Clear Form

Note: To fill out the forms in this PDF packet on your computer before printing, complete this Data Form first, then review the remaining documents to verify data inserted properly. This packet is set up for double sided paper printing.

UnitedHealthcare Community Plan

CONSUMER DIRECT CARE NETWORK

Participant Data Form

Participant/FEIN Holder

Name: _____ _____ _____ **Gender:** _____
First. *Middle.* *Last.*

Physical Address: _____ *(Where service is provided. No PO Box.)*

City: _____ **State:** FL **Zip:** _____ **County:** _____

Phone: (___) _____ (___) _____ (___) _____ **Email:** _____
1st. *2nd.* *Fax.*

Date of Birth: _____ **Social Security #:** ___-___-____ **Medicaid #:** _____

Driver's License: _____ _____ **Note:** *A Driver's license number is needed for the FL Business Tax Application.*
Number. *State.*

Legal Guardian *(if applicable)*

Name: _____ ___ _____ **Relationship to Participant:** _____
First. *M.I.* *Last.*

Street Address: _____ ☐ check here to insert participant address from above

City: _____ **State:** _____ **Zip:** _____ ☐ check here to insert participant phone #s from above

Phone: (___) _____ (___) _____ (___) _____ **Email:** _____
1st. *2nd.* *Fax.*

❒ Yes or ❒ No. Will legal guardian sign tax forms for the participant? If yes attach court guardianship paperwork. Also enter social security and driver's license numbers.

Social Security #: ___-___-____ **Driver's License:** # _____ State _____

Representative *(if applicable)*

Name: _____ **Relationship to Participant:** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: (___) _____ (___) _____ (___) _____ **Email:** _____
1st. *2nd.* *Fax.*

Date of Birth: _____ **Social Security #:** ___-___-____ **BG Check Clearance Date:** _____

Approving Entity

Managed Care Plan: United **Case Mgr/Care Coordinator Name:** _____

Phone: (___) _____ (___) _____ (___) _____ **Email:** _____
1st. *2nd.* *Fax.*

Prior Relationships/Business Accounts

1. ❒ Yes or ❒ No. Is participant **Switching** from another Fiscal Provider? If yes, Provider name _____.
2. ❒ Yes or ❒ No. Are there **Prior Business Accounts**? If yes, enter account info.

___-_____ _____ _____
FEIN. **Reemployment Tax Account #.** **SUTA Rate.**

❒ Yes or ❒ No. If previous FEIN, does FEIN holder have employees other than care givers?

3. **Auth Start Date:** _____.

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UnitedHealthcare Community Plan

If you need help, please contact Consumer Direct at 877-270-9580 or UnitedHealthcare Toll-Free 800- 791-9233; TTY/TTD 711. We are happy to help.

UnitedHealthcare Community Plan does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

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Online:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html

Phone:
Toll-free **1-800-368-1019**, **1-800-537-7697** (TDD)

Mail:
U.S. Dept. of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201

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UnitedHealthcare®
Community Plan

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ATANSYON: Si w pa pale Anglè, gen sèvis èd pou lang ki disponib san w pa peye anyen. Rele **1-800-791-9233, TTY 711**.

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UnitedHealthcare Community Plan

CONSUMER DIRECT CARE NETWORK

Participant Orientation and Enrollment Checklist

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

This list helps you organize the paperwork needed to enroll in this program. Some forms need to be returned to Consumer Direct. Some are only needed if a Representative is assigned. Some forms get reviewed and saved. This check list will help you keep track. Check each one off as it is completed. Please ensure all forms are clear and complete. Thank you!

Review of Participant Guidelines

Participant Enrollment Packet (submit to Consumer Direct)

- 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 a Representative directs 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)

Supplements (Discuss each and keep for future use)

- Payroll Calendar
- Online Time Sheet Instructions
- Paper Time Sheets and Time Sheet Instructions
- 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)

Coordinator: _____ (Printed Name) _____ (Signature) _____ (Date)

Participant: _____ (Printed Name) _____ (Signature) _____ (Date)

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UnitedHealthcare Community Plan

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Toll-Free 800-791-9233
and TTY/TTD 711,
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UnitedHealthcare Community Plan

CONSUMER DIRECT CARE NETWORK

Participant Agreement and Acknowledgement

Print Participant's Name _____ Print Legal Guardian's Name (if applicable) _____

TERMS.

- **In this agreement:**
  - **a. "LG" means Legal Guardian**
  - **b. "I, my, me" refers to the Participant and/or the LG**
  - **c. "CDCN" refers to Consumer Direct for Florida LLC. doing business as Consumer Direct Care Network Florida**
  - **d. "DSW" means Direct Service Worker**
  - **e. "PDO" means Participant Direction Option**
  - **f. "HIPAA" means Health Insurance Portability and Accountability Act**
  - **g. "ANE" means Abuse, Neglect, and/or Exploitation**

INSTRUCTIONS.

