

Participant/FEIN Holder Information

Name _____ Gender Male Female
First Middle Last

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

City _____ State _____ Zip _____ County _____

Phone (____) _____ (____) _____ (____) _____ Email _____
Primary Secondary Fax

Date of Birth _____ Social Security # _____ - _____ - _____ Driver's License _____
Number State

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

Legal Guardian Information (if applicable)

Name _____ Relationship to Participant _____
First MI Last

Street Address _____

City _____ State _____ Zip _____

Phone (____) _____ (____) _____ (____) _____ Email _____
Primary Secondary Fax

Yes No - Will legal guardian sign the enclosed Federal and State tax forms on the participant's (FEIN holder's) behalf?
 If yes, attach court-appointed guardianship paperwork, and enter social security and driver's license information below.

Social Security # _____ - _____ - _____ Driver's License _____
Number State

Representative Information (if applicable)

Name _____ Relationship to Participant _____

Street Address _____

City _____ State _____ Zip _____

Phone (____) _____ (____) _____ (____) _____ Email _____
Primary Secondary Fax

Date of Birth _____ Social Security # _____ - _____ - _____ BG Check Clearance Date _____

Approving Entity Information

Managed Care Plan _____

External Case Mgr/Care Coordinator Name _____ Phone (____) _____

Address _____ Cell (____) _____

City _____ State _____ Zip _____ Email _____

Prior Relationships/Business Accounts

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

2. Yes No - Are **Prior Business Accounts** established? If yes, enter account information below:
 → _____ - _____
FEIN Reemployment Tax Account # SUTA Rate

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

3. Budget/Auth Start Date _____





FISCAL EMPLOYER AGENT
PARTICIPANT ORIENTATION AND
ENROLLMENT CHECKLIST

Table with 2 columns: Participant (FEIN holder) Name, Representative Name (if applicable)

Review of Participant Guidelines

Participant Enrollment Packet (submit to Consumer Direct)

Check as completed.

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

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

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

Supplemental Forms (Discuss each and keep for future use)

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

Direct Service Worker Enrollment Packet (discuss)

Completed on date: ___/___/___

Program

Coordinator: _____
Name

Signature

Participant: _____
Name

Signature

03463





PARTICIPANT AGREEMENT AND ACKNOWLEDGEMENT FORM

Print Participant's Name

Print Legal Guardian's Name (if applicable)

INSTRUCTIONS:

1. Review each topic and ask questions, if necessary. Please initial by each to show your (Participant or Legal Guardian) agreement and understanding.
2. In this agreement, "I, my, me" refers to the Participant and/or the Legal Guardian (LG), as appropriate.

I authorize Consumer Direct to Initial for me ONLY because it is difficult for me to write

RECEIPT OF EMPLOYMENT HANDBOOK: The Handbook describes policies, procedures, and requirements for participants and direct service workers (DSW) in the Participant Direction Option (PDO). I will read the Handbook. If I have questions, I will contact Consumer Direct. I will review the Handbook with my DSW(s) and give them a copy. I am responsible for making sure my DSW(s) follow program requirements, policies, and procedures contained in the Handbook.

OTHER TRAINING MATERIALS: I have received and will read the following training materials:

- PDO Participant Guidelines
- Abuse, Neglect and Exploitation (Handbook Supplement)
- Medicaid Fraud (Handbook Supplement)
- Employer-related training; completing federal and state tax documents; developing a PDO Emergency Backup Plan; interviewing, training, and evaluating DSW(s); and completing and submitting time sheets.

HIRING DIRECT SERVICE WORKER(S): I am responsible for recruiting, interviewing and hiring DSW(s). The DSW can be a family member, friend, or someone from the community. I must be comfortable with the person.

- DSW(s) cannot be a participant's representative.
- Before a DSW can begin to work and be paid in this program, I must receive a completed "Okay to Work Form" from Consumer Direct for each DSW.

PARTICIPANT TRAINING PLAN: I am responsible for training and supervising my DSW(s). I can get information about how to do this in the Employment Handbook. I also can get information from Consumer Direct staff members who meet with me. I know that Consumer Direct will answer questions, clarify issues, and assist me in learning to supervise and manage my DSW(s).

