IL EMPLOYEE APPLICATION PACKET

Complete, Sign, & Submit These Forms to PPL

Dear Employee:

Welcome aboard! You have received this packet because a participant in the IL DD program has selected you to provide personal support worker services.

Illinois' DHS Division of Developmental Disabilities has contracted with **Public Partnerships, LLC (PPL)** to act as a Fiscal Employer Agent (F/EA) for participants who choose to self-direct their waiver services. PPL will make payments on behalf of participants who employ personal support workers. The timesheets you complete will be submitted to PPL for payment. PPL will issue paychecks to you based on properly completed timesheets. These paychecks will reflect tax withholdings.

When filling out this packet, be sure to refer to the instructions throughout the packet—they will help you fill out the necessary forms and answer the most commonly asked questions.

Before you are eligible to provide services, you must:

1. Complete and submit all required forms listed in this packet.
2. Pass a health care worker registry, child abuse registry and sex offender registry check. PPL will perform these checks on you automatically. You may not be eligible for employment if there are any positive findings.
3. Have a criminal background check submitted and in process. You may provide services while PPL waits for results of your background check. You may not be eligible for further employment if there are any positive findings.

After you start working for a participant, you will:

1. Submit timesheets PPL twice a month before or on the pay period due date (see payroll schedule in this packet). You can submit timesheets either via the Web Portal or on paper (via fax or mail). Your employer must always verify your timesheets, either by approving on the Web Portal, or by signing the paper timesheets.
2. Receive a paycheck or direct deposit from PPL twice a month based on submitted, approved, and properly completed timesheets.
3. Receive a W-2 Wage Statement from PPL every year, on behalf of your employer.

Some Common Questions You May Have

When can I start working? Your employer will receive notification from the Service Facilitator when you can start working. There are several different steps that must be completed before you can start. One of them is the submission and processing of the employee documents in this packet. PPL cannot pay for any services performed before a completed packet is received,

Phone:	**(888) 866-0582**	**Administrative Fax:**	(866) 826-7287
TTY:	**(800) 360-5899**	**Timesheet Fax:**	(866) 340-1653
Email:	**ildd@pcgus.com**	**Web:**	**www.publicpartnerships.com**

processed, and marked as complete by PPL. You will also need to pass registry checks and a criminal background check*.

I am going to work for more than one participant. Do I have to fill out the employee application forms twice? Yes, you must complete a separate packet for each employer/participant who employs you. However, only one criminal background check will be performed.

Who is responsible for submitting timesheets to PPL? If you choose paper timesheets, your employer will decide whether s/he would like you to fax (or mail) the timesheets to PPL, or if s/he will do it. If you choose to submit timesheets through the Web Portal, you will create and submit your timesheet first, and then your employer will view and approve it.

What taxes will be withheld? Will I see them on my paycheck stub? PPL will withhold Social Security, Medicare, Federal Income taxes and State Income taxes from your paycheck as applicable. A summary of all tax withholdings will appear on your paycheck stub throughout the calendar year. PPL also will mail you a W-2 form each January. You will need this W-2 form to file your individual tax return by April of each year. Your employer will receive regular reports from PPL about your total hours worked. It is your responsibility to check your pay stubs and to notify PPL immediately if you believe that any of the withholdings on your paycheck are incorrect.

How do I submit my timesheet? There are two options for timesheet submission—online via our Web Portal or on paper. Instructions for using the Web Portal as well as paper timesheets are available in your employee information packet and Web Portal instruction packet. If you prefer, you may also obtain blank timesheets by calling Customer Service.

If you have any other questions, please contact us and we will be happy to help.

Thank you,
Public Partnerships, LLC (PPL)

*(*It is expected that all employees applying on or after January 1, 2011 will be required to submit to a fingerprint based criminal background check. Personal Support Workers will be allowed to work once the criminal background checks have been submitted and PPL is waiting for results to be received.)*

PPL IL DD EMPLOYEE APPLICATION PACKET

For assistance, call Customer Service at (888) 866-0582.

Forms Required For All Employees:

- ❑ Employee Application: This document gathers background information about you as the employee and collects the qualifications from you required to be an employee.

- ❑ Employment Agreement (2 copies): This document describes the responsibilities and duties of both the participant and the employee (you). This document must be kept by the employer and also sent to PPL. ***Both employee & employer need to sign this form.***

- ❑ USCIS Form I-9. Department of Homeland Security - Employment Eligibility Verification: This form is used to confirm your immigration and US citizenship information. Your employer will review the documents, confirm your identity and verify your identity by signing this form. ***Ask your employer to certify and sign Section 2 of the I-9 Form.*** Make sure to include copies of the documents listed in Section 2. **Federal law requires that all employers & employees complete this form**.

- ❑ IRS Form W-4. Employee's Withholding Allowance Certificate. This form is used to calculate your federal tax withholding. The form contains instructions developed by the IRS.

- ❑ IL Form IL-W-4. Employee's Withholding Allowance Certificate. This form is used to calculate your state tax withholding. The form contains instructions developed by the IL DOR .

- ❑ Familial Relationship Form: This form collects information about your relationship to your employer and determines whether you meet certain Federal tax exemptions.

- ❑ Registry/Background Checks Instructions & Forms: See attached forms & instructions. You will need to sign the attached CANTS form & State Police Request form to complete your registry checks.

- ❑ IL DHFS Provider Registration and Enrollment: Registration forms required by the State of Illinois Dept of Healthcare and Family Services for the purpose of Medicaid waiver participation.

Informational & Optional Forms:

- ❑ Sample Timesheet & Instructions: This section contains a sample paper timesheet, instructions for completing timesheets and a copy of the pay schedule with timesheet due dates.

- ❑ Direct Deposit & Pay Card Info: This form will establish direct deposit of your paycheck with PPL. You can use direct deposit with a bank account, debit card or pay card.

- ❑ IL W-5 NR: This form is used if you are a resident of Iowa, Kentucky, Michigan or Wisconsin and you wish to file for exemption from Illinois income Tax under IL's reciprocal withholding agreements.

All forms should be mailed to:
Mail: PPL IL DD, 6 Admirals Way, Chelsea, MA 02150
You may also Fax Forms to: (866) 826-7287, but originals must also be mailed

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PUBLIC PARTNERSHIPS

EMPLOYEE APPLICATION

Complete, Sign, & Submit These Forms to PPL

Application Date:	Participant First & Last Name:
	Employer First & Last Name (if different):

PROVIDER'S PERSONAL INFORMATION		
Last Name:	First Name:	
Address:		
City:	State:	Zip:
SSN:	DOB:	
Phone:	Alt. Phone:	
Email Address:		

Why am I applying to be a directly-hired employee? Can't I be an independent contractor?
Every worker must follow IRS guidelines. Workers who meet the guidelines for being a directly-hired employee cannot be independent contractors.

You are probably a directly-hired employee if:

- Your employer tells you when to work and how to do your work.
- Your employer chooses the rate at which to pay you.
- Your employer hired you for on-going work, not a specific period of time.

Provider Directory Opt-In

Beginning in 2011, Public Partnerships, LLC will maintain a provider directory to help new participants/employers locate available personal support workers in their area. Would you like to be listed in this directory?

☐ **Yes**, please list my name, city and phone number in the provider directory.

☐ **No**, I would prefer not to be listed in the provider directory.

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Email: ildd@pcgus.com **Web:** www.publicpartnerships.com

PPL IL DD Employee Application

Trainings

Personal Support Workers are not currently required to complete any training. If you have First Aid and/or CPR training, you may include copies of your current credentials for inclusion with your provider profile.

Background & Registry Checks

In order to provide services in this program, you will be required to pass several registry and background checks:

Check	Required result to work
Illinois State Police Sex Offender Database	Cannot be listed.
Illinois Child Abuse and Neglect Tracking System (CANTS)	Cannot be listed.
Illinois Department of Public Health's Healthcare Worker's Registry; with a substantiated finding of abuse or neglect or financial exploitation.	Cannot be listed
Illinois State Police Bureau of Identification Criminal Background Check	**

You will be required to submit to these checks. Any offer of employment is contingent upon successfully passing the criminal background check. **To pass the background check, you must not have any cases of "Offenses Against the Person" or "Offenses against Morals, Decency, and Family." This includes but is not limited to crimes such as: homicide, kidnapping, sexual assault, robbery and blackmail, assault and battery, bigamy, incest, abandoning or endangering children, violation of an order of protection, or endangering children via controlled substances.