- **Review each topic. Please ask questions if you need to. Please initial by each line. Your initial shows that you agree and understand the information.**

_____ **RECEIPT OF EMPLOYER HANDBOOK.** The Handbook describes policies, procedures, and requirements for Participants and DSWs in the PDO. I will read the Handbook. If I have questions, I will ask CDCN. I will review the Handbook with my DSW(s). I will give my DSW(s) a copy of the Handbook. I must make sure that my DSW(s) follow program requirements and procedures; I can find these in the Handbook. Examples of covered topics are:

- How to develop a PDO Emergency Backup Plan.
- How to interview, train, and assess DSW(s).
- How to complete and submit time sheets.

_____ **OTHER TRAINING TOOLS.** I have received and will read the below training materials:

- PDO Participant Guidelines.
- ANE; this can be found in the Handbook.
- Medicaid Fraud; this can be found in the Handbook.
- Payroll Calendar.
- Employer-related training; how to complete federal and state tax forms.
- Time sheets.
- Guide on how to complete time sheets.

_____ **HIRING DSW(S).** I must recruit, interview, and hire DSW(s). The DSW cannot be my representative; the DSW can be a family member, friend, etc. I must be confident in the ability of the DSW to do the job.

- All DSWs must be at least 18 years old.

Participant Agreement and Acknowledgement

- Background checks must be done on all DSWs and representatives. They must be rerun every five (5) years. CDCN will let me know the results of the background check. Additional exclusion checks are run monthly:
  - Office of Inspector General (OIG)
  - System Award Management (SAM)
- In PDO, my DSW will not begin to work and be paid until I receive an "Okay to Work" form. The "Okay to Work" form must be sent from CDCN. I must have an "Okay to Work" form for each DSW.

_____ **MY TRAINING PLAN.** I must train and supervise my DSW(s). There is information on how to do this in the Handbook. If I have questions, I can ask CDCN staff members. I know that CDCN will clarify issues.

a. I will train and schedule DSW(s) to meet my service needs. The DSW will be scheduled as approved on my Plan of Care.
b. I will give feedback and re-train my DSW if he or she does a poor job; I will dismiss my DSW if he or she continues to do a poor job. I will dismiss a DSW if they have not followed the guidelines of the program.
c. I know that I must train my DSW(s) on the Plan of Care. I must train my DSW(s) on my specific needs.
d. I know that in the PDO program it is advised, but not required, that DSWs receive First Aid/CPR training. This is at my discretion.

_____ **APPROVING TIME WORKED.** I will make sure that the **tasks** I plan for the DSW to do match the Plan of Care. I will confirm that the **time the DSW works** matches the Plan of Care. I know that it is Medicaid fraud if I approve time that the DSW has not worked.

- I can begin services with CDCN once I receive an "Okay to Work" form for my DSW. For my DSW to be approved to work, their enrollment forms must be sent to CDCN. I must receive an "Okay to Work" form for each DSW.
- For my DSW to be paid, I must send paper or online time sheets to CDCN. I know that I should send time sheets to CDCN within 30 days of the shift worked; if I do not send time within 30 days, I may be responsible for payment.
- I know that CDCN has the right to withhold future payments; CDCN may do this if a time sheet is falsified.
- I will make an Emergency and Backup Plan with my case manager. I will use this if my planned DSW cannot work. I will also use this plan if my regular services are not available.
- I know that I am financially responsible for payment of a DSW if:
  - I do not qualify or lose my Medicaid.
  - I allow my DSW(s) to work overtime.
  - I allow my DSW(s) to work more time than is approved on my Plan of Care.
  - I instruct my DSW(s) to do tasks that are not approved on my Plan of Care.

_____ **REPORTING.** For my health, I need to report certain things. This can help make sure that I remain safe. It may ensure that I remain in the PDO program as well. I will report:

Participant Agreement and Acknowledgement

a. ANE to Adult Protective Services. I will also report ANE to my Case Manager. ANE is covered in the Participant Guidelines. An ANE training is in the Handbook as well.
b. Any possible Medicaid fraud. I will report fraud to my Case Manager and CDCN.
c. Any change in my health status or living situation. I will report changes to CDCN and my case manager. I will report these changes within five (5) days. Examples are:
   - Improved health status.
   - Declined health status.
   - Hospitalization.
d. Any change in my information. I will report changes to CDCN and my case manager. I will report these changes within five (5) days. Examples are:
   - Name change.
   - Address change.
   - Phone number change.

_____ **ROLES AND RESPONSIBILITIES OF CDCN.** CDCN must:

- Send required forms.
- Make sure that forms filled out are complete.
- Pay my DSW.
- Make sure that my DSW is not paid with funds from the PDO program if my DSW works more hours than approved on the Plan of Care.
- File and pay all state and federal taxes for my DSW.
- Have a toll free customer service number. This number may be called if I have questions about the PDO program.

