

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 _____





FISCAL EMPLOYER AGENT
PARTICIPANT ORIENTATION AND
ENROLLMENT CHECKLIST

Table with 2 columns: 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

03463



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) siga 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 entreno 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.



- 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 realice 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 notificación de "aprobado para trabajar" para cada DSW trabajador directo.
- Yo diseñe un Plan de Emergencia y Reemplazo 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





ACUERDO DEL PARTICIPANTE Y FORMULARIO DE RECONOCIMIENTO

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 reconozco 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

03466



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.

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)? <input type="checkbox"/> Yes <input type="checkbox"/> No	8b If 8a is "Yes," enter the number of LLC members ▶
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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.

<input type="checkbox"/> Sole proprietor (SSN) _____	<input type="checkbox"/> Estate (SSN of decedent) _____
<input type="checkbox"/> Partnership	<input type="checkbox"/> Plan administrator (TIN) _____
<input type="checkbox"/> Corporation (enter form number to be filed) ▶ _____	<input type="checkbox"/> Trust (TIN of grantor) _____
<input type="checkbox"/> Personal service corporation	<input type="checkbox"/> Military/National Guard <input type="checkbox"/> State/local government
<input type="checkbox"/> Church or church-controlled organization	<input type="checkbox"/> Farmers' cooperative <input type="checkbox"/> Federal government
<input type="checkbox"/> Other nonprofit organization (specify) ▶ _____	<input type="checkbox"/> REMIC <input type="checkbox"/> Indian tribal governments/enterprises
<input type="checkbox"/> Other (specify) ▶ _____	Group Exemption Number (GEN) if any ▶ _____

9b If a corporation, name the state or foreign country (if applicable) where incorporated	State	Foreign country
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10 Reason for applying (check only one box)

<input type="checkbox"/> Started new business (specify type) ▶ _____	<input type="checkbox"/> Banking purpose (specify purpose) ▶ _____
<input type="checkbox"/> Hired employees (Check the box and see line 13.)	<input type="checkbox"/> Changed type of organization (specify new type) ▶ _____
<input type="checkbox"/> Compliance with IRS withholding regulations	<input type="checkbox"/> Purchased going business
<input type="checkbox"/> Other (specify) ▶ _____	<input type="checkbox"/> Created a trust (specify type) ▶ _____
	<input type="checkbox"/> Created a pension plan (specify type) ▶ _____

11 Date business started or acquired (month, day, year). See instructions.	12 Closing month of accounting year
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13 Highest number of employees expected in the next 12 months (enter -0- if none). If no employees expected, skip line 14.	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. <input type="checkbox"/>			
<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%; border-right: 1px solid black; text-align:center;">Agricultural</td> <td style="width:33%; border-right: 1px solid black; text-align:center;">Household</td> <td style="width:33%; text-align:center;">Other</td> </tr> </table>	Agricultural	Household	Other	
Agricultural	Household	Other		

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.

<input type="checkbox"/> Construction	<input type="checkbox"/> Rental & leasing	<input type="checkbox"/> Transportation & warehousing	<input type="checkbox"/> Accommodation & food service	<input type="checkbox"/> Wholesale-agent/broker	<input type="checkbox"/> Wholesale-other	<input type="checkbox"/> Retail
<input type="checkbox"/> Health care & social assistance	<input type="checkbox"/> Real estate	<input type="checkbox"/> Manufacturing	<input type="checkbox"/> Finance & insurance	<input type="checkbox"/> 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 ▶



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

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

OMB No. 1545-0748

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

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

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

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

For IRS use:

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

(Check one)

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

Part 2: Employer or Payer Information: 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)*	<input type="checkbox"/>	<input type="checkbox"/>
Form 941, 941-PR, 941-SS (Employer's QUARTERLY Federal Tax Return)	<input type="checkbox"/>	<input type="checkbox"/>
Form 943, 943-PR (Employer's Annual Federal Tax Return for Agricultural Employees)	<input type="checkbox"/>	<input type="checkbox"/>
Form 944, 944(SP) (Employer's ANNUAL Federal Tax Return)	<input type="checkbox"/>	<input type="checkbox"/>
Form 945 (Annual Return of Withheld Federal Income Tax)	<input type="checkbox"/>	<input type="checkbox"/>
Form CT-1 (Employer's Annual Railroad Retirement Tax Return)	<input type="checkbox"/>	<input type="checkbox"/>
Form CT-2 (Employee Representative's Quarterly Railroad Tax Return)	<input type="checkbox"/>	<input type="checkbox"/>