By signing here, you certify that: "All answers given herein are true and complete to the best of my knowledge. I authorize the background and registry checks above, as well as the investigation of all matters contained in this application and I understand that misrepresentations, omissions of fact or incomplete information requested in this application may remove me from further consideration for employment."

Signature: _____ Date: _____

If you have other questions, please feel free to contact Customer Service at (888) 866-0582.

Thank you,

Public Partnerships, LLC (PPL)

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IL DD EMPLOYMENT AGREEMENT
Between Employer & Provider

This document must be signed and retained by the Employer and Employee.
A copy must also be sent to PPL.

Parties to Agreement

This agreement confirms the conditions of employment between the following parties within the IL Department of Human Services Division of Developmental Disabilities (IL DD) Home-based Support Services Personal Direction Program:

_____ _____

Participant/Employer Provider/Employee

Mutual Responsibilities

The parties agree to follow the policies and procedures of the program. The Employee and Participant agree to hold harmless, release, and forever discharge IL DD and Public Partnerships, LLC (PPL) from any claims and/or damages that might arise out of any action or omissions by the Employee, Employer, or Participant.

The Employer shall:

1. Verify Employee qualifications, including ability to work in the United States;
2. Schedule Employee to provide services for payment only after being authorized by PPL;
3. Orient, train, direct, and supervise the Employee;
4. Establish a mutually agreeable schedule for the Employee's services;
5. Provide a safe workplace free from excess hazards, employment discrimination, and harassment;
6. Request Employee to perform permitted and planned for duties, as determined in the Participant's Individual Service Plan;
7. Notify Employee in advance if services are not required or if Participant is no longer eligible for services;
8. Verify services provided by Employee by reviewing and approving timesheets and documentation of services rendered, and ensuring submission to PPL;
9. Accept responsibility for compensating the Employee for any services performed in excess of the amount authorized in the Individual Service Plan/Service Authorization; and
10. Ensure that there is no misrepresentation of time, services, individuals and/or other information.

The Employee shall:

1. Be 18 years of age or older and not the parent, step-parent or legally responsible relative of the Participant (Children's waiver) or the spouse of the participant (Adult Waiver);
2. Be punctual, neatly dressed, and respectful of employer's person, belongings, family members and acquaintances;
3. Use Participant's personal property only if agreed upon by both parties;
4. Submit accurate timesheets and documentation to Employer for review and signature;
5. Notify the Participant in advance if not able to provide services as scheduled or if quitting employment;
6. Report any allegations or suspicions of abuse, neglect, or exploitation immediately to IL DD;
7. Maintain confidentiality of all Participant information, and only release information with the written consent of the Participant; and,
8. Ensure that there is no misrepresentation of time, services, individuals and/or other information.

PPL IL DD EMPLOYMENT AGREEMENT

Employee understands and acknowledges the following:

1. Employee is employed by the Participant/Employer; not PPL or IL DD.
2. Employment is "at-will." No guarantee or promise of continued employment is intended or implied by this agreement.
3. Employees may work more than 40 hours per work week; however, authorized services are exempt from overtime requirements under the Fair Labor Standards Act (FLSA) as companionship services. Accordingly, no Employee will receive overtime premium pay. Services provided must be directly related to the care of the Participant
4. Employee shall only perform work within the amount authorized by IL DD as stated within the Participant's Individual Service Plan. Employee shall not be compensated by IL DD or PPL for any work performed in excess of the authorized amount.
5. PPL is required to report certain information on newly-hired employees to the Illinois Department of Employment Security as required by Federal and State Child Support Enforcement Laws.

Both Employee and Participant acknowledge the following:
Any false claims, statements, documents, or concealment of material facts by Employer or Employee may be considered Medicaid fraud and will be reported for review and potential prosecution under applicable Federal and State laws.

The Participant/Employer and Employee agree to indemnify and hold harmless PPL, its officers, employees and agents from any and all costs, expenses, losses, claims, damages, liabilities, settlements and judgments, including reasonable value of time spent by counsel for PPL and the costs and expenses and reasonable attorneys' fees of other counsel required to defend PPL relating to or arising from any and all claims brought by Personal Support Workers against PPL relating to damages caused by work related injuries.

Compensation
The Personal Support Worker shall be compensated for his or her services at the hourly rate of $_____ as stated in the Service Authorization.

Payment for Services and Work Performed
PPL shall pay the Employee for services provided by the Employee and verified by the Employer in accordance with the in effect at the time of service provision.

Termination of Agreement
Either party may terminate this agreement by notifying the other party and PPL in writing.

Signatures
By signing below, the Employer and Employee agree to the above terms and conditions.

_____ _____
Participant/Employer Date

_____ _____
Employee Date

IL DD EMPLOYMENT AGREEMENT
Between Employer & Provider

This document must be signed and retained by the Employer and Employee.
A copy must also be sent to PPL.

Parties to Agreement

This agreement confirms the conditions of employment between the following parties within the IL Department of Human Services Division of Developmental Disabilities (IL DD) Home-based Support Services Personal Direction Program:

_____ _____

Participant/Employer Provider/Employee

Mutual Responsibilities

The parties agree to follow the policies and procedures of the program. The Employee and Participant agree to hold harmless, release, and forever discharge IL DD and Public Partnerships, LLC (PPL) from any claims and/or damages that might arise out of any action or omissions by the Employee, Employer, or Participant.

The Employer shall:

1. Verify Employee qualifications, including ability to work in the United States;
2. Schedule Employee to provide services for payment only after being authorized by PPL;
3. Orient, train, direct, and supervise the Employee;
4. Establish a mutually agreeable schedule for the Employee's services;
5. Provide a safe workplace free from excess hazards, employment discrimination, and harassment;
6. Request Employee to perform permitted and planned for duties, as determined in the Participant's Individual Service Plan;
7. Notify Employee in advance if services are not required or if Participant is no longer eligible for services;
8. Verify services provided by Employee by reviewing and approving timesheets and documentation of services rendered, and ensuring submission to PPL;
9. Accept responsibility for compensating the Employee for any services performed in excess of the amount authorized in the Individual Service Plan/Service Authorization; and
10. Ensure that there is no misrepresentation of time, services, individuals and/or other information.

The Employee shall:

1. Be 18 years of age or older and not the parent, step-parent or legally responsible relative of the Participant (Children's waiver) or the spouse of the participant (Adult Waiver);
2. Be punctual, neatly dressed, and respectful of employer's person, belongings, family members and acquaintances;
3. Use Participant's personal property only if agreed upon by both parties;
4. Submit accurate timesheets and documentation to Employer for review and signature;
5. Notify the Participant in advance if not able to provide services as scheduled or if quitting employment;
6. Report any allegations or suspicions of abuse, neglect, or exploitation immediately to IL DD;
7. Maintain confidentiality of all Participant information, and only release information with the written consent of the Participant; and,
8. Ensure that there is no misrepresentation of time, services, individuals and/or other information.

PPL IL DD EMPLOYMENT AGREEMENT

Employee understands and acknowledges the following:

1. Employee is employed by the Participant/Employer; not PPL or IL DD.
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The Participant/Employer and Employee agree to indemnify and hold harmless PPL, its officers, employees and agents from any and all costs, expenses, losses, claims, damages, liabilities, settlements and judgments, including reasonable value of time spent by counsel for PPL and the costs and expenses and reasonable attorneys' fees of other counsel required to defend PPL relating to or arising from any and all claims brought by Personal Support Workers against PPL relating to damages caused by work related injuries.

Compensation
The Personal Support Worker shall be compensated for his or her services at the hourly rate of $_____ as stated in the Service Authorization.

Payment for Services and Work Performed
PPL shall pay the Employee for services provided by the Employee and verified by the Employer in accordance with the in effect at the time of service provision.

Termination of Agreement
Either party may terminate this agreement by notifying the other party and PPL in writing.

Signatures
By signing below, the Employer and Employee agree to the above terms and conditions.

