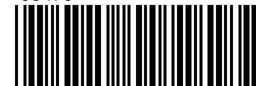

________11. Le informaré al administrador del caso del participante si decido despedir al(los) trabajador(es) de servicio directo.

________12. Comprendo que no seré pagado por ser el(la) representante del participante.

________13. Comprendo que no puedo ser un trabajador de servicio directo para el participante.

________14. Crearé un Plan de Emergencia Alterno para saber que hacer en dado caso que el(los) trabajador(es) de servicio directo del participante no se presente(n) a proveer servicios.

________15. Comprendo que tengo la opción de parar de ser el(la) representante del participante en cualquier momento. Yo le informare al participante y al administrador de caso del participante si deseo parar de ser el(la) representante. El administrador del caso le asistirá al participante a seleccionar a otro representante.

________16. Yo seguiré los requisitos en este Acuerdo del representante, el Formulario de Consentimiento, el Acuerdo del Participante y las Guías del Participante PDO. Si yo no sigo los requisitos, el Plan del participante pudiese no permitirme continuar siendo el representante. Si el Plan no me permite continuar siendo el representante, el administrador del caso del participante le ayudara al participante a seleccionar otro representante.

Favor de firmar en la línea abajo indicando que usted ha leído y comprende cada asunto en este acuerdo. Si tiene alguna pregunta, por favor pídale al administrador del caso del participante que le ayude.

____

Nombre en letra de molde del Representante | Firma | Fecha

____

Nombre en letra de molde del Participante | Firma | Fecha

____

Nombre en letra de molde del Administrador del caso | Firma | Fecha

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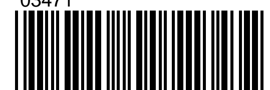


REPRESENTATIVE INFORMATION NEEDED FOR FINGERPRINTING

Instructions: *Complete each and every field below with your demographic information. Please print clearly. This information is required to register you for a fingerprint background check.*

* Last Name ______________________________
* First Name ______________________________
* Middle Name ______________________________
* Date of birth ______________________________
* State/Country of birth ______________________________
* City of birth ______________________________
* Social security number ______________________________
* Sex ______________________________
* Race ______________________________
* Eye color ______________________________
* Hair color ______________________________
* Height (feet/inches) ______________________________
* Weight ______________________________
* Country of citizenship ______________________________
* Address - Street ______________________________
* Address - City, State, Zip Code ______________________________
* Phone number ______________________________
* Email address ______________________________

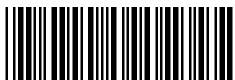
To be completed by Consumer Direct

CD Representative Name: ______________________________

Participant Name: ______________________________

Health Care Plan: ______________________________

Date of Enrollment Meeting: ______________________________



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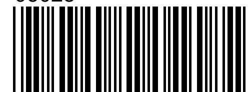

ATTESTATION OF COMPLIANCE
with Background Screening Requirements

Authority: This form shall be used by **all employees** to comply with:

- the attestation requirements of **section 435.05(2), Florida Statutes**, which state that every employee required to undergo Level 2 background screening must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer; **AND**

- the proof of screening within the previous 5 years in **section 408.809(2), Florida Statutes,** which requires proof of compliance with level 2 screening standards that have been screened through the Care Provider Background Screening Clearinghouse created under Section 435.12, F.S., or screened within the previous 5 years by the Agency, Department of Health, Department of Elder Affairs, the Agency for Persons with Disabilities, Department of Children and Families, or the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S., and in accordance with the standards in Section 408.809(2), F.S., if that agency is not currently implemented in the Care Provider Background Screening Clearinghouse.

This form must be maintained in the employee's personnel file. If this form is used as proof of screening for an administrator or chief financial officer to satisfy the requirements of an **application for a health care provider license**, please attach a copy of the screening results and submit with the licensure application.

Employee/Contractor Name:
Health Care Provider/ Employer Name:
Address of Health Care Provider:

You must attest to meeting the requirements for employment and you may not have been arrested for and awaiting final disposition of, have been found guilty of, regardless of adjudication, or have entered a plea of nolo contendere (no contest) or guilty to, or have been adjudicated delinquent and the record has not been sealed or expunged for, any offense prohibited under *any* of the following provisions of state law or similar law of another jurisdiction:

Criminal offenses found in section 435.04, F.S.

(a) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.

(b) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.

(c) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.

(d) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(e) Section 782.04, relating to murder.

(g) Section 782.071, relating to vehicular homicide

(h) Section 782.09, relating to killing of an unborn child by injury to the mother.

(i) Chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.