*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. ➔





Florida Business Tax Application

DR-1
R. 07/21
Rule 12A-1.097, F.A.C.
Effective 07/21
Page 1 of 15

Register online at
floridarevenue.com/taxes/registration.
It's fast and secure.



ALL information provided as a part of this application is held confidential by the Florida Department of Revenue. Social security numbers are used by the Florida Department of Revenue as unique identifiers for the administration of Florida's taxes. Social security numbers 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 social security number is authorized under state and federal law. Visit the Department's website at floridarevenue.com/privacy for more information regarding the state and federal law governing the collection, use, or release of social security numbers, including authorized exceptions.

Use Black or Blue Ink to Complete This Application

Business Information

All Applicants -
Identification Numbers

1. Identification Numbers:

Federal Employer Identification Number (FEIN):

You must provide your FEIN before you can register for Reemployment Tax. If you are not required by the Internal Revenue Service to obtain an FEIN, you must provide your social security number, unless you are not a citizen of the United States.

Social Security Number (SSN):

If you are not a citizen of the United States and you do not have a social security number, provide your complete Visa number.

Visa Number:

Florida Business Partner Number (if registered):
(business partner numbers are 4 to 7 digits in length)

Consolidated Sales and Use Tax Filing Number:
(if you file a consolidated sales and use tax return)

County Control Number:
(if you use this number to report tax for the county where your business is located)

2. Reason for Applying (select only one):

Business entity not currently registered

Date of first Florida taxable activity:
mm dd yyyy

Additional Florida location for currently registered business

Date of first taxable activity
mm dd yyyy

Sales and use tax for this location will be reported using my current:
(select all that apply)

consolidated return county control reporting number

Additional Florida rental property for currently registered business

Date of first taxable activity:
mm dd yyyy

Sales and use tax for this location will be reported using my current:
(select all that apply)

consolidated return county control reporting number

Moved registered Florida location to another Florida county -

Effective date:
mm dd yyyy

Current sales and use tax certificate number for location

(this number will be cancelled)

Sales and use tax for this location will be reported using my current
(select all that apply)

consolidated return county control reporting number

All Applicants -
Reason for Applying



11045





Starting a new taxable activity at a registered location - Effective date: _____ mm dd yyyy
Current sales and use tax certificate number for location _____

Change the form of business ownership - Effective date: _____ mm dd yyyy

Acquired existing business - Effective date: _____ mm dd yyyy

3. Business Name, Location, and Mailing Address: **Others** - Use name filed with the Florida Department of State or similar agency in another state
Sole proprietors - Use last name, first name, middle initial
Partnerships - Use partnership name or last name of general partners
Legal name of business: _____

Business trade name "doing business as" if you have one: _____

Physical Address: Provide the street address of the business location or Florida rental property - Do not use PO Box or Rural Route Numbers.

Street address: _____	Florida County: _____	Telephone #: <input type="checkbox"/> Check if # is outside U.S. #: _____ ext: _____
City / State / ZIP: _____		Fax #: _____

Mailing Address: Provide the name and mailing address where tax returns and other correspondence for your business are to be mailed.

Mail to: _____	Mailing Address (if different than business location address): _____
City / State / ZIP: _____	

4. Is this business location only open during a portion of a calendar year? Yes No

If yes, provide the:

First calendar month this business location is open: _____ ; and the

Last calendar month this business location is open: _____ .