_____ **PDO CONSENT FORM.** I must fill out this form. If I do not fill out this form, I cannot be in the PDO program. This form lists my and CDCN's rights and responsibilities. I understand that CDCN does some of the duties of the managed care plan for the PDO. Items listed in the Consent form also apply as part of this Agreement.

_____ **PRIVACY.** I have a copy of CDCN's Notice of Privacy Practices. This can be found in my copy of the Handbook. It tells me my rights and privileges under CDCN's privacy rules. The rules follow federal privacy regulations. These rules are modeled off of HIPAA. If I have questions or concerns, I will contact the CDCN Privacy Officer; I may do so by calling CDCN's compliance hotline: (877) 532-8530

_____ **CHOICE TO SERVE.** CDCN can choose to not serve me. This will happen if I do not follow the policies and procedures that I agreed to. It will also happen if my health and safety needs cannot be met in the PDO program. CDCN will discuss their concerns with me and my Case Manager. My Case Manager will help me transition out of PDO within thirty (30) days, if needed. CDCN may choose to end services right away; this may happen if I violate a CDCN policy.

Participant Agreement and Acknowledgement

AGREEMENT TERMS AND CONDITIONS

A. Term and Termination. This Agreement will be in effect as of the date signed on the last page of this Agreement. The Agreement will be in effect until ended. Both CDCN and I have the right to end this Agreement; CDCN or I may choose to end this Agreement at any time.

B. Partial Invalidity. This Agreement is subject to change. Changes may occur if any portion of this Agreement:

a. does not apply to me; or
b. is found to be illegal or invalid.

If a or b above are found, the relevant part(s) of the Agreement will be changed; the change(s) will be made to give the Agreement its intended effect and/or meaning. All other parts of the Agreement shall continue in full force and effect.

C. Arbitration. CDCN and I may have a dispute. If CDCN and I have a dispute, we will try to resolve the dispute within thirty (30) days. If the dispute has not been resolved within thirty (30) days of CDCN and I being notified of the dispute, CDCN and I, together, will choose someone to help us settle the dispute. This person:

- Will be from the American Arbitration Association;
- Is called an independent arbitrator; and
- Will help work out the dispute.

The cost of the person chosen will be paid by CDCN and I; we will share the cost equally. The arbitrator may not reach a decision that is accepted by either party; in this case, a judge may be used to reach a verdict.

D. Governing Law. This Agreement shall be upheld by all applicable laws; this Agreement shall be governed by the laws of the State on which my local office is located, without regard to its conflict of laws rules. CDCN and I agree that the courts in the Judicial District in which my primary State office sits shall have exclusive jurisdiction; this will be with respect to any controversy or dispute arising out of or relating to this Agreement and not resolved pursuant to the terms of this Agreement.

E. Indemnification and Hold Harmless. Indemnify means to compensate someone for harm or loss. CDCN and I are the "Indemnifying Party". We agree to the following:

- I will hold CDCN harmless for any of the reasons listed below when caused by any injury sustained by any person or to property by reason of any act, neglect, default, or omission on my behalf**:**
  - Liability;
  - Loss;
  - Cost;
  - Expense; or
  - Damage.

  If I do not defend CDCN, I will pay CDCN, within reason, for anything they have to pay in defending the action; this includes judgement, award, or settlement.

Participant Agreement and Acknowledgement

- CDCN will hold me harmless for any of the reasons listed below when caused by any injury sustained by any person or to property by reason of any act, neglect, default, or omission on CDCN's behalf**:**
  - Liability;
  - Loss;
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  In other words, CDCN will ensure that I am not held liable if someone sues due to negligence on CDCN's part. If I am sued, or an action is brought against me, CDCN will defend against the action on my behalf. If CDCN does not defend me, CDCN will pay me, within reason, for anything I have to pay in defending the action; this includes judgement, award, or settlement.

F. Waiver of Terms and Conditions. The failure of CDCN or I in any of the instance(s) listed below shall not be construed as thereafter waiving any such terms, conditions, rights, or privileges to:

- enforce the terms and conditions of this Agreement;
- exercise any of its rights or privileges; or
- waive any breach of such terms or conditions

The terms, conditions, rights, and privileges shall continue and remain in force and effect as if no waiver had occurred.

G. Timely Notification. CDCN and I agree that all contact must occur in a timely way. Any notice will be given immediately. As such, neither CDCN nor I shall be hurt by a delay.

H. Modification of Agreement. Any changes to the terms of this Agreement must be in writing. Changes must be signed and dated by me and CDCN.

I. Privacy. All actions related to this Agreement shall adhere to state and federal privacy laws and regulations; this includes HIPAA and regulations issued thereunder, 45 C.F.R. Parts 160 – 164.