- a. I will train and schedule DSW(s) to meet my service needs. The DSW will be scheduled as approved on my Care Plan.
- b. I will give my DSW feedback if he or she is not doing a task as I trained him or her or is not doing a good job. I also will give the DSW positive feedback when he or she is doing tasks well.
- c. I will dismiss a DSW if he or she continues to do a poor job after receiving feedback and training or if he or she has not followed the guidelines of the program.
- d. I have received the following DSW training information. I know that I am responsible for training my DSW(s) when applicable.



- Infection Control
 - Abuse and Neglect
 - Medicaid Fraud
 - Lifting and Moving Patients
 - HIPAA and Confidentiality
- e. I know that other training materials on other topics, such as: bathing, dressing, home and fire safety, safe transfers and nutrition, are available from Consumer Direct upon request.
- f. I know that Consumer Direct will help me make sure my DSW(s) are approved to work for me.

_____ I will make sure that the **services** I schedule the DSW to perform and the **time the DSW works** agree with the Care Plan. I know that approving a time sheet when a DSW has not worked, or approving a time sheet that does not agree with the Care Plan, is Medicaid fraud.

- I can begin services with Consumer Direct after DSW enrollment materials are forwarded to Consumer Direct and I receive an “Okay to work” form for each DSW.
- I will design an Emergency and Backup Plan to use when my regularly scheduled DSW(s) and 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 Care Plan.
 - I allow my DSW(s) to do tasks that are not approved on my Care Plan.

_____ **REPORTING:** I will report:

- a. Any possible Medicaid fraud to Consumer Direct immediately and to the MCO.
- b. Abuse, neglect and exploitation (described in the Employment Handbook and Participant Guidelines) to Adult Protective Services and Consumer Direct.
- c. Any change in health status or living situation to Consumer Direct (examples: hospitalization, improvement or decline in health status, or change of address) within five days.
- d. A change in my or my representative’s name or address within five days.

_____ **PRIVACY:** I have received a copy of Consumer Direct’s Notice of Privacy Practices. It describes my rights and privileges under Consumer Direct’s privacy rules. The rules follow federal privacy regulations (HIPAA).

Daryl Holzer, Compliance Officer
Toll-free phone: 1-877-532-8530

_____ **DECISION TO SERVE:** Consumer Direct can choose to not serve me. This will happen if I do not follow policy and procedures or if my health and safety needs cannot be met with the self-directed program. Consumer Direct will discuss their concerns with me and my case manager. My case manager will assist me with transitioning services out of PDO within thirty (30) days.

_____ **CONSENT FORM:** The Consent Form (State Form) outlines rights and responsibilities of Consumer Direct and the Participant. I understand that Consumer Direct is performing some of the responsibilities of the managed care organization for the Participant Directed Option. These rights and responsibilities also apply as part of this Agreement.





PARTICIPANT AGREEMENT AND ACKNOWLEDGEMENT FORM

AGREEMENT TERMS AND CONDITIONS

Non-Emergent Service: I know Consumer Direct does not provide any emergency medical services. I know that I must call emergency services (such as 911) during a medical emergency.

Indemnification and Hold Harmless: I acknowledge that I will be in a better position to monitor, supervise and watch over my employee in the performance of his or her duties. I agree to indemnify, which means to repay, defend and hold harmless Consumer Direct from any claims, causes of actions, complaints, lawsuits claiming any damages or liability against Consumer Direct, as the result of any actions, inactions, or any conduct by my DSW, while employed by me. This indemnification agreement includes any claims for damage to my property or my person, or the property or persons of any third party. I understand that this means that I will be required to pay for any damages caused by my DSW, while employed by me, that are made against Consumer Direct, including the costs that Consumer Direct develops in defending itself against such claims.

Partial Invalidity: If any part of this Agreement does not apply to you or changes with time, the other parts of the Agreement still apply and are valid. If one part of this Agreement is broken, the rest of the Agreement remains in place.

Arbitration: I agree that any dispute I or Consumer Direct have under this Agreement will be resolved by means of binding arbitration, instead of in Court. In the event of a disagreement, either I or Consumer Direct may request binding arbitration under the rules and auspices (support) of the American Arbitration Association. The cost of the arbitration will be split evenly between Consumer Direct and me.