(j) Section 784.011, relating to assault, if the victim of the offense was a minor.

(k) Section 784.03, relating to battery, if the victim of the offense was a minor.

(l) Section 787.01, relating to kidnapping.

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(m) Section 787.02, relating to false imprisonment.

(n) Section 787.025, relating to luring or enticing a child.

(o) Section 787.04(2), relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings.

(p) Section 787.04(3), relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person.

(q) Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.

(r) Section 790.115(2)(b), relating to possessing an electric weapon or device, destructive device, or other weapon on school property.

(s) Section 794.011, relating to sexual battery.

(t) Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.

(u) Section 794.05, relating to unlawful sexual activity with certain minors.

(v) Chapter 796, relating to prostitution.

(w) Section 798.02, relating to lewd and lascivious behavior.

(x) Chapter 800, relating to lewdness and indecent exposure.

(y) Section 806.01, relating to arson.

(z) Section 810.02, relating to burglary.

(aa) Section 810.14, relating to voyeurism, if the offense is a felony.

(bb) Section 810.145, relating to video voyeurism, if the offense is a felony.

(cc) Chapter 812, relating to theft, robbery, and related crimes, if the offense is a felony.

(dd) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.

(ee) Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.

(ff) Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.

(gg) Section 825.103, relating to exploitation of an elderly person or disabled adult, if the offense was a felony.

(hh) Section 826.04, relating to incest.

(ii) Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child

(jj) Section 827.04, relating to contributing to the delinquency or dependency of a child.

(kk) Former s. 827.05, relating to negligent treatment of children.

(ll) Section 827.071, relating to sexual performance by a child.

(mm) Section 843.01, relating to resisting arrest with violence.

(nn) Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication.

(oo) Section 843.12, relating to aiding in an escape.

(pp) Section 843.13, relating to aiding in the escape of juvenile inmates in correctional institutions.

(qq) Chapter 847, relating to obscene literature.

(rr) Section 874.05(1), relating to encouraging or recruiting another to join a criminal gang.

(ss) Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.

(tt) Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.

(uu) Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.

(vv) Section 944.40, relating to escape.

(ww) Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.

(xx) Section 944.47, relating to introduction of contraband into a correctional facility.

(yy) Section 985.701, relating to sexual misconduct in juvenile justice programs.

(zz) Section 985.711, relating to contraband introduced into detention facilities.

(3) The security background investigations under this section must ensure that no person subject to this section has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense that constitutes domestic violence as defined in s. 741.28, whether such act was committed in this state or in another jurisdiction.

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Criminal offenses found in section 408.809(4), F.S.

(a) Any authorizing statutes, if the offense was a felony.

(b) This chapter, if the offense was a felony.

(c) Section 409.920, relating to Medicaid provider fraud.

(d) Section 409.9201, relating to Medicaid fraud.

(e) Section 741.28, relating to domestic violence.

(f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(g) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.

(h) Section 817.234, relating to false and fraudulent insurance claims.

(i) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.

(j) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider.

(k) Section 817.505, relating to patient brokering.

(l) Section 817.568, relating to criminal use of personal identification information.

(m) Section 817.60, relating to obtaining a credit card through fraudulent means.

(n) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.

(o) Section 831.01, relating to forgery.

(p) Section 831.02, relating to uttering forged instruments.

(q) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.

(r) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.

(s) Section 831.30, relating to fraud in obtaining medicinal drugs.

(t) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony

(u) Section 895.03, relating to racketeering and collection of unlawful debts.

(v) Section 896.101, relating to the Florida Money Laundering Act.

☐ **I have been granted an Exemption from Disqualification through the Agency for Healthcare Administration (AHCA).**

Date of Decision: ____________________

☐ **I have been granted an Exemption from Disqualification through the Florida Department of Health.**

Date of Decision: ____________________

*****A copy of the Exemption from Disqualification decision letter must be attached*****

If you are also using this form to provide evidence of prior Level 2 screening (fingerprinting) in the last 5 years and have not been unemployed for more than 90 days, please provide the following information. **A copy of the prior screening results must be attached**.

Purpose of Prior Screening: ________________________________

Screening conducted by: Date of Prior Screening: __________

☐ Agency for Healthcare Administration
☐ Department of Health
☐ Agency for Persons with Disabilities
☐ Department of Elder Affairs
☐ Department of Financial Services
☐ Department of Children and Families

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Attestation

Under penalty of perjury, I, ______________________________, hereby swear or affirm that I meet the requirements for qualifying for employment in regards to the background screening standards set forth in Chapter 435 and section 408.809, F.S. In addition, I agree to immediately inform my employer if arrested or convicted of any of the disqualifying offenses while employed by any health care provider licensed pursuant to Chapter 408, Part II F.S.