J. Entire Agreement. This Agreement replaces all prior oral and written statements. This Agreement may be modified, amended or changed. If altered, the new agreement must be signed by both me and CDCN. This Agreement applies only to the parties that sign it.

Participant or LG Signature	*Date*	*CDCN Rep. Signature*	*Date*

UnitedHealthcare Community Plan

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

Application for Employer Identification Number

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

OMB No. 1545-0003

EIN

Type or print clearly.

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

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)
100 Consumer Direct Way, Suite 303-FL

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

4b City, state, and ZIP code (if foreign, see instructions)
Missoula, MT 59808

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

6 County and state where principal business is located

7a Name of responsible party

7b SSN, ITIN, or EIN

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

8b If 8a is "Yes," enter the number of LLC members . . . . . ► **0**

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

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

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

Group Exemption Number (GEN) if any ►

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

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

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

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

12 Closing month of accounting year **December**

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

Agricultural	Household	Other
0	**0**	**0**

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

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

16 Check **one** box that best describes the principal activity of your business.

☐ Health care & social assistance ☐ Wholesale-agent/broker
☐ Construction ☐ Rental & leasing ☐ Transportation & warehousing ☐ Accommodation & food service ☐ Wholesale-other ☐ Retail
☐ Real estate ☐ Manufacturing ☐ Finance & insurance ☑ Other (specify) ► **HCSR**

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

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
Nathyn Snyder

Designee's telephone number (include area code)
406-532-1900

Address and ZIP code
100 Consumer Direct Way, Suite 304, Missoula, MT 59808

Designee's fax number (include area code)
406-532-8588

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) ► **Home Care Service Recipient**

Applicant's fax number (include area code)

Signature ► Date ►

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

05151

Witnessed by: _____ **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) HCSR

3 Trade name (if any)

4 Address

100 Consumer Direct Way (Number, Street) Suite 303-FL (Suite or room number)

Missoula (City) MT (State) 59808 (ZIP code)

(Foreign country name) (Foreign province/county) (Foreign postal code)

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

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

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

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

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

X **Sign your name here**

Print your name here

Print your title here HCSR - Household Employer

Date / /

Best daytime phone

Now give this form to the agent to complete.

Witnessed by: _____ **Date:** _____

Florida Business Tax Application

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)

All Applicants - Reason for Applying

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

- ◯ 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**:
Sole proprietors - Use last name, first name, middle initial
Partnerships - Use partnership name or last name of general partners
Others - Use name filed with the Florida Department of State or similar agency in another state

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 #: ☐ Check if # is outside U.S.

City / State / ZIP: | #: ext: | Fax #:

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

Mail to: **c/o Consumer Direct**

Mailing Address (if different than business location address): **100 Consumer Direct Way, Suite 303**

City / State / ZIP: **Missoula, MT 59808**

Seasonal Business

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: _____ .

All Applicants - Business Ownership

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

- ☑ Sole Proprietor (individual owner)
- ◯ Partnership (select one below):
  - ◯ Married couple
  - ◯ General partnership
  - ◯ Limited liability partnership (LLP)
  - ◯ Limited partnership (LP)
  - ◯ Joint venture
- ◯ Corporation (select one below):
  - ◯ C Corporation
  - ◯ S Corporation
  - ◯ Not-for-profit
  - ◯ Foreign corporation
- ◯ Limited liability company (LLC) (select one below):
  - ◯ Single member
  - ◯ Multi-member

  If single member,select the box that applies to how your LLC is treated for federal income tax.
  - ◯ C Corporation
  - ◯ S Corporation
  - ◯ Disregarded (reported by single member)

  If multi-member, select the box that applies to how your LLC is treated for federal income tax.
  - ◯ Partnership
  - ◯ C Corporation
  - ◯ S Corporation
- ◯ Estate
- ◯ Trust
  - ◯ Business
  - ◯ Other
- ◯ Governmental agency

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:

Sole Proprietors

Legal Name (first name, middle initial, last name):	SSN: or Visa #:
Home address:	Telephone #: ☐ 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.)

Business Owners and Managers

Name:	Title:
Home address:	SSN: or Visa #: or FEIN:
City / State / ZIP:	Telephone #: ☐ Check if # is outside U.S. #: _____ ext: _____
Name:	Title:
Home address:	SSN: or Visa #: or FEIN:
City / State / ZIP:	Telephone #: ☐ Check if # is outside U.S. #: _____ ext: _____
Name:	Title:
Home address:	SSN: or Visa #: or FEIN:
City / State / ZIP:	Telephone #: ☐ Check if # is outside U.S. #: _____ ext: _____
Name:	Title:
Home address:	SSN: or Visa #: or FEIN:
City / State / ZIP:	Telephone #: ☐ Check if # is outside U.S. #: _____ ext: _____

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 #: ☐ 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 #: ☐ 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 #: ☐ 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 #: ☐ Check if # is outside U.S. #: ____________ ext: ______

Applicants - Background

10. Background:

Has your business ever been known by another name?	☐ Yes ☑ No	Name:
Was that business issued a Florida certificate of registration or tax account number?	☐ Yes ☑ No	Number:

All Applicants - Business Activities

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

6 2 4 1 2 0

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.