5. Form of Business Ownership: (select only one form of ownership)

- | | | |
|---|--|---|
| <input type="radio"/> Sole Proprietor (individual owner) | <input type="radio"/> Limited liability company (LLC) | <input type="radio"/> Estate |
| <input type="radio"/> Partnership (select one below): | (select one below): | <input type="radio"/> Trust |
| <input type="radio"/> Married couple | <input type="radio"/> Single member | <input type="radio"/> Business |
| <input type="radio"/> General partnership | <input type="radio"/> Multi-member | <input type="radio"/> Other |
| <input type="radio"/> Limited liability partnership (LLP) | If single member , select the box that applies to how your LLC is treated for federal income tax. | <input type="radio"/> Governmental agency |
| <input type="radio"/> Limited partnership (LP) | <input type="radio"/> C Corporation | |
| <input type="radio"/> Joint venture | <input type="radio"/> S Corporation | |
| <input type="radio"/> Corporation (select one below): | <input type="radio"/> Disregarded (reported by single member) | |
| <input type="radio"/> C Corporation | If multi-member , select the box that applies to how your LLC is treated for federal income tax. | |
| <input type="radio"/> S Corporation | <input type="radio"/> Partnership | |
| <input type="radio"/> Not-for-profit | <input type="radio"/> C Corporation | |
| <input type="radio"/> Foreign corporation | <input type="radio"/> S Corporation | |



All Applicants - Reason for Applying

Seasonal Business

All Applicants - Business Ownership



Sole Proprietors

6. If your business is a partnership, corporation, limited liability company, or trust, provide the following information:

Date of Florida incorporation or organization,
or date of authorization to conduct business at this location in Florida: mm dd yyyy

Fiscal year ending date (This date is generally "12/31"; however
a business may elect a different fiscal year): mm dd

7. If you are a sole proprietor, provide the following information:

Legal Name (first name, middle initial, last name):	SSN: or Visa #:
Home address:	Telephone #: <input type="checkbox"/> Check if # is outside U.S.
City / State / ZIP:	#: _____ ext: _____

8. If your business is a partnership (including married couples), provide the following information for each general partner:
(Attach additional pages, if needed.)

Name:	Title:
Home address:	SSN: or Visa #: or FEIN:
City / State / ZIP:	Telephone #: <input type="checkbox"/> Check if # is outside U.S. #: _____ ext: _____
Name:	Title:
Home address:	SSN: or Visa #: or FEIN:
City / State / ZIP:	Telephone #: <input type="checkbox"/> Check if # is outside U.S. #: _____ ext: _____
Name:	Title:
Home address:	SSN: or Visa #: or FEIN:
City / State / ZIP:	Telephone #: <input type="checkbox"/> Check if # is outside U.S. #: _____ ext: _____
Name:	Title:
Home address:	SSN: or Visa #: or FEIN:
City / State / ZIP:	Telephone #: <input type="checkbox"/> Check if # is outside U.S. #: _____ ext: _____

Business Owners and Managers



Business Owners and Managers

9. If your business is a corporation, limited liability company, or trust, provide the following information for each director, officer, managing member, grantor, personal representative, or trustee of the business entity:
(Attach additional pages, if needed.)

Name:	Title:
Home address:	Last 4 Digits of Social Security Number: or Visa #: or FEIN:
City / State / ZIP:	Telephone #: <input type="checkbox"/> Check if # is outside U.S. #: _____ ext: _____
Name:	Title:
Home address:	Last 4 Digits of Social Security Number: or Visa #: or FEIN:
City / State / ZIP:	Telephone #: <input type="checkbox"/> Check if # is outside U.S. #: _____ ext: _____
Name:	Title:
Home address:	Last 4 Digits of Social Security Number: or Visa #: or FEIN:
City / State / ZIP:	Telephone #: <input type="checkbox"/> Check if # is outside U.S. #: _____ ext: _____
Name:	Title:
Home address:	Last 4 Digits of Social Security Number: or Visa #: or FEIN:
City / State / ZIP:	Telephone #: <input type="checkbox"/> Check if # is outside U.S. #: _____ ext: _____

10. Background:

Has your business ever been known by another name? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name:
Was that business issued a Florida certificate of registration or tax account number? <input type="checkbox"/> Yes <input type="checkbox"/> No	Number:

11. Business Activities:

Enter the six-digit North American Industry Classification System (NAICS) code(s) that best describes your business activities at this location. Enter your primary code first. (Enter at least **one**.)