______________________________ ______________________ ______________

Employee/Contractor Signature Title Date

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

PRIVACY POLICY ACKNOWLEDGEMENT FORM

I acknowledge that I have received a copy of the privacy policies from the Florida Department of Law Enforcement and the Federal Bureau of Investigation, which describe the exchange of information where criminal record results will become part of the Care Provider Background Screening Clearinghouse.

I understand and agree that I will read and comply with the guidelines contained in the privacy policies.

____

Employee Name (Printed)

____

Employee Signature

____

Date

2727 Mahan Drive, MS#40
Tallahassee, Florida 32308

04793

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORD RESULTS WILL BECOME PART OF THE CARE PROVIDER BACKGROUND SCREENING CLEARINGHOUSE

NOTICE OF:

- **SHARING OF CRIMINAL HISTORY RECORD INFORMATION WITH SPECIFIED AGENCIES,**
- **RETENTION OF FINGERPRINTS,**
- **PRIVACY POLICY, AND**
- **RIGHT TO CHALLENGE AN INCORRECT CRIMINAL HISTORY RECORD**

This notice is to inform you that when you submit a set of fingerprints to the Florida Department of Law Enforcement (FDLE) for the purpose of conducting a search for any Florida and national criminal history records that may pertain to you, the results of that search will be returned to the Care Provider Background Screening Clearinghouse. By submitting fingerprints, you are authorizing the dissemination of any state and national criminal history record that may pertain to you to the Specified Agency or Agencies from which you are seeking approval to be employed, licensed, work under contract, or to serve as a volunteer, pursuant to the National Child Protection Act of 1993, as amended, and Section 943.0542, Florida Statutes. "Specified agency" means the Department of Health, the Department of Children and Family Services, the Division of Vocational Rehabilitation within the Department of Education, the Agency for Health Care Administration, the Department of Elder Affairs, the Department of Juvenile Justice, and the Agency for Persons with Disabilities when these agencies are conducting state and national criminal history background screening on persons who provide care for children or persons who are elderly or disabled. The fingerprints submitted will be retained by FDLE and the Clearinghouse will be notified if FDLE receives Florida arrest information on you.

Your Social Security Number (SSN) is needed to keep records accurate because other people may have the same name and birth date. Disclosure of your SSN is imperative for the performance of the Clearinghouse agencies' duties in distinguishing your identity from that of other persons whose identification information may be the same as or similar to yours.

Licensing and employing agencies are allowed to release a copy of the state and national criminal record information to a person who requests a copy of his or her own record if the identification of the record was based on submission of the person's fingerprints. Therefore, if you wish to review your record, you may request that the agency that is screening the record provide you with a copy. After you have reviewed the criminal history record, if you believe it is incomplete or inaccurate, you may conduct a personal review as provided in s. 943.056, F.S., and Rule 11C8.001, F.A.C. If national information is believed to be in error, the FBI should be contacted at 304-625-2000. You can receive any national criminal history record that may pertain to you directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34. You have the right to obtain a prompt determination as to the validity of your challenge before a final decision is made about your status as an employee, volunteer, contractor, or subcontractor.

Until the criminal history background check is completed, you may be denied unsupervised access to children, the elderly, or persons with disabilities.

The FBI's Privacy Statement follows on a separate page and contains additional information.

1-789 (08-11-2010)

US Department of Justice
Federal Bureau of Investigation
Criminal Justice Information Services Division

PRIVACY STATMENT

Authority: The FBI's acquisition, preservation, and exchange of information requested by this form is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include numerous Federal statutes, hundreds of State statutes pursuant to Pub.L. 92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub.L. 94-29; Pub.L. 101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion or approval of your application.

Social Security Account Number (SSAN). Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal agencies to use this number to help identify individuals in agency records.

Principal Purpose: Certain determinations, such as employment, security, licensing, and adoption, may be predicated on fingerprint based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other information that may be pertinent to the application. During the processing of this application, and for as long hereafter as may be relevant to the activity for which this application is being submitted, the FBI may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

Routine Uses: The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as may be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System (Justice/FBI009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosures to: appropriate governmental authorities responsible for civil or criminal law enforcement, counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law, treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing this application, they may have additional routine uses.

Additional Information: The requesting agency and/or the agency conducting the application investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice in the Federal Register describing any system(s) of records in which that agency may also maintain your records, including the authorities, purposes, and routine uses for the system(s).