11048

All Applicants - Business Activities

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

Home care service recipient (IRS Code Sec. 3504) who employs workers to provide services in a private home due to disability and/or aging.

Business Changes and Acquisitions

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: ☐ All ☐ Part ☐ Unknown
Did your business share any common ownership, management, or control with the acquired business at the time of acquisition? ☐ Yes ☐ No	Did the previous legal entity or acquired business have employees at the time of the change or acquisition? ☐ Yes ☐ No
Were employees transferred to the new legal entity or new business? ☐ Yes ☐ 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

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)

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 #: ☐ 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

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 operate a car-sharing service, a peer-to-peer car sharing program, or motor vehicle rental company at this location that provides 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: ☐ All ☐ Part	Date of leasing agreement for workers in Florida: mm dd yyyy

11051

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: **1**

Principal products or services: **Home health care services** | If services, indicate if: ☐ Administrative ☐ Research ☑ Other **Domestic home health care**

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:

Consumer Direct Care Network

Mailing address:

100 Consumer Direct Way, Suite 303

City / State / ZIP:

Missoula, MT 59808

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:	Tax Rate Information Tax Rate Notices Related Correspondence:	Benefits Paid Information Notice of Benefits Paid Related Correspondence:
☐ **Business Information** (address in the the first section of this application)	☐ **Business Information** (address in the first section of this application)	☐ **Business Information** (address in the first section of this application)
☐ **Payroll Agent Information** (address in Question 27)	☐ **Payroll Agent Information** (address in Question 27)	☐ **Payroll Agent Information** (address in Question 27)
☐ **Other** (enter below)	☐ **Other** (enter below)	☐ **Other** (enter below)

Other Address for Reporting Forms and Information

Name: **Nathyn Snyder**

Telephone #: **406 532-2986** Ext:

Mailing address: **100 Consumer Direct Way, Suite 303**

City / State / ZIP: **Missoula, MT 59808**

Email address: **taxdept@consumerdirectcare.com**

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).

Communications Services Tax (continued)

Communications Services Tax

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.

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

File and Pay 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.

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 #:
Nathyn Snyder	**406 532-2986**		**406-532-8588**

Mailing address:

100 Consumer Direct Way, Suite 303

City / State / ZIP:	Email address:
Missoula, MT 59808	**taxdept@consumerdirectcare.com**
☐ A company employee ☐ A non-related tax preparer ☑ Payroll agent	Federal Preparer Tax Identification Number (PTIN): **46-2752008**

Enrollment to File and Pay Tax Electronically (continued)

File and Pay Electronically

41. Contact Person for Electronic Return Filing (If different than contact person for electronic payments.)

Name:	Telephone #: Ext:	Fax #:

Mailing address:

City / State / ZIP:	Email address:

☐ A company employee ☐ A non-related tax preparer ☐ Payroll agent

Federal Preparer Tax Identification Number (PTIN):

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

Bank / financial institution name:	Account type: ☑ Business ☐ Checking ☐ Personal ☐ Savings
Bank of Montana	
Bank account number:	Bank Routing Number: |: :|

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

43. Enrollee Authorization and Agreement:

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

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

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

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

Printed name: _____

Signature: _____ Title: _____ Date: _____

Printed name: _____

Signature: _____ Title: _____ Date: _____

(If account requires two signatures)

Authorization for Email Communication

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:	

Applicant Declaration and Signature

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:** _____

Witnessed by: _____ **Date:** _____

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

Florida Department of Revenue
POWER OF ATTORNEY
and Declaration of Representative

See Instructions for additional information

DR-835
R. 10/11
TC

Rule 12-6.0015
Florida Administrative Code
Effective 01/12

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 (**406**) **532-8588**

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)	
Consumer Direct Care Network FL - Consumer Direct Fiscal Vendor Agent for FL, LLC **100 Consumer Direct Way, Suite 304** **Missoula, MT 59808** E-mail address: **taxdept@consumerdirectcare.com**	Telephone number (**406**) **532-1900** Fax number (**406**) **532-8588** Cell phone number ( )
Name and address (include name of firm if applicable) E-mail address:	Telephone number ( ) Fax number ( ) Cell phone number ( )
Name and address (include name of firm if applicable) E-mail address:	Telephone number ( ) Fax number ( ) 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	**Consumer Direct**	Agent number (required)	**07381**
Firm name	**Consumer Direct**	Federal I.D. No. (required)	**46-2752008**
Address (if different from above)	**100 Consumer Direct Way, Suite 304, Missoula MT 59808**	Telephone number (**406**)	**532-1900**

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

Section 5. Acts Authorized.