State Law: If we cannot solve a problem through negotiation or talking about the problem, then Florida State law will apply. Any legal action related to this Agreement must be held in Florida.

Duration and Modification of Agreement: This Agreement will go into effect on the date it is signed by both the Participant and Consumer Direct. The Agreement can be changed. Any changes must be in writing, signed and dated by both the Participant and Consumer Direct. The Agreement may be stopped right away by either Participant or Consumer Direct by saying so in writing if it is okay to do so under program rules and related law.

Timely Notification: The Participant and Consumer Direct agree that all contact should occur in a timely way. Any notice will be given immediately, so that the Participant or Consumer Direct is not harmed by a delay.

Entire Agreement: This Agreement and other written materials together describe the complete understanding between a Participant/Legal Guardian and Consumer Direct. Any verbal agreements do not apply. All agreements must be put in writing by the Participant/LG or Consumer Direct.

I am the direct (managing) employer of the DSW(s). I know I am responsible for recruiting, hiring, training and supervising DSW(s). I accept all responsibility for any personal injury, medical or related liability for services provided under this program. My signature indicates my agreement.

Participant or LG Signature

Date

Consumer Direct Rep. Signature

Date



Application for Employer Identification Number

(For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, Indian tribal entities, certain individuals, and others.)

▶ Go to www.irs.gov/FormSS4 for instructions and the latest information.
 ▶ See separate instructions for each line. ▶ Keep a copy for your records.

EIN _____

Type or print clearly.	1 Legal name of entity (or individual) for whom the EIN is being requested	
	2 Trade name of business (if different from name on line 1)	3 Executor, administrator, trustee, "care of" name
	4a Mailing address (room, apt., suite no. and street, or P.O. box)	5a Street address (if different) (Don't enter a P.O. box.)
	4b City, state, and ZIP code (if foreign, see instructions)	5b City, state, and ZIP code (if foreign, see instructions)
	6 County and state where principal business is located	
	7a Name of responsible party	7b SSN, ITIN, or EIN

8a Is this application for a limited liability company (LLC) (or a foreign equivalent)? <input type="checkbox"/> Yes <input type="checkbox"/> No	8b If 8a is "Yes," enter the number of LLC members ▶
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8c If 8a is "Yes," was the LLC organized in the United States? Yes No

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

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

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

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

11 Date business started or acquired (month, day, year). See instructions.	12 Closing month of accounting year
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13 Highest number of employees expected in the next 12 months (enter -0- if none). If no employees expected, skip line 14.	14 If you expect your employment tax liability to be \$1,000 or less in a full calendar year and want to file Form 944 annually instead of Forms 941 quarterly, check here. (Your employment tax liability generally will be \$1,000 or less if you expect to pay \$5,000 or less in total wages.) If you don't check this box, you must file Form 941 for every quarter. <input type="checkbox"/>			
<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%; border-right: 1px solid black; text-align:center;">Agricultural</td> <td style="width:33%; border-right: 1px solid black; text-align:center;">Household</td> <td style="width:33%; text-align:center;">Other</td> </tr> </table>	Agricultural	Household	Other	
Agricultural	Household	Other		

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

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

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

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

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

Third Party Designee	Complete this section only if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form.	
	Designee's name	Designee's telephone number (include area code)
	Address and ZIP code	Designee's fax number (include area code)

Under penalties of perjury, I declare that I have examined this application, and to the best of my knowledge and belief, it is true, correct, and complete.	Applicant's telephone number (include area code)
Name and title (type or print clearly) ▶	Applicant's fax number (include area code)
Signature ▶	Date ▶



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

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

OMB No. 1545-0748

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

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

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

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

For IRS use:

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

(Check one)

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

Part 2: Employer or Payer Information: Complete this part if you want to appoint an agent or revoke an appointment.