Primary code

All Applicants -
Business Activities
Applicants -
Background

If you do not know your NAICS code(s), go to <http://www.census.gov/eos/www/naics/index.html>. Enter a keyword to search the most recent NAICS list.

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Describe the primary nature of your business and type(s) of products or services to be sold.

12. Change in Form of Business Ownership or Acquired Business

If your form of business ownership has changed (e.g., sole proprietorship to a corporation or partnership to a limited liability company), or you acquired an existing business, **provide the following for your prior form of ownership or for the acquired business:**

Name:	FEIN:
Address:	Florida certificate or tax account number:
City / State / ZIP:	If acquired, portion acquired: <input type="checkbox"/> All <input type="checkbox"/> Part <input type="checkbox"/> Unknown
Did your business share any common ownership, management, or control with the acquired business at the time of acquisition? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did the previous legal entity or acquired business have employees at the time of the change or acquisition? <input type="checkbox"/> Yes <input type="checkbox"/> No
Were employees transferred to the new legal entity or new business? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date transferred: mm dd yyyy

You must also submit a completed *Report to Determine Succession and Application for Transfer of Experience Rating Records* (Form RTS-1S) within 90 days after the date of transfer when:

- You acquired an existing business in whole or in part, and
- There was no common ownership, management or control between your business and the acquired business at the time of transfer.

Sales and Use Tax

13. For each of the business activities below, select all that apply to this location:

Sales, Rentals, or Repairs of Products

- Sell products at retail (to consumers)
- Sell products at wholesale (to registered dealers who will sell to consumers)
- Sell products or goods from nonpermanent locations (such as flea markets or craft shows)
- Sell products or goods by mail using catalogs or the internet
- Sell, serve, or prepare food products or drinks for immediate consumption on your premises, or that you package or wrap for take-out or to go, from a temporary or permanent location
- Repair or alter consumer products or equipment
- Rent equipment or other property or goods to individuals or businesses
- Charge admissions or membership fees

Property Rentals, Leases, or Licenses

- Rent or lease commercial real property to individuals or businesses
- Manage commercial real property for individuals or businesses
- Rent or lease living or sleeping accommodations to others for periods of six months or less
- Manage the rental or leasing of living or sleeping accommodations belonging to others
- Rent or lease parking or storage spaces for motor vehicles in parking lots or garages
- Rent or lease docking or storage spaces for boats in boat docks or marinas
- Rent or lease tie-down or storage spaces for aircraft at airports





Sales and Use Tax (continued)

Sales and Use Tax

Real Property Contractors

- Improve real property as a contractor
- Sell products at retail (to consumers)
- Construct, assemble, or fabricate building components at your plant or shop away from a project site that are used in your real property improvement projects
- Purchase products or supplies from vendors located outside Florida for use in Florida real property improvement projects

Services

- Pest control services for nonresidential buildings
- Interior cleaning services for nonresidential buildings
- Detective services
- Protection services
- Security alarm system monitoring services

Fuel

- Sell tax paid gasoline, diesel fuel, or aviation fuel to retail dealers or end users in Florida (select all that apply below):
 - Gas station only
 - Gas station and convenience store
 - Truck stop
 - Marine fueling
 - Aircraft fueling
 - Reseller of fuel in bulk quantities
- Purchase dyed diesel fuel for off-road purposes

Secondhand Goods or Scrap Metal

- Purchase, consign, trade, or sell secondhand goods
- Purchase, gather, obtain, or sell salvage or scrap metal to be recycled or convert ferrous or nonferrous metals into raw material products

If you select either of these activities, you must also submit a *Registration Application for Secondhand Dealers and Secondary Metals Recyclers (Form DR-1S)*.

Coin-Operated Amusement Machines

- Place and operate coin-operated amusement machines at locations belonging to others
- Operate coin-operated amusement machines at this location (select all that apply below):
 - Self-operate some or all the amusement machines at this location (no other machine operator used)
 - Have entered into a written agreement with the following person or business to operate some or all the machines at this location.