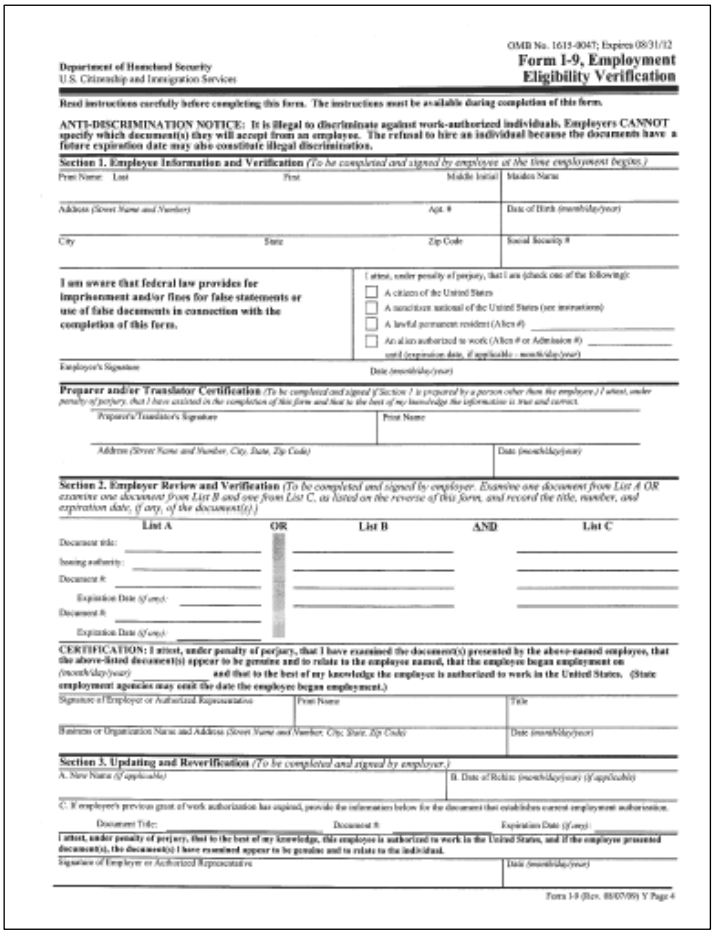
_____ _____
Participant/Employer Date

_____ _____
Employee Date

PUBLIC PARTNERSHIPS

EMPLOYEE I-9 FORM INSTRUCTIONS

Fill out Section 1 of the form with your information. This includes your name, address, date of birth and social security number. Remember to check the appropriate box regarding your residency status and to sign at the bottom of Section 1.



OMB No. 1615-0047; Expires 08/31/12

Department of Homeland Security
U.S. Citizenship and Immigration Services

Form I-9, Employment Eligibility Verification

Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification *(To be completed and signed by employee at the time employment begins.)*

Print Name: Last | First | Middle Initial | Maiden Name

Address (Street Name and Number) | Apt. # | Date of Birth (month/day/year)

City | State | Zip Code | Social Security #

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

- ☐ A citizen of the United States
- ☐ A noncitizen national of the United States (see instructions)
- ☐ A lawful permanent resident (Alien #) _____
- ☐ An alien authorized to work (Alien # or Admission #) _____ until (expiration date, if applicable - month/day/year) _____

Employee's Signature | Date (month/day/year)

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

Preparer's/Translator's Signature | Print Name

Address (Street Name and Number, City, State, Zip Code) | Date (month/day/year)

Section 2. Employer Review and Verification *(To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)*

	List A	OR	List B	AND	List C
Document title:					
Issuing authority:					
Document #:					
Expiration Date (if any):					
Document #:					
Expiration Date (if any):					

CERTIFICATION: I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) _____ **and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)**

Signature of Employer or Authorized Representative | Print Name | Title

Business or Organization Name and Address (Street Name and Number, City, State, Zip Code) | Date (month/day/year)

Section 3. Updating and Reverification *(To be completed and signed by employer.)*

A. New Name (if applicable) | B. Date of Rehire (month/day/year) (if applicable)

C. If employment previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.

Document Title: | Document #: | Expiration Date (if any):

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative | Date (month/day/year)

Form I-9 (Rev. 08/07/09) Y Page 4

Your employer must complete Section 2 of the form with your information. This is information that proves you are legal to work in the United States. Look on the attached "Lists of Acceptable Documents" to see what documents you can use. Remember, if you use something from List A, you do not have to complete List B or List C. If you use something from List B, you must also do something from List C. **You must send copies of all the documents you use.**

Your employer (the person receiving the services) signs and dates in the certification section. People often forget to do this, so make sure your employer signs the form!

<u>We will not be able to pay you until you send this in, so this is very important!</u>

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Section 1. Employee Information and Verification *(To be completed and signed by employee at the time employment begins.)*

Print Name: Last	First	Middle Initial	Maiden Name

Address *(Street Name and Number)*	Apt. #	Date of Birth *(month/day/year)*

City	State	Zip Code	Social Security #

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

- ☐ A citizen of the United States
- ☐ A noncitizen national of the United States (see instructions)
- ☐ A lawful permanent resident (Alien #) _____
- ☐ An alien authorized to work (Alien # or Admission #) _____ until (expiration date, if applicable - *month/day/year*)

Employee's Signature | Date *(month/day/year)*

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

Preparer's/Translator's Signature	Print Name

Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

Section 2. Employer Review and Verification *(To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)*

	List A	OR	List B	AND	List C
Document title:					
Issuing authority:					
Document #:					
Expiration Date *(if any)*:					
Document #:					
Expiration Date *(if any)*:					

CERTIFICATION: I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on *(month/day/year)* _____ **and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)**

Signature of Employer or Authorized Representative	Print Name	Title

Business or Organization Name and Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

Section 3. Updating and Reverification *(To be completed and signed by employer.)*

A. New Name *(if applicable)*	B. Date of Rehire *(month/day/year) (if applicable)*

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.

Document Title: _____ Document #: _____ Expiration Date *(if any)*: _____

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Date *(month/day/year)*

LISTS OF ACCEPTABLE DOCUMENTS

All documents must be unexpired

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. Social Security Account Number card other than one that specifies on the face that the issuance of the card does not authorize employment in the United States
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)				2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		3. School ID card with a photograph		
		4. Voter's registration card		4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. In the case of a nonimmigrant alien authorized to work for a specific employer incident to status, a foreign passport with Form I-94 or Form I-94A bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, as long as the period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form		5. U.S. Military card or draft record		
		6. Military dependent's ID card		
		7. U.S. Coast Guard Merchant Mariner Card		5. Native American tribal document
		8. Native American tribal document		6. U.S. Citizen ID Card (Form I-197)
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		10. School record or report card		8. Employment authorization document issued by the Department of Homeland Security
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274)

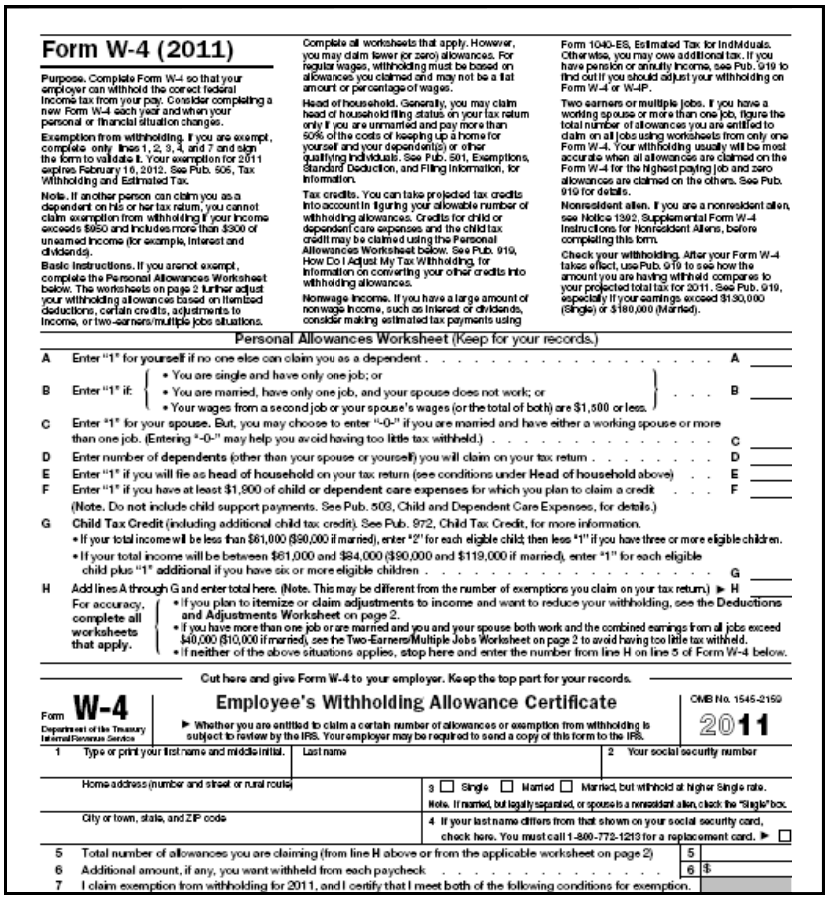
PUBLIC PARTNERSHIPS

IRS FORM W-4 INSTRUCTIONS
Employee Withholding Certificate

What is it for?
This form tells the IRS about the withholding allowances for which the employee is eligible.