1 Employer identification number (EIN) -

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

3 Trade name (if any)

4 Address

Number Street Suite or room number

City State ZIP code

Foreign country name Foreign province/county Foreign postal code

5 Forms for which you want to appoint an agent or revoke the agent's appointment to file. (Check all that apply.)	For ALL employees/ payees/payments	For SOME employees/ payees/payments
Form 940, 940-PR (Employer's Annual Federal Unemployment (FUTA) Tax Return)*	<input type="checkbox"/>	<input type="checkbox"/>
Form 941, 941-PR, 941-SS (Employer's QUARTERLY Federal Tax Return)	<input type="checkbox"/>	<input type="checkbox"/>
Form 943, 943-PR (Employer's Annual Federal Tax Return for Agricultural Employees)	<input type="checkbox"/>	<input type="checkbox"/>
Form 944, 944(SP) (Employer's ANNUAL Federal Tax Return)	<input type="checkbox"/>	<input type="checkbox"/>
Form 945 (Annual Return of Withheld Federal Income Tax)	<input type="checkbox"/>	<input type="checkbox"/>
Form CT-1 (Employer's Annual Railroad Retirement Tax Return)	<input type="checkbox"/>	<input type="checkbox"/>
Form CT-2 (Employee Representative's Quarterly Railroad Tax Return)	<input type="checkbox"/>	<input type="checkbox"/>

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

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

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

X Sign your name here

Print your name here

Print your title here

Date

Best daytime phone

Now give this form to the agent to complete. ➡





Florida Business Tax Application

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

For DOR Use Only



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

Section A – Reason for Applying and Applicant Information

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

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

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

BUSINESS ENTITY INFORMATION

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





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

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

BUSINESS STRUCTURE & OWNERSHIP

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

<input type="checkbox"/> a. Sole proprietorship	d. Limited Liability Company (check one below)	<input type="checkbox"/> e. Business trust
<input type="checkbox"/> b. Partnership (check one below)	<input type="checkbox"/> Single member LLC	<input type="checkbox"/> f. Nonbusiness trust/Fiduciary
<input type="checkbox"/> Married couple <input type="checkbox"/> General partnership	<input type="checkbox"/> Elects treatment as C-corporation **	<input type="checkbox"/> g. Estate
<input type="checkbox"/> Limited partnership <input type="checkbox"/> Joint venture	<input type="checkbox"/> Multi-member LLC	Provide date of death: <input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="checkbox"/> c. Corporation (check one below)	<input type="checkbox"/> Elects treatment as C-corporation **	<input type="checkbox"/> h. Government agency
<input type="checkbox"/> C-corporation <input type="checkbox"/> Not-for-profit corporation	**Refers to elections made for federal income tax purposes.	
<input type="checkbox"/> S-corporation		

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

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

12. Identify the owner/sole proprietor, or general partners, officers, managing members, grantors, trustees, or personal representatives of the business entity.

Note: The person signing this application must be listed here.

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

(Attach additional pages, if necessary)

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





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

- Y N r. Purchase items for use in your business that were not taxed by the seller when purchased (includes purchases through catalogs, the Internet, or from out-of-state vendors)?
- Y N s. Use dyed diesel fuel for off-road purposes?
- Y N t. Provide any of the following services? If yes, check the box next to each service you provide.
 - (1) Pest control services for nonresidential buildings
 - (2) Interior cleaning services for nonresidential buildings
 - (3) Detective services
 - (4) Protection services
 - (5) Security alarm system monitoring services

Coin-Operated Amusement Machines

21. Are coin-operated amusement machines operated at your business location? Y N

If yes, answer question a. If no, skip to question 22.

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

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

Real Property Contractors

22. Do you improve real property as a contractor? Y N

If yes, answer questions a–d. If no, skip to question 23.

- a. Indicate your industry category(s) (check all that apply): residential commercial industrial utility bridge/road
- b. Do you sell products at retail? Y N
- c. Do you purchase materials/supplies from out-of-state vendors for use in your Florida projects? Y N
- d. Do you construct or assemble building components away from your project sites? Y N

Motor Fuel Sales

23. Do you sell gasoline, diesel fuel, or aviation fuel at posted retail prices? Y N

If yes, complete item a. If no, skip to question 24.

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

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

24. Do you sell prepaid phones, phone cards or calling arrangements? Y N

If yes, check the box next to each activity below that describes your sales.