Name:	Telephone #: <input type="checkbox"/> Check if # is outside U.S. #: _____ ext: _____
-------	---

Mailing address: _____

City / State / ZIP: _____

If you operate amusement machines at your location or at locations belonging to others, you must also submit an *Application for Amusement Machine Certificate (Form DR-18)* to obtain an annual *Amusement Machine Certificate* for each location where you operate amusement machines.

Vending Machines

(select all that apply below)

- Place and operate vending machines at locations belonging to others:
(Select the type or types of vending machines you operate.)
 - Food or beverage vending machines
 - Nonfood or nonbeverage vending machines
- Operate vending machines at this location:
(Select the type or types of vending machines you operate.)
 - Food or beverage vending machines
 - Nonfood or nonbeverage vending machines

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Sales and Use Tax (continued)

Sales and Use Tax

Purchases

- Purchase items to use in my business without paying Florida sales tax to the seller at the time of purchase (such as from a seller located outside Florida)
- Applying for a direct pay permit to self-accrue and remit use tax directly to the Department
To apply for a permit, submit an *Application for Self-Accrual Authority/Direct Pay Permit Sales and Use Tax (Form DR-16A)*.
- Applying for authority to remit sales tax to the Department for independent sellers or distributors (see Rule 12A-1.0911, Florida Administrative Code, for more information)
- This business does not conduct activities at this location subject to Florida sales and use tax**

Prepaid Wireless E911 Fee

E911 Fee

14. Do you sell prepaid phones, phone cards, or calling arrangements at this location? Yes No
- If yes**, select the box that describes your sales:
- Domestic or international long distance calling or phone cards (non-wireless)
 - Prepaid wireless services (cards, plans, devices) that provide access to wireless networks and interaction with 911 emergency services

Solid Waste - New Tire Fee, Lead-Acid Battery Fee, and Rental Car Surcharge

Solid Waste Fees and Surcharge

15. Do you sell (at retail) new tires for motorized vehicles at this location that are sold separately or as part of a vehicle? Yes No
16. Do you sell (at retail) new or remanufactured lead-acid batteries at this location that are sold separately or as a component part of another product such as new automobiles, golf carts, or boats? Yes No
17. Do you rent, lease, or sell car-sharing membership services at this location for the use of motor vehicles that transport fewer than nine passengers? Yes No

Gross Receipts Tax on Dry-cleaning

Dry-Cleaning Tax

18. Do you own or operate a dry-cleaning plant or dry drop-off facility in Florida? Yes No
- If yes, and you import or produce perchloroethylene or other dry-cleaning solvents, you must also complete a *Registration Package (GT-400401)* for fuels and pollutants.**

Reemployment Tax

Reemployment Tax

For purposes of reemployment tax, employees include officers of a corporation and members of a limited liability company classified as a corporation for federal tax purposes who perform services for the corporation or limited liability company and receive payment for such services (salary or distributions).

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 at servicesforemployers.floridarevenue.com.
- Florida employers are required to obtain appropriate workers' compensation insurance coverage for their employees. Visit www.myfloridacfo.com/division/wc/.

19. Do you have or will you have, employees in Florida? Yes No
20. Do you, or will you, lease workers from an employee leasing company to work in Florida? Yes No
- If yes**, provide the following:

Name of leasing company:

FEIN:	Department of Business and Professional Regulation license number:
Portion of workforce that is leased: <input type="checkbox"/> All <input type="checkbox"/> Part	Date of leasing agreement for workers in Florida: mm dd yyyy

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Reemployment Tax (continued)

Reemployment Tax

21. Do you use the services of persons in Florida whom you consider to be self-employed, independent contractors other than those engaged in a distinct business, occupation, or profession that serves the general public (e.g., plumber, general contractor, or certified public accountant)? Yes No

If yes, you must also submit a completed *Independent Contractor Analysis (Form RTS-6061)*.

If you answered No to questions 19, 20, and 21, proceed to the Communications Services Tax section.
If you answered Yes, continue to the next question.