Who needs to sign?
Every provider working with a participant who is self-directing services through Public Partnerships, LLC.

What if I do not want to sign this tax form?
PPL needs this form completed and signed in order to withhold taxes with your desired allowances. If you do not return a W-4 to PPL we will be required to withhold Federal income taxes at the highest rate (Single with zero allowances).



Form W-4 (2011)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2011 expires February 16, 2012. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $950 and includes more than $300 of unearned income (for example, interest and dividends).

Basic instructions. If you are not exempt, complete the Personal Allowances Worksheet below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the Personal Allowances Worksheet below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 919 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2011. See Pub. 919, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for yourself if no one else can claim you as a dependent . . . . . A

B Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less. . . . B

C Enter "1" for your spouse. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) C

D Enter number of dependents (other than your spouse or yourself) you will claim on your tax return . . . . . D

E Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above) . . E

F Enter "1" if you have at least $1,900 of child or dependent care expenses for which you plan to claim a credit . . . F
(Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

G Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.
• If your total income will be less than $61,000 ($90,000 if married), enter "2" for each eligible child; then less "1" if you have three or more eligible children.
• If your total income will be between $61,000 and $84,000 ($90,000 and $119,000 if married), enter "1" for each eligible child plus "1" additional if you have six or more eligible children . . . . . G

H Add lines A through G and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.) ▶ H

For accuracy, complete all worksheets that apply. • If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2. • If you have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed $40,000 ($10,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld. • If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.

Cut here and give Form W-4 to your employer. Keep the top part for your records.

Form W-4 — Department of the Treasury, Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.

OMB No. 1545-0159

2011

1 Type or print your first name and middle initial. | Last name | 2 Your social security number

Home address (number and street or rural route) | 3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate.
Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.

City or town, state, and ZIP code | 4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ ☐

5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2) | 5

6 Additional amount, if any, you want withheld from each paycheck . . . . . | 6 $

7 I claim exemption from withholding for 2011, and I certify that I meet both of the following conditions for exemption.

How should I complete the W-4 worksheet?
The PPL cannot give advice about what allowances you should claim. If you have questions about what allowances you should claim, contact your personal tax professional.

Form W-4 (2014)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2014 expires February 17, 2015. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,000 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity iincome, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2014. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	**A** _____
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less. . . .	**B** _____
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	**C** _____
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	**D** _____
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . .	**E** _____
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit . . . (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	**F** _____
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $65,000 ($95,000 if married), enter "2" for each eligible child; then **less** "1" if you have three to six eligible children or **less** "2" if you have seven or more eligible children. • If your total income will be between $65,000 and $84,000 ($95,000 and $119,000 if married), enter "1" for each eligible child . . .	**G** _____
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ►	**H** _____

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Separate here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

► **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2014

1	Your first name and middle initial	Last name	**2** **Your social security number**
	Home address (number and street or rural route)	**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
	City or town, state, and ZIP code	**4** **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ► ☐	
5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	**5**	
6	Additional amount, if any, you want withheld from each paycheck	**6** $	
7	I claim exemption from withholding for 2014, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here . . . . . ►	**7**	

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

Employee's signature
(This form is not valid unless you sign it.) ► **Date** ►

8	Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2014 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1950) of your income, and miscellaneous deductions. For 2014, you may have to reduce your itemized deductions if your income is over $305,050 and you are married filing jointly or are a qualifying widow(er); $279,650 if you are head of household; $254,200 if you are single and not head of household or a qualifying widow(er); or $152,525 if you are married filing separately. See Pub. 505 for details	1	$
2	Enter: { $12,400 if married filing jointly or qualifying widow(er); $9,100 if head of household; $6,200 if single or married filing separately }	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2014 adjustments to income and any additional standard deduction (see Pub. 505)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2014 Form W-4* worksheet in Pub. 505.)	5	$
6	Enter an estimate of your 2014 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero or less, enter "-0-"	7	$
8	**Divide** the amount on line 7 by $3,950 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**)	1	
2	Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3"	2	
3	If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet	3	

Note. If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4	Enter the number from line 2 of this worksheet	4	
5	Enter the number from line 1 of this worksheet	5	
6	**Subtract** line 5 from line 4	6	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here	7	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	$
9	Divide line 8 by the number of pay periods remaining in 2014. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2014. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	$

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $6,000	0	$0 - $6,000	0
6,001 - 13,000	1	6,001 - 16,000	1
13,001 - 24,000	2	16,001 - 25,000	2
24,001 - 26,000	3	25,001 - 34,000	3
26,001 - 33,000	4	34,001 - 43,000	4
33,001 - 43,000	5	43,001 - 70,000	5
43,001 - 49,000	6	70,001 - 85,000	6
49,001 - 60,000	7	85,001 - 110,000	7
60,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 100,000	10	140,001 and over	10
100,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $74,000	$590	$0 - $37,000	$590
74,001 - 130,000	990	37,001 - 80,000	990
130,001 - 200,000	1,110	80,001 - 175,000	1,110
200,001 - 355,000	1,300	175,001 - 385,000	1,300
355,001 - 400,000	1,380	385,001 and over	1,560
400,001 and over	1,560		

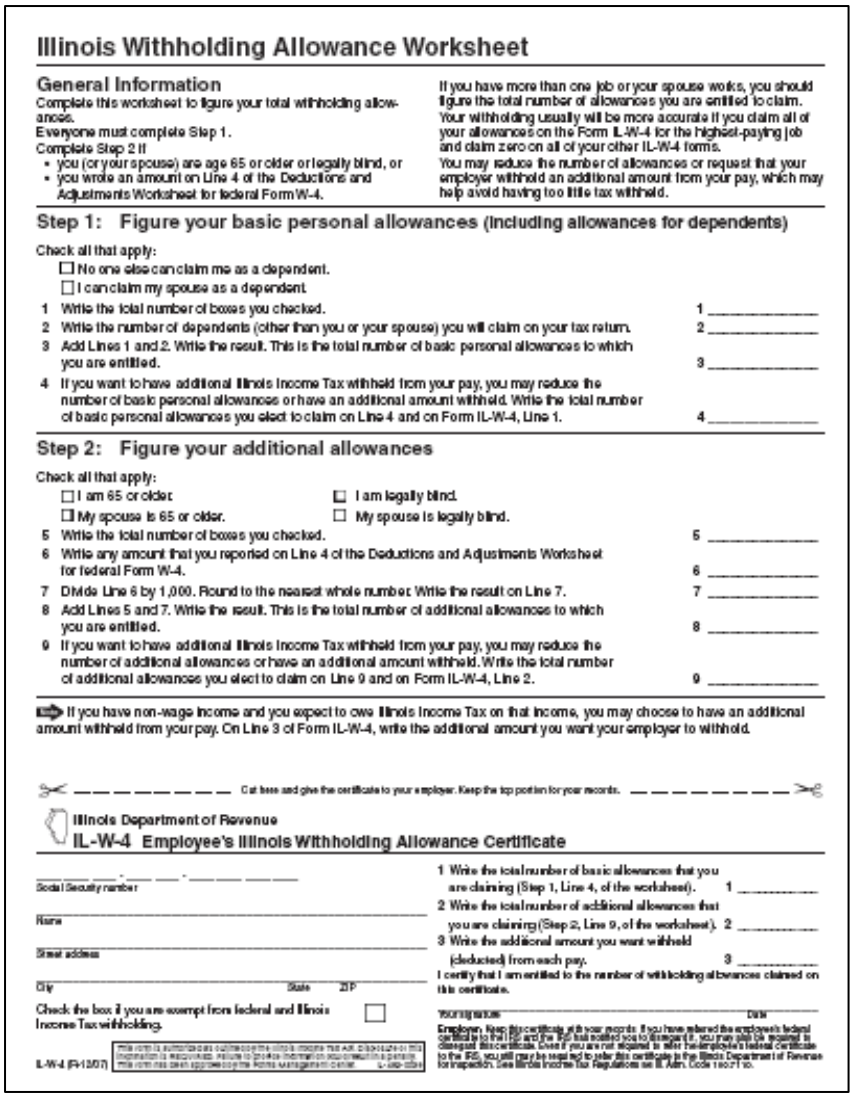
Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

IL FORM IL-W-4 INSTRUCTIONS
Employee Withholding Certificate



Illinois Withholding Allowance Worksheet

General Information

Complete this worksheet to figure your total withholding allowances.
Everyone must complete Step 1.
Complete Step 2 if
- you (or your spouse) are age 65 or older or legally blind, or
- you wrote an amount on Line 4 of the Deductions and Adjustments Worksheet for federal Form W-4.