- a. Domestic or international long distance calling/phone cards (non-wireless)
- b. Prepaid wireless services (cards, plans, devices) that provide access to wireless networks and interaction with 911 emergency services.

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

25. Do you sell tires or batteries, or rent or lease motor vehicles to others? Y N

If yes, answer questions a–c. If no, skip to question 26.

- a. Do you sell (at retail) new tires for motorized vehicles that are sold separately or as part of a vehicle? Y N
- b. Do you sell (at retail) new or remanufactured lead-acid batteries that are sold separately or as a component part of another product such as new automobiles, golf carts, or boats? Y N
- c. Do you rent, lease, or sell car-sharing membership services for the use of, motor vehicles that transport fewer than nine passengers? Y N





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

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

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

NOTE: In addition to registering for Reemployment Tax:

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

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

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

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

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

31. Employment type (check all that apply):

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

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

33. If your employment type is:

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

Have you or will you pay gross wages of at least \$1,500 within a calendar quarter? ** Y N
If yes, provide the date you reached or will reach \$1,500 gross wages: / /

Have you or will you employ one or more workers for 20 or more weeks within a calendar year? ** Y N
If yes, provide the date of the 20th week: / /

b. **Nonprofit organization**

Have you or will you employ four or more workers for 20 or more weeks within a calendar year? ** Y N
If yes, provide the date of the 20th week: / /

c. **Domestic employer**

Have you or will you pay gross wages of at least \$1,000 within a calendar quarter? ** Y N
If yes, provide the date you reached or will reach \$1,000 gross wages: / /

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

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





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

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

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

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

If yes, in which state: _____ in which year:.....

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

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

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

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

a. Leasing company's name:			
b. FEIN:	c. DBPR License Number:	d. RT Account Number:	
e. Portion of workforce that is leased: <input type="checkbox"/> All <input type="checkbox"/> Part		f. Date of leasing arrangement: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>	

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

Address:	City:	County:	Number of employees:
Principal products or services:	If services, indicate if <input type="checkbox"/> Administrative <input type="checkbox"/> Research <input type="checkbox"/> Other: _____		
Address:	City:	County:	Number of employees:
Principal products or services:	If services, indicate if <input type="checkbox"/> Administrative <input type="checkbox"/> Research <input type="checkbox"/> Other: _____		
Address:	City:	County:	Number of employees:
Principal products or services:	If services, indicate if <input type="checkbox"/> Administrative <input type="checkbox"/> Research <input type="checkbox"/> Other: _____		

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

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

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

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

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

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

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





c. **Claims** – Mail notices of benefits paid and other correspondence about claims and benefits to (check one):

Payroll address (item 38) Other, below

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

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

40. **Do you sell communications services; purchase communications services to integrate into prepaid calling arrangements; or are you applying for a direct pay permit for communications services tax?** Y N

If yes, check the box next to each service you sell, and answer questions 41-44. If no, skip Section F (questions 41-44).

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

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

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

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

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

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

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

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

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

45. **Do you make sales, finalized by written financing agreements, that are not recorded by the Clerk of the Court, but do require documentary stamp tax to be paid?** Y N

If yes, complete items a-b. If no, skip to question 46.

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





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

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

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

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

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

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

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

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

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

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

49. Contact Person for Electronic Payments

Name:	Telephone number: ()	Fax number: ()
Mailing address:	City/State/ZIP:	
Email address:		
<input type="checkbox"/> a company employee <input type="checkbox"/> a non-related tax preparer <input type="checkbox"/> the party named in item 38		Federal PTIN (if tax preparer):

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

Name:	Telephone number: ()	Fax number: ()
Mailing address:	City/State/ZIP:	
Email address:		
<input type="checkbox"/> a company employee <input type="checkbox"/> a non-related tax preparer <input type="checkbox"/> the party named in item 38		Federal PTIN (if tax preparer):





51. Choose your filing/payment method:

File Electronically Pay Electronically (select one): ACH-Debit (e-check) ACH-Credit

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

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

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

a. Bank/financial institution name:	b. Account type: <input type="checkbox"/> Business, or <input type="checkbox"/> Personal and <input type="checkbox"/> Checking, or <input type="checkbox"/> Savings
c. Bank account number:	d. Bank Routing Number: : <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> :