22. Is your business registered for reemployment tax? Yes No
If yes, provide your RT account number:

Are you currently reporting wages to the Florida Department of Revenue? Yes No

Are you reactivating your reemployment tax account? Yes No

23. On what date did you, or will you, first have an employee in Florida?
mm dd yyyy

24. Employment Type (select only one employment type):

- Regular employer
- Nonprofit organization [must hold a 501(c)(3) determination letter from the Internal Revenue Service]
- Domestic employer [employer of persons performing only domestic (household) services (e.g., maid or cook)]
- Indian tribe or Tribal unit
- Governmental entity
- Agricultural (noncitrus) employer
- Agricultural (citrus) employer
- Agricultural crew chief

25. Select one category for your employment:

Regular, Indian tribe or Tribal unit, or Governmental employer

Have you or will you pay gross wages of at least \$1,500 within a calendar quarter? Yes No

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

mm dd yyyy

Have you or will you have one or more employees for a day (or portion of a day) during 20 or more weeks in a calendar year? Yes No

If yes, provide the last day of the 20th week.

mm dd yyyy

Nonprofit organization

Have you or will you employ four or more workers for a day (or portion of a day) during 20 or more weeks in a calendar year? Yes No

If yes, provide the last day of the 20th week.

mm dd yyyy

Domestic employer (Employer whose employees only perform domestic services.)

Have you or will you pay gross wages of at least \$1,000 within a calendar quarter? Yes No

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

mm dd yyyy





Reemployment Tax (continued)

Agricultural (noncitrus, citrus, or crew chief) employer

Have you or will you pay gross wages of at least \$10,000 within a calendar quarter?

Yes No

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

mm dd yyyy

Have you or will you have five or more employees for a day (or portion of a day) during 20 or more weeks in a calendar year?

Yes No

If yes, provide the last day of the 20th week.

mm dd yyyy

26. List all Florida locations where you have employees.

(Attach a separate sheet, if needed.)

Address:

City / State / ZIP:

Number of employees:

Principal products or services:

If services, indicate if:

Administrative Research Other

Address:

City / State / ZIP:

Number of employees:

Principal products or services:

If services, indicate if:

Administrative Research Other

Address:

City / State / ZIP:

Number of employees:

Principal products or services:

If services, indicate if:

Administrative Research Other

Address:

City / State / ZIP:

Number of employees:

Principal products or services:

If services, indicate if:

Administrative Research Other

27. **Payroll Agent Information.** If you will use a payroll agent (such as an accountant or bookkeeper) or firm that will maintain your payroll information, provide the following:

Name of payroll agent or firm:

Mailing address:

City / State / ZIP:

Reemployment Tax





Reemployment Tax (continued)

Reemployment Tax

28. **Mailing Addresses for Reemployment Tax.** To receive correspondence about reemployment tax reporting, tax rates, and benefits paid, select the appropriate mailing address for each type of correspondence below.

Reporting Forms and Information

Employer's Quarterly Reports, Certifications, Reporting-related Correspondence:

- Business Information** (address in the first section of this application)
- Payroll Agent Information** (address in Question 27)
- Other** (enter below)

Tax Rate Information

Tax Rate Notices Related Correspondence:

- Business Information** (address in the first section of this application)
- Payroll Agent Information** (address in Question 27)
- Other** (enter below)

Benefits Paid Information

Notice of Benefits Paid Related Correspondence:

- Business Information** (address in the first section of this application)
- Payroll Agent Information** (address in Question 27)
- Other** (enter below)

Other Address for Reporting Forms and Information

Name:	Telephone #:	Ext:
Mailing address:		
City / State / ZIP:	Email address:	

Other Address for Tax Rate Information

Name:	Telephone #:	Ext:
Mailing address:		
City / State / ZIP:	Email address:	

Other Address for Benefits Paid Information

Name:	Telephone #:	Ext:
Mailing address:		
City / State / ZIP:	Email address:	

Communications Services Tax

Communications Services Tax

29. 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? Yes No

If yes, select each service you sell.

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

30. Are you applying for a direct pay permit for communications services tax? Yes No

If yes, you must also submit an **Application for Self-Accrual Authority/Direct Pay Permit (Form DR-700030)**.