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

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

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

_____

_____

03502

Florida Tax Registration Number:

Taxpayer Name(s): Federal Identification Number:

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

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

- Notices and other written communications will be sent to the first representative listed in Part I, Section 2, unless the taxpayer selects one of the options below. Receipt by either the representative or the taxpayer will be considered receipt by both.

a. If you want notices and communications sent to both you and your representative, check this box ..... ▶ ☐

b. If you want notices or communications sent to you and not your representative, check this box ..... ▶ ☐

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

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

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

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

Section 8. Signature of Taxpayer(s).

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

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

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

Signature	Date	Title (if applicable)
Print name		
Signature	Date	Title (if applicable)
Print name		

Witnessed by: _____ Date: _____

PART II - DECLARATION OF REPRESENTATIVE

Under penalties of perjury, I declare that:

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

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

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

Participant Direction Option (PDO) Consent Form

I, _____, choose to participate in the Participant Direction Option (PDO). I know that I will be responsible for the following:

Please write your initials on each line below to show that you have read and understand each item. If enrollee/participant is unable to initial each line, someone else can check each item off for them.

_____1. I have the PDO Participant Guidelines. The guidelines tell me how the PDO works and my responsibilities. I will read the guidelines. I am responsible for following the guidelines.

_____2. I will get in touch with my case manager if I need help.

_____3. I will tell my case manager if I wish to choose a representative.

_____4. I agree that I am responsible for interviewing, hiring, training, supervising, and firing (if needed), my direct service worker(s).

_____5. I will hire a qualified direct service worker(s). The qualifications for direct service workers are in the PDO Participant Guidelines. I should hire a direct service worker(s) who is trained in CPR, universal precautions and HIPAA privacy standards.

_____6. I will create a list of job duties and a work schedule for my direct service worker(s). The list of job duties and work schedule must be written on the Participant/Direct Service Worker Agreement.

_____7. I will make sure that my direct service worker(s) does not work more hours than approved on the Participant/Direct Service Worker Agreement.

_____8. In the event that I have more than 40 hours of services under PDO, I will have more than 1 Direct Service Worker.

_____9. I know that I can get more training if I want/need it. I will contact my case manager if I want/need more training.

_____10. I know that my direct service worker's timesheets submitted through the EVV (electronic visit verification) system must be correct.

_____11. I will ensure my direct service worker's EVV timesheets are submitted to the Fiscal/Employer Agent. The timesheets must be sent in by the date on the payroll schedule. If I have any problems with my EVV timesheet I will tell my care manager or F/EA .

_____12. I will give my direct service worker schedule to my Case Manager/Health plan.

_____13. I will tell my case manager if I decide to fire my direct service worker(s).

_____14. I will create an Emergency Back-up Plan so I will know what to do if my direct service worker(s) does not show up to provide my services.

_____15. I will tell my case manager if I'm having problems with my direct service worker(s).

_____16. I know that I can stop participating in the PDO at any time. I will tell my case manager if I wish to stop participating in the PDO. My case manager will make sure that my services will continue to be provided to me. If I stop participating in the PDO my services will be provided to me by a provider in my Plan's network.

_____17. I will follow the requirements on this Consent Form, my Participant/Direct Service Worker Agreement(s), my Participant Agreement, and the PDO Participant Guidelines. If I do not follow the requirements, my Plan may stop my participation in the PDO. If my Plan stops my participation in the PDO, my case manager will make sure that my services will continue to be provided to me by a provider in my Plan's network.

I have read and understand this PDO Consent Form. I know that my participation in the PDO is voluntary.

Participant Printed Name	Signature	Date

Representative Printed Name (if applicable)	Signature	Date

I have explained all the required information for this participant to make an informed decision about participating in the PDO.

Case Manager Printed Name	Signature	Date

This information is available for free in other languages. Please contact our customer service number at 800-791-9233 and TTY/TTD 711, Monday through Friday, 8:00 a.m. to 8:00 p.m.

Esta información está disponible de forma gratuita en otros idiomas. Por favor, póngase en contacto con nuestro número de servicio al cliente en 800-791-9233 y 711 TTY/TTD, el lunes al viernes de 8:00 a 20:00.

Enfòmasyon sa a ki disponib pou gratis nan lòt lang. Souple kontakte nimewo sèvis Kliyantèl nou nan 800-791-9233 ak 711 TTY/TTD, Lendi rive Vandredi, 8:00 a.m. pou 8:00 p.m.

UnitedHealthcare Community Plan

CONSUMER DIRECT CARE NETWORK

Participant Emergency and Backup Plan

Participant Name	**Representative or Legal Guardian (if applicable)**

I understand that:

1. My health plan will help me create a backup plan. My plan will be used if a regularly scheduled direct service worker (DSW) cannot work when I need them to.
2. I will use, change, update, or decide whether the backup plan is effective.
3. I must report a gap in service right away. I should report all gaps to my health plan. A gap in service is when a DSW is unable to provide services as planned. Consumer Direct Care Network (CDCN) will report all gaps to my health plan.
4. I need to call **911** in the case of an emergency.

