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:** _____.

10290

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:

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UnitedHealthcare Civil Rights Grievance
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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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Community Plan

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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

UnitedHealthcare Community Plan

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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
Alisha Matt

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.

Name and title (type or print clearly) ► **Home Care Service Recipient**

Applicant's telephone number (include area code)

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 It's convenient, free, secure and saves paper, postage, and time.

For DOR Use Only

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

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

Section A – Reason for Applying and Applicant Information

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

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

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

BUSINESS ENTITY INFORMATION

3a. Legal name of individual owner (for sole proprietor only):	**Last** name:	**First** name:	**Middle** name/initial:	3b. Owner's telephone number: ( )
3c. Legal name of business entity (e.g., corporation, limited liability company, partnership, trust, estate):				
4. Trade, fictitious, or "doing business as" name:				
5a. Physical street address of business location or rental property being registered (see instructions):				5b. Business telephone number: (**406**) **532-1900**
City/State/ZIP:			County:	5c. Fax number: (**406**) **532-8588**
6. Mail to the attention of: **c/o Consumer Direct**		Mailing address (if different from # 5a): **100 Consumer Direct Way, Suite 303**		
City/State/ZIP: **Missoula, MT 59808**				
7. Email address: **taxdept@consumerdirectcare.com** 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: ☐ All ☐ Part ☐ Unknown	g. Date of purchase or acquisition: ☐☐/☐☐/☐☐☐☐	
h. Was the business operating at the time of purchase/acquisition? ☐ Yes ☐ No	i. **If no**, on what date did the business close? ☐☐/☐☐/☐☐☐☐	
j. Did the business have employees at the time of purchase/acquisition? ☐ Yes ☐ No	k. **If yes**, did you acquire the employees? ☐ Yes ☐ No	
l. Did the acquired entity and your entity share any common ownership, management, or control at the time of purchase/acquisition? ☐ Yes ☐ No		

BUSINESS STRUCTURE & OWNERSHIP

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

☑ a. Sole proprietorship

b. Partnership (check one below)
- ☐ Married couple
- ☐ General partnership
- ☐ Limited partnership
- ☐ Joint venture

c. Corporation (check one below)
- ☐ C-corporation
- ☐ Not-for-profit corporation
- ☐ S-corporation

d. Limited Liability Company (check one below)
- ☐ Single member LLC
  - ☐ Elects treatment as C-corporation **
- ☐ Multi-member LLC
  - ☐ Elects treatment as C-corporation **

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

- ☐ e. Business trust
- ☐ f. Nonbusiness trust/Fiduciary
- ☐ g. Estate
  Provide date of death: ☐☐/☐☐/☐☐☐☐
- ☐ h. Government agency

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

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

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

Name:	Social Security Number *:	Home address:	Percent of ownership/control: **100%**
Title:	Driver license number/Issuing state:	City/State/ZIP:	Telephone number: ( )
Name:	Social Security Number*:	Home address:	Percent of ownership/control:
Title:	Driver license number/Issuing state:	City/State/ZIP:	Telephone number: ( )
Name:	Social Security Number *:	Home address:	Percent of ownership/control:
Title	Driver license number/Issuing state:	City/State/ZIP:	Telephone number: ( )

(Attach additional pages, if necessary)

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

BUSINESS BACKGROUND INFORMATION

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

BUSINESS ACTIVITIES DESCRIPTION

19a. Describe the primary nature of your business and list all activities, products, and services. Include all of your taxable activities if known.	**Home care service recipient (IRS Code Sec. 3504) who employs workers to provide services in a private home due to disability and/or aging.**

19b. If known, provide your North American Industry Classification System (NAICS) Code(s). Enter your primary code first. To determine your NAICS code, go to **www.census.gov/eos/www/naics** Primary Code: 6 2 4 1 2 0

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

General

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

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

Item 20 continues on Page 4

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

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

Y ☑ 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):