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Communications Services Tax (continued)

If you answered No to questions 29 and 30, proceed to the Documentary Stamp Tax section.
If you answered Yes, continue.

If you are a reseller only, sell only pay telephone or direct-to-home satellite services, or only purchase services to integrate into prepaid calling arrangements, go to question 34.

Communications Services Tax

31. To charge the correct amount of tax, you must know the taxing jurisdiction (county and municipality) in which your customers are located. How will you verify the assignment of customer location to the correct taxing jurisdictions? If you use multiple methods, select all that apply.

- An electronic database provided by the Department of Revenue
- Your own database that will be certified by the Department of Revenue
To apply for certification, you must submit an *Application for Certification of Communications Services Database (Form DR-700012)*.

A database supplied by a vendor. Provide the name of the vendor and product:

Vendor: _____ Product: _____

- ZIP + 4 and a methodology for assignment when the ZIP codes overlap jurisdictions
- ZIP + 4 that does not overlap jurisdictions (e.g., a hotel located in one jurisdiction)
- None of the above.

The method you use to verify the assignment of a customer location to the correct taxing jurisdictions (county and municipality) for purposes of collecting local communications services tax determines the collection allowance rate that will be assigned to your business. If you change your method of assigning a customer's location to the correct taxing jurisdictions, you must submit a *Notification of Method Employed to Determine Taxing Jurisdiction (Form DR-700020)* indicating the new method(s). For more information, visit floridarevenue.com/taxes/cst.

32. If you use multiple assignment methods, you may need to file two separate returns to maximize your collection allowances. If you will file separate returns for each assignment method, check the box below.

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

33. Name and contact information of the person who can answer questions about communications services tax returns filed with the Department:

Name: _____	Telephone #: _____	Ext: _____
-------------	--------------------	------------

Email address: _____

Documentary Stamp Tax

Documentary Stamp Tax

34. Do you enter into written obligations to pay money with customers at this location that are not recorded with the Clerk of the Court or County Comptroller (e.g., financing agreements, title loans, pay-day loans, liens, promissory notes, or similar documents)?

Yes No

If yes, do you anticipate executing five or more written obligations to pay money subject to documentary stamp tax per month?

Yes No

Gross Receipts Tax on Electrical Power and Gas

Gross Receipts Tax

35. Do you own or operate an electric or natural or manufactured gas (LP gas is excluded) utility distribution facility in Florida?

Yes No

If yes, select the type of utility facility:

Electric Natural or manufactured gas

36. Do you import natural or manufactured gas (LP gas is excluded) into Florida for your own use?

Yes No





Severance Taxes and Miami-Dade County Lake Belt Fees

Severance Taxes

37. Do you extract oil, gas, sulfur, solid minerals, phosphate rock, lime rock, sand, or heavy minerals from the soils or waters of Florida? Yes No
- If yes**, select each extraction activity that you will engage in:
- Extracting oil for sale, transport, storage, profit, or commercial use
 - Extracting gas for sale, transport, profit, or commercial use
 - Extracting sulfur for sale, transport, storage, profit, or commercial use
 - Extracting solid minerals, phosphate rock, or heavy minerals from the soil or water for commercial use
 - Extracting lime rock or sand from within the Miami-Dade County Lake Belt Area (see section 373.4149, Florida Statutes, for boundary description)

Enrollment to File and Pay Tax Electronically

Filing and paying electronically is quick, easy, and secure at floridarevenue.com/taxes/eservices. You can electronically file and pay most taxes, fees and surcharges.

Marketplace providers and persons making a substantial number of remote sales (total of taxable remote sales in the previous calendar year exceeds \$100,000) must file and remit tax electronically.

You may choose to enroll to file or pay tax electronically. Enrolling allows you to view your payment history, reprint your payment information, and view bills posted to your account. Your bank account and contact information are saved for future transactions.

If you enroll using this application, you will receive a user ID and password for each tax account created based on the information you provide. Each account will have the same contact, banking, and payment method. After you receive your user ID and password, you may log into each tax account and change the contact, banking, and method of payment information.