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

53. Enrollee Authorization and Agreement

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

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

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

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

Signature: _____ Title: _____ Date: _____

Printed name: _____

Second Signature: _____ Title: _____ Date: _____
(If account requires two signatures)

Printed name: _____

Section K - Applicant Acknowledgement, Declaration and Signature

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

- _____ I understand it is my responsibility to notify the Department of Revenue of any changes of business structure, activities, location, mailing address or contact information.
- _____ I understand that any person who is required to collect, truthfully account for, and pay any tax, surcharge, or fee, and willfully fails to do so shall be personally liable for penalties and twice the amount of tax, under the provisions of s. 213.29, F.S.

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

- _____ Fail or refuse to register (a late registration fee or penalty may also be imposed).
- _____ Not timely file a tax return or report.
- _____ Underreport a tax, surcharge or fee liability on a return or report filed.
- _____ Fail or refuse to collect a required tax, surcharge or fee.
- _____ Not remit a collected tax, surcharge or fee.
- _____ Make a worthless check, draft, debit card payment, or electronic funds transfer to the Department.





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

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

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

Applicant Attestation, Declaration, and Signature

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

Signature: _____

Title: _____

Printed name: _____

Date: _____

USE THIS CHECKLIST TO ENSURE FAST PROCESSING OF YOUR APPLICATION.

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

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

FOR DOR USE ONLY

PM/Delivery	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Contract Object (MO)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
B.P. No.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Certificate No.	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>
RT Acct. No.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Contract Object (other)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
NAICS Code(s):	<input type="text"/>	<input type="text"/>	<input type="text"/>





**Florida Department of Revenue
POWER OF ATTORNEY
and Declaration of Representative**

DR-835

R. 10/11
TC

Rule 12-6.0015
Florida Administrative Code
Effective 01/12

See Instructions for additional information

PART I - POWER OF ATTORNEY

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

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

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

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

Name and address (include name of firm if applicable) 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 ()
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	Agent number (required)
Firm name	Federal I.D. No. (required)
Address (if different from above)	Telephone number ()

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

Section 5. Acts Authorized.

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

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

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

03502





Florida Tax Registration Number:

Taxpayer Name(s):

Federal Identification Number:

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

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

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

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

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

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

Attorney, check this box

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

Section 8. Signature of Taxpayer(s).

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

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

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

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

PART II - DECLARATION OF REPRESENTATIVE

Under penalties of perjury, I declare that:

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

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

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





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.

- _____ 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 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. I know that I can get more training if I need it. I will contact my case manager if I want more training.
- _____ 9. I know that my direct service worker's timesheets must be correct.
- _____ 10. I will give my direct service worker's timesheets to my Plan. The timesheets must be sent in by the date on the payroll schedule.
- _____ 11. I will tell my case manager if I decide to fire my direct service worker(s).
- _____ 12. 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.



- _____ 13. I will tell my case manager if I'm having problems with my direct service worker(s).
- _____ 14. 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.
- _____ 15. 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
---------------------------	-----------	------



Participant Name	Representative or Legal Guardian (if applicable)

I understand that:

1. Consumer Direct will assist the Participant/Representative with the development of a backup plan that is used if a regularly scheduled direct service worker (DSW) cannot provide services.
2. It is the Participant/Representative's responsibility to use, change, update, or decide whether the backup plan is effective.
3. It is the Participant/Representative's responsibility to immediately report a gap in service to Consumer Direct.
4. In the case of an emergency call 911.

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 (may include friends, family, past DSWs, church members, other volunteers):

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 arises about employment, pay, their availability and my care needs. I know that my backup worker(s) must be eligible for work and trained in order to be paid.

D. I understand that Consumer Direct maintains a Job Board that I can reference when recruiting backup workers.





PARTICIPANT EMERGENCY AND BACKUP PLAN

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 contact the Adult Protective Services or Child Abuse hotline at **1-800-962-2873**.

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

*This form is submitted to the case manager and reviewed quarterly.