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

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

33. If your employment type is:

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

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

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

b. **Nonprofit organization**

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

c. **Domestic employer**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Address:	City:	County:	Number of employees: **1**
Principal products or services: **Home health care services**	If services, indicate if ☐ Administrative ☐ Research ☑ Other: **Domestic home health care**		
Address:	City:	County:	Number of employees:
Principal products or services:	If services, indicate if ☐ Administrative ☐ Research ☐ Other: _____		
Address:	City:	County:	Number of employees:
Principal products or services:	If services, indicate if ☐ Administrative ☐ Research ☐ Other: _____		

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

Individual or firm name: **Consumer Direct**	Federal ID number (FEIN, PTIN): **46-2752008**
Mailing address: **100 Consumer Direct Way, Suite 304**	City/State/ZIP: **Missoula, MT 59808**
Email address: **taxdept@consumerdirectcare.com**	Telephone number: (**406**) **532-1900**

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: **Malcolm Graham**		Telephone number: (**406**) **532-2916**
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: **Alisha Matt**		Telephone number: (**406**) **532-2917**
Mailing address: **100 Consumer Direct Way, Suite 303**	City/State/ZIP: **Missoula, MT 59808**	
Email address: **taxdept@consumerdirectcare.com**		

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

Name: Malcolm Graham	Telephone number: (406) 532-2916
Mailing address:	City/State/ZIP:
Email address:	

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. ☐ Electricity ☐ Natural or manufactured gas

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

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

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

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

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

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

49. Contact Person for Electronic Payments

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

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

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

51. Choose your filing/payment method:

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

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

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

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

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

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

53. Enrollee Authorization and Agreement

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

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

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

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

Signature: _____ Title: _____ Date: _____

Printed name: _____

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

Printed name: _____

Section K - Applicant Acknowledgement, Declaration and Signature

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

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

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

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

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

_____ Not timely file a tax return or report.

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

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

_____ Not remit a collected tax, surcharge or fee.

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

Witnessed by: _____ Date: _____

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: _____

Witnessed by: _____ Date: _____

USE THIS CHECKLIST TO ENSURE FAST PROCESSING OF YOUR APPLICATION.

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

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

FOR DOR USE ONLY

PM/Delivery ☐☐/☐☐/☐☐☐☐ **Contract Object (MO)** ☐☐☐☐☐☐☐☐☐☐

B.P. No. ☐☐☐☐☐☐☐☐☐ **Certificate No.** ☐☐-☐☐☐☐☐☐☐☐☐☐☐-☐

RT Acct. No. ☐☐☐☐☐☐☐ **Contract Object (other)** ☐☐☐☐☐☐☐☐☐☐

NAICS Code(s):

03692

FLORIDA

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			

UnitedHealthcare Community Plan

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

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

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

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ATTESTATION OF COMPLIANCE
with Background Screening Requirements

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

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

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

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

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

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

Criminal offenses found in section 435.04, F.S.

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

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

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

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

(e) Section 782.04, relating to murder.

(g) Section 782.071, relating to vehicular homicide

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

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

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

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

(l) Section 787.01, relating to kidnapping.

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(m) Section 787.02, relating to false imprisonment.

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

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

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

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

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

(s) Section 794.011, relating to sexual battery.

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

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

(v) Chapter 796, relating to prostitution.

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

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

(y) Section 806.01, relating to arson.

(z) Section 810.02, relating to burglary.

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

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

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

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

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

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

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

(hh) Section 826.04, relating to incest.

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

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

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

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

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

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

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

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

(qq) Chapter 847, relating to obscene literature.

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

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

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

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

(vv) Section 944.40, relating to escape.

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

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

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

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

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

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

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

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

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

(d) Section 409.9201, relating to Medicaid fraud.

(e) Section 741.28, relating to domestic violence.

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

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

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

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

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

(k) Section 817.505, relating to patient brokering.

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

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

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

(o) Section 831.01, relating to forgery.

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

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

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

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

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

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

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

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

Date of Decision: _____

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

Date of Decision: _____

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

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

Purpose of Prior Screening:_____

Screening conducted by: Date of Prior Screening: _____

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

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Attestation

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

Employee/Contractor Signature	Title	Date
_____	_____	_____

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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