Plan of Action

A. Backup Workers.

Please list below who you will call if your current DSW(s) fails to report for his or her shift. This may include friends, family, past DSWs, etc.

Name	Address (City and Zip)	Days/Time Not Available	Phone

B. Other Backup.

Beyond calling the individuals listed above or emergency personnel to see if they can provide assistance, I will contact the following for services:

Other MCO Providers

Name	Address	City	Zip	Phone

C. I will talk with backup workers before an emergency comes up. I will talk to them about:

- employment;
- pay;
- their availability; and
- my care needs.

I know that my backup worker(s) may be paid. To be paid, they must be eligible for work and trained.

Participant Emergency and Backup Plan

D. I understand that CDCN maintains a Job Board. I can use this when looking for backup workers.

E. ***I know that PDO does not provide emergency services. Therefore, in case of emergency, I will:***

☐ **Activate my Lifeline** ☐ **Contact 911**

F. If I believe I am at risk of harm for abuse, neglect or exploitation, I know that I should:

a. Contact the Adult Protective Services or Child Abuse hotline at: **1-800-962-2873**; and
b. Contact my case manager.

G. If an emergency has occurred, I will contact:

☐ **Relative**

Name	Address	City	Zip	Phone

☐ **Case Manager**

Name	Address	City	Zip	Phone

☐ **Physician**

Name	Address	City	Zip	Phone

☐ **Other**

Name	Address	City	Zip	Phone

_____ _____

Participant or Legal Guardian Signature *Date*

_____ _____

Consumer Direct Rep. Signature *Date*

10293

UnitedHealthcare Community Plan

Questions?
We're here to help. United Healthcare Community & State.
Toll-Free 800-791-9233 and TTY/TTD 711,
Monday through Friday, 8:00 a.m. to 8:00 p.m.

UnitedHealthcare Community Plan does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free member phone number listed on your health plan member ID card, TTY 711, Monday through Friday, 8:00 a.m. to 7:00 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html

Phone:
Toll-free **1-800-368-1019**, **1-800-537-7697** (TDD)

Mail:
U.S. Dept. of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201

If you need help with your complaint, please call the toll-free member phone number listed on your member ID card.

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan member ID card, TTY 711, Monday through Friday, 8:00 a.m. to 7:00 p.m.

UnitedHealthcare Community Plan no da un tratamiento diferente a sus miembros en base a su sexo, edad, raza, color, discapacidad o nacionalidad.

Si usted piensa que ha sido tratado injustamente por razones como su sexo, edad, raza, color, discapacidad o nacionalidad, puede enviar una queja a:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

Usted tiene que enviar la queja dentro de los 60 días de la fecha cuando se enteró de ella. Se le enviará la decisión en un plazo de 30 días. Si no está de acuerdo con la decisión, tiene 15 días para solicitar que la consideremos de nuevo.

Si usted necesita ayuda con su queja, por favor llame al número de teléfono gratuito para miembros que aparece en su tarjeta de identificación del plan de salud, TTY 711, de lunes a viernes, de 8:00 a.m. a 7:00 p.m.

Usted también puede presentar una queja con el Departamento de Salud y Servicios Humanos de los Estados Unidos.Usted también puede presentar una queja con el Departamento de Salud y Servicios Humanos de los Estados Unidos.

Internet:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Formas para las quejas se encuentran disponibles en:
http://www.hhs.gov/ocr/office/file/index.html

Teléfono:
Llamada gratuita, **1-800-368-1019**, **1-800-537-7697** (TDD)

Correo:
U.S. Department of Health and Human
Services 200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201

Si necesita ayuda para presentar su queja, por favor llame al número gratuito para miembros anotado en su tarjeta de identificación como miembro.

Ofrecemos servicios gratuitos para ayudarle a comunicarse con nosotros. Tales como, cartas en otros idiomas o en letra grande. O bien, puede solicitar un intérprete. Para pedir ayuda, llame a Servicios para Miembros al **1-800-791-9233, TTY 711**, de lunes a viernes, de 8:00 a.m. a 7:00 p.m.

UnitedHealthcare®
Community Plan

ATTENTION: If you do not speak English, language assistance services, at no cost to you, are available. Call **1- 800-791-9233, TTY 711**.

ATENCIÓN: Si no habla inglés, los servicios de asistencia de idiomas están disponibles sin costo para usted. Llame al **1- 800-791-9233, TTY 711**.

ATANSYON: Si w pa pale Anglè, gen sèvis èd pou lang ki disponib san w pa peye anyen. Rele **1- 800-791-9233, TTY 711**.