Participant or Representative Signature

Date

Consumer Direct Rep. Signature

Date

PDO Specialist/Case Manager Signature

Date





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





REPRESENTATIVE INFORMATION NEEDED FOR FINGERPRINTING

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

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

To be completed by Consumer Direct

CD Representative Name: _____

Participant Name: _____

Health Care Plan: _____

Date of Enrollment Meeting: _____





ATTESTATION OF COMPLIANCE with Background Screening Requirements

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

- the attestation requirements of **section 435.05(2), Florida Statutes**, which state that every employee required to undergo Level 2 background screening must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer; **AND**
- the proof of screening within the previous 5 years in **section 408.809(2), Florida Statutes**, which requires proof of compliance with level 2 screening standards that have been screened through the Care Provider Background Screening Clearinghouse created under Section 435.12, F.S., or screened within the previous 5 years by the Agency, Department of Health, Department of Elder Affairs, the Agency for Persons with Disabilities, Department of Children and Families, or the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S., and in accordance with the standards in Section 408.809(2), F.S., if that agency is not currently implemented in the Care Provider Background Screening Clearinghouse.

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

Employee/Contractor Name:

Health Care Provider/ Employer Name:

Address of Health Care Provider:

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

Criminal offenses found in section 435.04, F.S.

- (a) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.
- (b) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.
- (c) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.
- (d) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.
- (e) Section 782.04, relating to murder.

- (g) Section 782.071, relating to vehicular homicide
- (h) Section 782.09, relating to killing of an unborn child by injury to the mother.
- (i) Chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.
- (j) Section 784.011, relating to assault, if the victim of the offense was a minor.
- (k) Section 784.03, relating to battery, if the victim of the offense was a minor.
- (l) Section 787.01, relating to kidnapping.



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(m) Section 787.02, relating to false imprisonment.

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

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

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

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

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

(s) Section 794.011, relating to sexual battery.

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

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

(v) Chapter 796, relating to prostitution.

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

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

(y) Section 806.01, relating to arson.

(z) Section 810.02, relating to burglary.

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

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

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

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

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

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

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

(hh) Section 826.04, relating to incest.

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

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

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

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

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

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

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

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

(qq) Chapter 847, relating to obscene literature.

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

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

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

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

(vv) Section 944.40, relating to escape.

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

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

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

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

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

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

- (a) Any authorizing statutes, if the offense was a felony.
- (b) This chapter, if the offense was a felony.
- (c) Section 409.920, relating to Medicaid provider fraud.
- (d) Section 409.9201, relating to Medicaid fraud.
- (e) Section 741.28, relating to domestic violence.
- (f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.
- (g) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.
- (h) Section 817.234, relating to false and fraudulent insurance claims.
- (i) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.
- (j) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider.
- (k) Section 817.505, relating to patient brokering.
- (l) Section 817.568, relating to criminal use of personal identification information.

- (m) Section 817.60, relating to obtaining a credit card through fraudulent means.
- (n) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.
- (o) Section 831.01, relating to forgery.
- (p) Section 831.02, relating to uttering forged instruments.
- (q) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.
- (r) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.
- (s) Section 831.30, relating to fraud in obtaining medicinal drugs.
- (t) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony.
- (u) Section 895.03, relating to racketeering and collection of unlawful debts.
- (v) Section 896.101, relating to the Florida Money Laundering Act.

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

Date of Decision: _____

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

Date of Decision: _____

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

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

Purpose of Prior Screening: _____

Screening conducted by: _____ Date of Prior Screening: _____

- Agency for Healthcare Administration
- Department of Health
- Agency for Persons with Disabilities

- Department of Elder Affairs
- Department of Financial Services
- Department of Children and Families

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Attestation

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

Employee/Contractor Signature

Title

Date

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RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

PRIVACY POLICY ACKNOWLEDGEMENT FORM

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

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

Employee Name (Printed)

Employee Signature

Date

2727 Mahan Drive, MS#40
Tallahassee, Florida 32308



Visit AHCA online at
AHCA.MyFlorida.com



FLORIDA DEPARTMENT OF LAW ENFORCEMENT

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

NOTICE OF:

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

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

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

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

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

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



PRIVACY STATEMENT

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

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

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

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

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