If you have more than one job or your spouse works, you should figure the total number of allowances you are entitled to claim. Your withholding usually will be more accurate if you claim all of your allowances on the Form IL-W-4 for the highest-paying job and claim zero on all of your other IL-W-4 forms.
You may reduce the number of allowances or request that your employer withhold an additional amount from your pay, which may help avoid having too little tax withheld.

Step 1: Figure your basic personal allowances (including allowances for dependents)

Check all that apply:
☐ No one else can claim me as a dependent.
☐ I can claim my spouse as a dependent.

1 Write the total number of boxes you checked. 1 _____
2 Write the number of dependents (other than you or your spouse) you will claim on your tax return. 2 _____
3 Add Lines 1 and 2. Write the result. This is the total number of basic personal allowances to which you are entitled. 3 _____
4 If you want to have additional Illinois Income Tax withheld from your pay, you may reduce the number of basic personal allowances or have an additional amount withheld. Write the total number of basic personal allowances you elect to claim on Line 4 and on Form IL-W-4, Line 1. 4 _____

Step 2: Figure your additional allowances

Check all that apply:
☐ I am 65 or older. ☐ I am legally blind.
☐ My spouse is 65 or older. ☐ My spouse is legally blind.

5 Write the total number of boxes you checked. 5 _____
6 Write any amount that you reported on Line 4 of the Deductions and Adjustments Worksheet for federal Form W-4. 6 _____
7 Divide Line 6 by 1,000. Round to the nearest whole number. Write the result on Line 7. 7 _____
8 Add Lines 5 and 7. Write the result. This is the total number of additional allowances to which you are entitled. 8 _____
9 If you want to have additional Illinois Income Tax withheld from your pay, you may reduce the number of additional allowances or have an additional amount withheld. Write the total number of additional allowances you elect to claim on Line 9 and on Form IL-W-4, Line 2. 9 _____

Hint If you have non-wage income and you expect to owe Illinois Income Tax on that income, you may choose to have an additional amount withheld from your pay. On Line 3 of Form IL-W-4, write the additional amount you want your employer to withhold.

Cut here and give the certificate to your employer. Keep the top portion for your records.

Illinois Department of Revenue
IL-W-4 Employee's Illinois Withholding Allowance Certificate

Social Security number
Name
Street address
City State ZIP

Check the box if you are exempt from federal and Illinois Income Tax withholding. ☐

1 Write the total number of basic allowances that you are claiming (Step 1, Line 4, of the worksheet). 1 _____
2 Write the total number of additional allowances that you are claiming (Step 2, Line 9, of the worksheet). 2 _____
3 Write the additional amount you want withheld (deducted) from each pay. 3 _____

I certify that I am entitled to the number of withholding allowances claimed on this certificate.

Your signature Date

Employer: Keep this certificate with your records. If you have relieved the employee's federal certificate or the IRS has notified you to disregard it, you may also be required to disregard this certificate. Even if you are not required to refer the employee's federal certificate to the IRS, you still may be required to refer this certificate to the Illinois Department of Revenue for inspection. See Illinois Income Tax Regulations at Ill. Adm. Code 1401.71 (c).

IL-W-4 (R-12/07)

What is it for?
This form tells the IL Department of Revenue (IL DOR) about the withholding allowances for which the employee is eligible.

Who needs to sign?
Every provider working with a participant who is self-directing services through Public Partnerships, LLC.

What if I do not want to sign this tax form?
PPL needs this form completed and signed in order to withhold taxes with your desired allowances. If you do not return an IL W-4 to PPL we will be required to withhold State income taxes at the highest rate (with zero allowances).

How should I complete the IL-W-4 worksheet?
The PPL cannot give advice about what allowances you should claim. If you have questions about what allowances you should claim, contact your personal tax professional.

Phone: **(888) 866-0582** **Administrative Fax:** (866) 826-7287
TTY: **(800) 360-5899** **Timesheet Fax:** (866) 340-1653
Email: ildd@pcgus.com **Web:** www.publicpartnerships.com

Illinois Department of Revenue

Form IL-W-4

Employee's Illinois Withholding Allowance Certificate and Instructions

Who must complete this form?

If you are an employee, you must complete this form so your employer can withhold the correct amount of Illinois Income Tax from your pay. The amount withheld from your pay depends, in part, on the number of allowances you claim on this form.

Even if you claimed exemption from withholding on your federal Form W-4, U.S. Employee's Withholding Allowance Certificate, because you do not expect to owe any federal income tax, you may be required to have Illinois Income Tax withheld from your pay. If you are claiming exempt status (see Publication 131, Withholding Income Tax Filing and Payment Requirements) from Illinois withholding, you must check the exempt status box on the IL-W-4.

Note If you do not file a completed Form IL-W-4 with your employer, if you fail to sign the form or to include all necessary information, or if you alter the form, your employer must withhold Illinois Income Tax on the entire amount of your compensation, without allowing any exemptions.

When must I file?

You must file Form IL-W-4 when Illinois Income Tax is required to be withheld from compensation that you receive as an employee. You should complete this form and give it to your employer on or before the date you start working for your employer. You may file a new Form IL-W-4 any time your withholding allowances increase. If the number of your previously claimed allowances decreases, you **must** file a new Form IL-W-4 within 10 days. However, the death of a spouse or a dependent does not affect your withholding allowances until the next tax year.

When does my Form IL-W-4 take effect?

If you do not already have a Form IL-W-4 on file with your employer, this form will be effective for the first payment of compensation made to you after this form is filed. If you already have a Form IL-W-4 on file with this employer, your employer may allow any change you file on this form to become effective immediately, but is not required by law to change your withholding until the first payment of compensation is made to you after the first day of the next calendar quarter (that is, January 1, April 1, July 1, or October 1) that falls at least 30 days after the date you file the change with your employer.

Example: If you have a baby and file a new Form IL-W-4 with your employer to claim an additional exemption for the baby, your employer may immediately change the withholding for all future payments of compensation. However, if you file the new form on September 1, your employer does not have to change your withholding until the first payment of compensation is made to you after October 1. If you file the new form on September 2, your employer does not have to change your withholding until the first payment of compensation made to you after December 31.

How long is Form IL-W-4 valid?

Your Form IL-W-4 remains valid until a new form you have filed takes effect or until your employer is required by the department to disregard it. Your employer is required to disregard your Form IL-W-4 if you claim total exemption from Illinois Income Tax withholding, but you have not filed a federal Form W-4 claiming total exemption. Also, if the Internal Revenue Service (IRS) has instructed your employer to disregard your federal Form W-4, your employer must also disregard your Form IL-W-4. Finally, if you claim 15 or more exemptions on your Form IL-W-4 without claiming at least the same number of exemptions on your federal Form W-4, and your employer is not required to refer your federal Form W-4 to the IRS for review, your employer must refer your Form IL-W-4 to the department for review. In that case, your Form IL-W-4 will be effective unless and until the department notifies your employer to disregard it.

What is an "exemption"?

An "exemption" is a dollar amount on which you do not have to pay Illinois Income Tax. Therefore, your employer will withhold Illinois Income Tax based on your compensation minus the exemptions to which you are entitled.

What is an "allowance"?

The dollar amount that is exempt from Illinois Income Tax is based on the number of allowances you claim on this form. As an employee, you receive one allowance unless you are claimed as a dependent on another person's tax return (*e.g.,* your parents claim you as a dependent on their tax return). If you are married, you may claim additional allowances for your spouse and any dependents that you are entitled to claim for federal income tax purposes. You also will receive additional allowances if you or your spouse are age 65 or older, or if you or your spouse are legally blind.

How do I figure the correct number of allowances?