ВНИМАНИЕ: Если Вы не говорите по-русски, Вы можете воспользоваться бесплатной языковой помощью. Позвоните по телефону **1- 800-791-9233, телетайп 711**.

ATENÇÃO: Se não fala inglês, estão disponíveis serviços de assistência linguística sem nenhum custo para si. Ligue para o **1- 800-791-9233, TTY 711**.

注意：如果您不會說英文，您可獲得免費語言協助服務。請致電 **1- 800-791-9233，聽障專線 (TTY) 711**。

UnitedHealthcare Community Plan

Participant Direction Option (PDO) Representative Agreement

I, _____, agree to be the representative for _____, who is participating in the Participant Direction Option (PDO). I know that I will be responsible for the following:

Please write your initials on each line below to show that you have read and understand each item.

_____1. I have the PDO Participant Guidelines. The guidelines tell me how the PDO works and my responsibilities. I will read the guidelines. I am responsible for following the guidelines.

_____2. I will get in touch with the participant's case manager if I need help.

_____3. I will involve the participant as much as they wish to be involved with any decisions made.

_____4. I agree that I am responsible for interviewing, hiring, training, supervising, and firing (if needed), the participant's direct service worker(s).

_____5. I agree that I will hire a qualified direct service worker(s). The qualifications for direct service workers are in the PDO Participant Guidelines. I should hire a direct service worker(s) who is trained in universal precautions and HIPAA privacy standards.

_____6. I will create a list of job duties and a work schedule for the participant's direct service worker(s). The list of job duties and work schedule must be written on the Participant/Direct Service Worker Agreement.

_____7. I will make sure that the participant's direct service worker(s) does not work more hours than approved on the Participant/Direct Service Worker Agreement.

_____8. I know that I can get more training if I need it. I will contact the participant's case manager if I want more training.

_____9. I know that the direct service worker's timesheets must be correct.

_____10. I will give the direct service worker's timesheets to the participant's Plan. The timesheets must be sent in by the date on the payroll schedule.

_____11. I will tell the participant's case manager if I decide to fire a direct service worker(s).

_____12. I know that I will not be paid to be the representative for the participant.

_____13. I know that I cannot be a direct service worker for the participant.

_____14. I will create an Emergency Back-up Plan so I will know what to do if the participant's direct service worker(s) does not show up to provide services.

_____15. I know that I have the option to stop being the representative at any time. I will tell the participant and the participant's case manager if I wish to stop being the representative. The case manager will help the participant choose another representative.

_____16. I will follow the requirements on this Representative Agreement, the PDO Consent Form, the Participant/Direct Service Worker Agreement, the Participant Agreement, and the PDO Participant Guidelines. If I do not follow the requirements, the participant's Plan may not allow me to continue to be the representative. If the Plan does not allow me to be the representative, the participant's case manager will help the participant choose another representative.

Please sign on the line below to show that you have read and understand each item in this agreement. If you have questions, please ask the participant's case manager to help you.

Representative's Printed Name	Signature	Date
Participant's Printed Name	Signature	Date
Case Manager's Printed Name	Signature	Date

UnitedHealthcare Community Plan

UnitedHealthcare does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan member ID card, TTY 711, Monday through Friday, 8:00 a.m. to 7:00 p.m.

ATENCIÓN: Si no habla inglés, hay servicios de asistencia con el idioma disponibles sin costo para usted. Llame al **1-800-791-9233, TTY 711**.

ATENÇÃO: Se não fala inglês, estão disponíveis serviços de assistência linguística sem nenhum custo para si. Ligue para o **1-800-791-9233, TTY 711**.

UnitedHealthcare Community Plan

CONSUMER DIRECT CARE NETWORK

Representative Information Needed for Fingerprinting

Instructions: Complete every field below with your information. Print clearly. This is needed 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 _____.
* Gender _____.
* Race _____.
* Eye color _____.
* Hair color _____.
* Height (feet/inches) _____.
* Weight _____.
* Country of citizenship _____.
* Address – Street _____.
* Address - City, State, Zip Code _____.
* Phone number _____.
* Email address _____.

Office use only.

CD Representative Name _____.

Participant Name _____.

Health Care Plan United _____.

Date of Enrollment Meeting _____.

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UnitedHealthcare Community Plan

If you need help, please contact Consumer Direct at 877-270-9580 or UnitedHealthcare Toll-Free 800- 791-9233; TTY/TTD 711. We are happy to help.

UnitedHealthcare does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan member ID card, TTY 711, Monday through Friday, 8:00 a.m. to 7:00 p.m.

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ATENÇÃO: Se não fala inglês, estão disponíveis serviços de assistência linguística sem nenhum custo para si. Ligue para o **1-800-791-9233, TTY 711**.

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.

_____	Representative	_____
Employee/Contractor Signature	Title	Date

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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/Contractor Name (Printed)

_____

Employee/Contractor Signature

_____

Date

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.

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

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/FBI-009) 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