If you choose not to file returns or pay tax electronically, proceed to the Authorization for Email Communication section.

File and Pay Electronically

38. Do you wish to: (select only one)
- Enroll for **both** filing returns and paying tax electronically?
 - Enroll **only** to pay tax electronically?
 - File returns and pay tax electronically **without** enrolling?
39. If you are enrolling, select only one electronic payment method.
- ACH-Debit (e-check)** – The Department’s bank withdraws a payment from your bank account when you authorize the payment.
 - ACH-Credit** – Your bank transfers a payment to the Department’s bank account when you authorize the bank to make the payment. **This is not a credit card payment. You are responsible for any costs charged by your bank to use this payment method.**

40. Contact Person for Electronic Payments:

Name:	Telephone #:	Ext:	Fax #:

Mailing address:

City / State / ZIP:	Email address:
<input type="checkbox"/> A company employee <input type="checkbox"/> A non-related tax preparer <input type="checkbox"/> Payroll agent	Federal Preparer Tax Identification Number (PTIN):





Authorization for Email Communication

Your privacy is important to the Department of Revenue. The Department will mail information regarding this application to you. If you wish to receive the information in an email, a written request from you is required. This request allows the Department to send information using its secure email software. This software requires additional steps before you can access the information.

Complete this section to receive information about this application by secure email.

- I authorize the Department to send information regarding this Application using the Florida Department of Revenue's secure email. I understand that this method requires additional steps to view the information provided.

Provide the name and contact information of the person who can respond to questions about this Application.

Name:

Telephone #: Check if # is outside U.S.

#: _____ ext: _____

Email address:

Email Communication

Applicant Declaration and Signature

I understand that any person who is required to collect, truthfully account for, and pay any tax, fee, or surcharge, and willfully fails to do so, or any officer or director of a corporation who directs any employee of the corporation to do so, is personally liable for the tax, fee, or surcharge evaded, not accounted for, or paid to the Florida Department of Revenue, plus a penalty equal to twice the amount of the tax, fee, or surcharge due that is evaded, not accounted for, or paid. (Section 213.29, Florida Statutes.)

I understand that, in addition to any other civil penalties provided by law, it is a criminal offense to fail or refuse to collect a required tax, fee, or surcharge; to fail to timely file a tax, fee, or surcharge return; to underreport a tax, fee, or surcharge liability on a return; or to give a worthless check, draft, debit card order, or other order on a bank to transfer funds to the Florida Department of Revenue.

I understand that I must notify the Florida Department of Revenue of any change in the form of ownership of this business or a change in business activities, location, mailing address, or contact information for this business.

I certify that I am authorized by _____ (Officer/Director) to execute this application. I understand that I will be creating a tax account that may result in the responsibility to file returns and to pay a tax, surtax, fee, or surcharge to the Florida Department of Revenue.

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

Printed name: _____ Title: _____

Signature: _____ Date: _____

Applicant Declaration and Signature

Before you submit your completed application

Have you:

- Provided your business identification numbers?
- Completed all sections of this application?
- Signed and dated this application?
- Included all additional applications, if required?

Mail to: Account Management MS 1-5730

Florida Department of Revenue

5050 W Tennessee St

Tallahassee FL 32399-0160





**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.
 - If you want notices and communications sent to both you and your representative, check this box
 - 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:
 - Attorney - a member in good standing of the bar of the highest court of the jurisdiction shown below.
 - Certified Public Accountant - duly qualified to practice as a certified public accountant in the jurisdiction shown below.
 - Enrolled Agent - enrolled as an agent pursuant to the requirements of Treasury Department Circular Number 230.
 - 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.
 - Reemployment Tax Agent authorized in Section 4 of this form.
 - 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



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
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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.





PLAN DE EMERGENCIA Y DE REPUESTO PARA EL PARTICIPANTE

E. Sé 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.



- _____ 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





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: _____





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

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RICK SCOTT
GOVERNOR

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



Visit AHCA online at
AHCA.MyFlorida.com



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.



PRIVACY STATEMENT

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).