Complete the worksheet on the back of this page to figure the correct number of allowances you are entitled to claim. Give your completed Form IL-W-4 to your employer. Keep the worksheet for your records.

Note If you have more than one job or your spouse works, you should figure the total number of allowances you are entitled to claim. Your withholding usually will be more accurate if you claim all of your allowances on the Form IL-W-4 for the highest-paying job and claim zero on all of your other IL-W-4 forms.

What if I underpay my tax?

If the amount withheld from your compensation is not enough to cover your tax liability for the year, (*e.g.*, you have non-wage income, such as interest or dividends), you may reduce the number of allowances or request that your employer withhold an additional amount from your pay. Otherwise, you may owe additional tax at the end of the year. If you do not have enough tax withheld from your pay, and you owe more than $500 tax at the end of the year, you may owe a late-payment penalty. You should either increase the amount you have withheld from your pay, or you must make estimated tax payments.

You may be assessed a **late-payment penalty** if your required estimated payments are not paid in full by the due dates.

Note You may still owe this penalty for an earlier quarter, even if you pay enough tax later to make up the underpayment from a previous quarter.

For additional information on penalties, see Publication 103, Uniform Penalties and Interest. Visit our web site at **tax.illinois.gov** to obtain a copy.

Where do I get help?

- Visit our web site at **tax.illinois.gov**
- Call our Taxpayer Assistance Division at **1 800 732-8866** or **217 782-3336**
- Call our TDD (telecommunications device for the deaf) at **1 800 544-5304**
- Write to
  ILLINOIS DEPARTMENT OF REVENUE
  PO BOX 19044
  SPRINGFIELD IL 62794-9044

Illinois Withholding Allowance Worksheet

General Information

Complete this worksheet to figure your total withholding allowances.

Everyone must complete Step 1.

Complete Step 2 if

- you (or your spouse) are age 65 or older or legally blind, or
- you wrote an amount on Line 4 of the Deductions and Adjustments Worksheet for federal Form W-4.

If you have more than one job or your spouse works, you should figure the total number of allowances you are entitled to claim. Your withholding usually will be more accurate if you claim all of your allowances on the Form IL-W-4 for the highest-paying job and claim zero on all of your other IL-W-4 forms.

You may reduce the number of allowances or request that your employer withhold an additional amount from your pay, which may help avoid having too little tax withheld.

Step 1: Figure your basic personal allowances (including allowances for dependents)

Check all that apply:

☐ No one else can claim me as a dependent.

☐ I can claim my spouse as a dependent.

1 Write the total number of boxes you checked. **1** _____

2 Write the number of dependents (other than you or your spouse) you will claim on your tax return. **2** _____

3 Add Lines 1 and 2. Write the result. This is the total number of basic personal allowances to which you are **entitled**. **3** _____

4 If you want to have additional Illinois Income Tax withheld from your pay, you may reduce the number of basic personal allowances or have an additional amount withheld. Write the total number of basic personal allowances you elect to claim on Line 4 and on Form IL-W-4, Line 1. **4** _____

Step 2: Figure your additional allowances

Check all that apply:

☐ I am 65 or older. ☐ I am legally blind.

☐ My spouse is 65 or older. ☐ My spouse is legally blind.

5 Write the total number of boxes you checked. **5** _____

6 Write any amount that you reported on Line 4 of the Deductions and Adjustments Worksheet for federal Form W-4. **6** _____

7 Divide Line 6 by 1,000. Round to the nearest whole number. Write the result on Line 7. **7** _____

8 Add Lines 5 and 7. Write the result. This is the total number of additional allowances to which you are **entitled**. **8** _____

9 If you want to have additional Illinois Income Tax withheld from your pay, you may reduce the number of additional allowances or have an additional amount withheld. Write the total number of additional allowances you elect to claim on Line 9 and on Form IL-W-4, Line 2. **9** _____

Note If you have non-wage income and you expect to owe Illinois Income Tax on that income, you may choose to have an additional amount withheld from your pay. On Line 3 of Form IL-W-4, write the additional amount you want your employer to withhold.

Cut here and give the certificate to your employer. Keep the top portion for your records.

Illinois Department of Revenue

IL-W-4 Employee's Illinois Withholding Allowance Certificate

____ ____ ____ - ____ ____ - ____ ____ ____ ____

Social Security number

Name

Street address

City State ZIP

Check the box if you are exempt from federal and Illinois Income Tax withholding. ☐

1 Write the total number of basic allowances that you are claiming (Step 1, Line 4, of the worksheet). **1** _____

2 Write the total number of additional allowances that you are claiming (Step 2, Line 9, of the worksheet). **2** _____

3 Write the additional amount you want withheld (deducted) from each pay. **3** _____

I certify that I am entitled to the number of withholding allowances claimed on this certificate.

Your signature Date

Employer: Keep this certificate with your records. If you have referred the employee's federal certificate to the IRS and the IRS has notified you to disregard it, you may also be required to disregard this certificate. Even if you are not required to refer the employee's federal certificate to the IRS, you still may be required to refer this certificate to the Illinois Department of Revenue for inspection. See Illinois Income Tax Regulations 86 Ill. Adm. Code 100.7110.

IL-W-4 (R-12/07)

This form is authorized as outlined by the Illinois Income Tax Act. Disclosure of this information is REQUIRED. Failure to provide information could result in a penalty. This form has been approved by the Forms Management Center. IL-492-0039

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Application for Tax Exemptions Based on Age, Student Status, and Family Relationship

Employees providing domestic services such as personal assistance may be exempt from paying certain federal and state taxes based on the employee's age, student status, or family relationship to the employer. In some cases, the employer may also be exempt based on the employee's status. These exemptions are not optional. If you and your employer qualify for these exemptions, you must take them. IMPORTANT: If your wages are exempt from certain taxes you may not qualify for related benefits such as retirement benefits and unemployment compensation. Please consult IRS Publication #926 and IRS website article: Foreign Student Liability for Social Security and Medicare Taxes. Public Partnerships cannot provide tax advice. IMPORTANT: The questions regarding family relationship refer to the relationship between the employee and the employer. In some cases, the program participant is the employer. In other cases, the employer of record may be someone other than the program participant. Check program rules.

State/Program: _____ Participant Name: _____

Employer Name: _____ Employee Name: _____

1. Tax Exemptions for Foreign Students in the United States for the Purpose of Providing Domestic Services

1.1. Are you a non-resident alien temporarily in the United States on an F-1, J-1, M-1, or Q-1 visa admitted to the US for the purpose of providing domestic services?

Yes ☐ That description fits my status.

No ☐ That description does not fit my status.

If answer is "Yes", the employer and employee are exempt from paying FICA (Social Security and Medicare taxes) and the employer is exempt from paying FUTA (Federal Unemployment Tax) on wages paid to this employee. The employer may also be exempt from paying State Unemployment Insurance Tax, depending on the rules in the state.

2. Tax Exemptions for Child Under 21 Employed by his/her Own Parent

2.1. Are you the child of the employer?

Yes ☐ I am an employee in the participant direction program and my employer is my parent.
Employee Date of Birth: _____/_____/_____

No ☐ My employer is not my parent.

If answer is "Yes" and the child employee is under 21 during the entire tax year, the employer and employee are both exempt from paying FICA (Social Security and Medicare taxes) and the employer is exempt from paying FUTA (Federal Unemployment Tax) on wages paid to this employee. The payments are subject to both FICA and FUTA tax when the employee reaches age 21. The employer may also be exempt from paying State Unemployment Insurance Tax, depending on the rules in the state.

Public Partnerships, LLC
Financial Administrator
6 Admiral's Way
Chelsea, MA 02150

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3. Tax Exemptions for Spouse Employed by his/her own Spouse

3.1. Is the employer your spouse? IMPORTANT: Not permitted in some programs. Check program rules.

Yes	☐	I am an employee in the participant direction program and my employer is my spouse.
No	☐	My employer is not my spouse.

If answer is "Yes", the employer and employee are exempt from paying FICA (Social Security and Medicare taxes) and the employer is exempt from paying FUTA (Federal Unemployment Tax) on wages paid to this employee. The employer may also be exempt from paying State Unemployment Insurance Tax, depending on the rules in the state.

4. Tax Exemptions for Parent Employed by his/her own Child

4.1. Are you the parent of the employer?

Yes	☐	I am an employee in the participant direction program and my employer is my child.
No	☐	My employer is not my child.

If answer is "Yes", the employer does not owe FUTA taxes. The employer may also be exempt from paying State Unemployment Insurance Tax, depending on the rules in the state. The employer and employee may be exempt from FICA taxes, depending on the answers to the "Additional Questions for Parent Employed by this/her Own Child" below.

5. Additional Questions for Parent Employed by his/her Own Child

Answer the questions in this section only if you answered "Yes" to Question #4 above.

5.1. Do you care for your grandchild or step-grandchild who is living in your son or daughter's home?

Yes	☐	I am an employee in the participant direction program, my employer is my child and I also provide care for my grandchild in my child's home.
No	☐	I do not provide care for my grandchild.

If answer is "Yes", go on to the next question. If answer is "No", employee and employer are exempt from paying FICA (Social Security and Medicare tax).

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Financial Administrator
6 Admiral's Way
Chelsea, MA 02150

5.2. Is your grandchild or step-grandchild under age 18 OR does he/she have a physical or mental condition that requires the personal care of an adult for at least 4 continuous weeks during the calendar quarter in which services are performed?

Yes	☐	I am an employee in the participant direction program, my employer is my child and that description fits my grandchild or step-grandchild.
No	☐	That description does not fit my grandchild or step-grandchild.

If answer is "Yes", go on to the next question. If answer is "No", employee and employer are exempt from paying FICA (Social Security and Medicare tax).

5.3. Is your son or daughter (your employer) widowed or divorced (and not remarried), or living with a spouse who has a mental or physical condition which prohibits the spouse from caring for your grandchild for at least 4 continuous weeks during the calendar quarter in which services are performed?

Yes	☐	I am an employee in the participant direction program, my employer is my child and that description fits my son or daughter (my employer).
No	☐	That description does not fit my son or daughter (my employer).

If answer is "Yes", employee and employer must pay FICA (Social Security and Medicare taxes). If answer is "No", employee and employer are exempt from paying FICA.

If the employee answered "No" to any of the above "Additional Questions for Parent Employed by their Own Child", the employer and employee are exempt from paying FICA (Social Security and Medicare taxes).

If the employee answered "Yes" to all of the above "Additional Questions for Parent Employed by their own Child", employee and employer must pay FICA (Social Security and Medicare taxes) for wages paid to this employee. However, the employer is still exempt from FUTA taxes, and may also be exempt from paying State Unemployment Insurance Tax, depending on the rules in the state.

6. Tax Exemption for Employees under the Age of 18

6.1. Are you under the age of 18, or will turn 18 in this calendar/tax year?

Yes	☐	I am under the age of 18, or will turn 18 in this calendar/tax year Employee Date of Birth: _____/_____/_____
No	☐	I am over the age of 18 for the entire tax year.

If answer is "Yes", go on to the next question. If answer is "No", the employer and employee are not exempt from paying FICA (Social Security and Medicare taxes).

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6.2. Is this job or performing household services your principal occupation? If you are a student, check "No".

Yes	☐	This job or performing household services is my principal occupation and I am NOT a student.
No	☐	No.

If answer is "Yes", employee and employer are exempt from paying FICA (Social Security and Medicare). The employer may also be exempt from paying State Unemployment Insurance Tax, depending on the rules in the state. If answer is "No", the employer and employee are not exempt from paying FICA (Social Security and Medicare taxes).

To be Completed by Employee:

I, _____ hereby certify that the information presented above is complete and correct to the best of my knowledge.

Please print your name

_____ _____

Employee signature | Date

To be Completed by Employer:

_____ _____

Participant Name | State Program Name

I, _____ hereby certify that the information presented above is complete and correct to the best of my knowledge

Employer Name (may be different from participant)

_____ _____

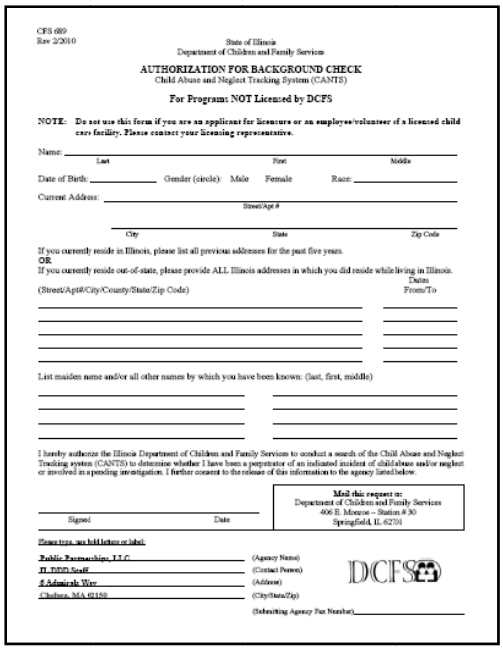
Employer Signature | Date

IMPORTANT: You must notify PPL if your student status or family relationship changes.

Revised 12/15/2011 for use in programs with employer authority (Version 14)

Public Partnerships, LLC
Financial Administrator
6 Admiral's Way
Chelsea, MA 02150

IL DCFS AUTHORIZATION FOR CANTS Check & ISP CHRI Request



CFS 689
Rev 2/2010

State of Illinois
Department of Children and Family Services

AUTHORIZATION FOR BACKGROUND CHECK
Child Abuse and Neglect Tracking System (CANTS)

For Programs NOT Licensed by DCFS

NOTE: Do not use this form if you are an applicant for licensure or an employee/volunteer of a licensed child care facility. Please contact your licensing representative.

Name: _____ (Last) (First) (Middle)

Date of Birth: _____ Gender (circle): Male Female Race: _____

Current Address: _____ (Street/Apt #)

_____ (City) (State) (Zip Code)

If you currently reside in Illinois, please list all previous addresses for the past five years.
OR
If you currently reside out-of-state, please provide ALL Illinois addresses in which you did reside while living in Illinois.

(Street/Apt#/City/County/State/Zip Code) Dates From/To

List maiden name and/or all other names by which you have been known: (last, first, middle)

I hereby authorize the Illinois Department of Children and Family Services to conduct a search of the Child Abuse and Neglect Tracking system (CANTS) to determine whether I have been a perpetrator of an indicated incident of child abuse and/or neglect or involved in a pending investigation. I further consent to the release of this information to the agency listed below.

Signed Date

Mail this request to:
Department of Children and Family Services
406 E. Monroe – Station # 30
Springfield, IL 62701

Please type, use bold letters or label.

Public Partnerships, LLC (Agency Name)
IT DD/PA Staff (Contact Person)
6 Admirals Way (Address)
Chelsea, MA 02150 (City/State/Zip)
(Submitting Agency Fax Number)

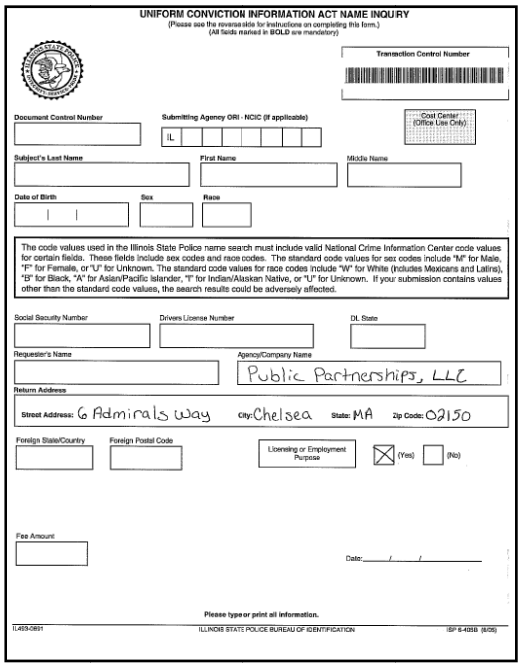
DCFS

What are these forms for?

These forms authorize the Department of Children and Family Services to conduct a search of the Child Abuse and Neglect Tracking system (CANTS) to determine if you have been a perpetrator of an indicated incident of child abuse and/or neglect and the Illinois State Police to conduct a search of Criminal History Record Information.

What happens after PPL submits these forms?

PPL will receive your results from DCFS and ISP. If you have any findings, you will not be eligible for employment in the IL DD program. PPL pays the processing fees for these background checks.



UNIFORM CONVICTION INFORMATION ACT NAME INQUIRY
(Please see the reverse side for instructions on completing this form.)
(All fields marked in BOLD are mandatory)

Transaction Control Number

Document Control Number | Submitting Agency ORI - NCIC (if applicable) IL | Cost Center (Office Use Only)

Subject's Last Name | First Name | Middle Name

Date of Birth | Sex | Race

The code values used in the Illinois State Police name search must include valid National Crime Information Center code values for certain fields. These fields include sex codes and race codes. The standard code values for sex codes include "M" for Male, "F" for Female, or "U" for Unknown. The standard code values for race codes include "W" for White (includes Mexicans and Latins), "B" for Black, "A" for Asian/Pacific Islander, "I" for Indian/Alaskan Native, or "U" for Unknown. If your submission contains values other than the standard code values, the search results could be adversely affected.

Social Security Number | Drivers License Number | DL State

Requester's Name | Agency/Company Name: Public Partnerships, LLC

Return Address

Street Address: 6 Admirals Way City: Chelsea State: MA Zip Code: 02150

Foreign State/Country | Foreign Postal Code

Licensing or Employment Purpose (Yes) (No)

Fee Amount

Date: ___/___/___

Please type or print all information.

IL493-0891 ILLINOIS STATE POLICE BUREAU OF IDENTIFICATION ISP 8-429B (6/05)

What if I do not want to fill out these forms?

If you do not complete and sign these forms PPL cannot complete your criminal background and registry checks. These processes are required in order to be employed by a participant in the IL DD program. If you do not complete or sign this form, you cannot be employed.

What sections do I have to complete?

Please complete all applicable information on the CANTS form. For the Uniform conviction form, you should fill out your name, date of birth, sex, race, social security number and drivers license number (if you have one).

Phone: **(888) 866-0582** **Administrative Fax:** (866) 826-7287
TTY: **(800) 360-5899** **Timesheet Fax:** (866) 340-1653
Email: ildd@pcgus.com **Web:** www.publicpartnerships.com

CFS 689
Rev 2/2010

State of Illinois
Department of Children and Family Services

AUTHORIZATION FOR BACKGROUND CHECK

Child Abuse and Neglect Tracking System (CANTS)

For Programs NOT Licensed by DCFS

NOTE: Do not use this form if you are an applicant for licensure or an employee/volunteer of a licensed child care facility. Please contact your licensing representative.

Name: _____
Last First Middle

Date of Birth: _____ Gender (circle): Male Female Race: _____

Current Address: _____
Street/Apt #

_____
City State Zip Code

If you currently reside in Illinois, please list all previous addresses for the past five years.
OR
If you currently reside out-of-state, please provide ALL Illinois addresses in which you did reside while living in Illinois.

(Street/Apt#/City/County/State/Zip Code)	Dates From/To

List maiden name and/or all other names by which you have been known: (last, first, middle)

I hereby authorize the Illinois Department of Children and Family Services to conduct a search of the Child Abuse and Neglect Tracking system (CANTS) to determine whether I have been a perpetrator of an indicated incident of child abuse and/or neglect or involved in a pending investigation. I further consent to the release of this information to the agency listed below.

_____
Signed Date

Mail this request to:
Department of Children and Family Services
406 E. Monroe – Station # 30
Springfield, IL 62701

Please type, use bold letters or label:

Public Partnerships, LLC (Agency Name)
Attn: IL DD Staff (Contact Person)
6 Admirals Way (Address)
Chelsea, MA 02150 (City/State/Zip)

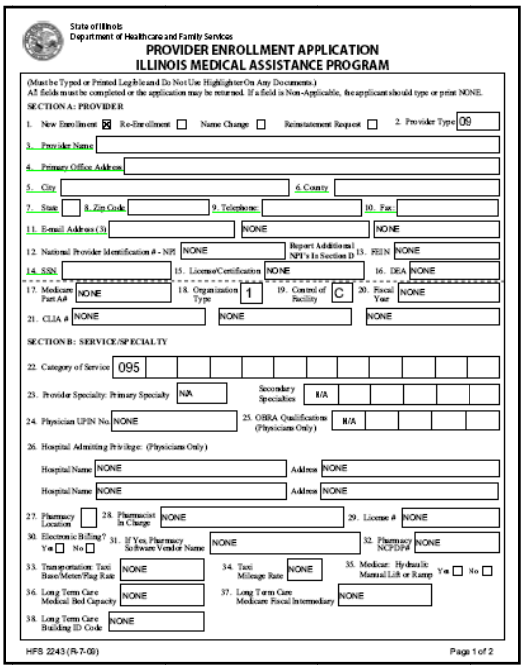
(Submitting Agency Fax Number) (866) 826-7287

PUBLIC PARTNERSHIPS

IL DHFS
Provider Enrollment Application

What is this form for?

This form authorizes the Department of Healthcare and Family Services to enroll you as a provider of Home Based Services in either the Adult DD Waiver or Children's Support Waiver, depending on your participant's waiver participation.



State of Illinois
Department of Healthcare and Family Services
PROVIDER ENROLLMENT APPLICATION
ILLINOIS MEDICAL ASSISTANCE PROGRAM

(Must be Typed or Printed Legible and Do Not Use Highlighter On Any Documents.)
All fields must be completed or the application may be returned. If a field is Non-Applicable, the applicant should type or print NONE.

SECTION A: PROVIDER

1. New Enrollment ☒ Re-Enrollment ☐ Name Change ☐ Reinstatement Request ☐ 2. Provider Type 09
3. Provider Name
4. Primary Office Address
5. City 6. County
7. State 8. Zip Code 9. Telephone 10. Fax
11. E-mail Address (3) NONE NONE
12. National Provider Identification # - NPI NONE Report Additional NPI's In Section D 13. FEIN NONE
14. SSN 15. License/Certification NONE 16. DEA NONE
17. Medicare Part A# NONE 18. Organization Type 1 19. Control of Facility C 20. Fiscal Year NONE
21. CLIA # NONE NONE NONE

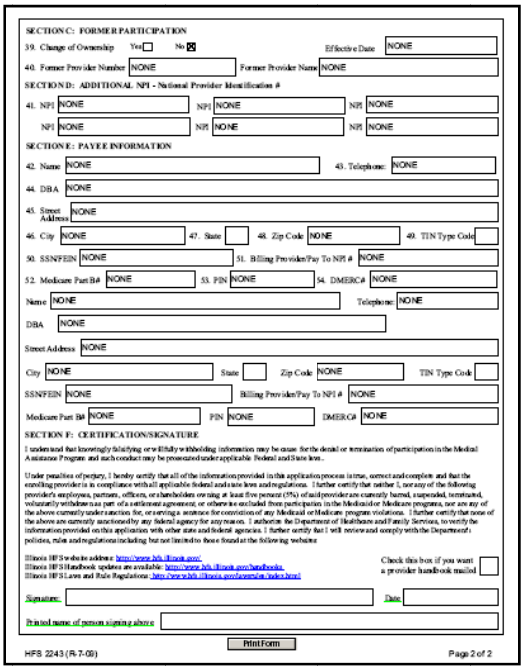
SECTION B: SERVICE/SPECIALTY

22. Category of Service 095
23. Provider Specialty: Primary Specialty N/A Secondary Specialties N/A
24. Physician UPIN No. NONE 25. OBRA Qualifications (Physicians Only) N/A
26. Hospital Admitting Privilege: (Physicians Only)
Hospital Name NONE Address NONE
Hospital Name NONE Address NONE
27. Pharmacy Location 28. Pharmacist In Charge NONE 29. License # NONE
30. Electronic Billing? Yes ☐ No ☐ 31. If Yes, Pharmacy Software Vendor Name NONE 32. Pharmacy NCPDP# NONE
33. Transportation: Taxi Base/Meter/Flag Rate NONE 34. Taxi Mileage Rate NONE 35. Medicaid: Hydraulic Manual Lift or Ramp Yes ☐ No ☐
36. Long Term Care Medicaid Bed Capacity NONE 37. Long Term Care Medicaid Fiscal Intermediary NONE
38. Long Term Care Building ID Code NONE

HFS 2243 (R-7-09) Page 1 of 2

What if I do not want to fill out these forms?

If you do not complete and sign these forms PPL cannot complete your Personal Support Worker registration. These processes are required in order to be employed by a participant in the IL DD program. If you do not complete or sign this form, you cannot be employed.



SECTION C: FORMER PARTICIPATION

39. Change of Ownership Yes ☐ No ☒ Effective Date NONE
40. Former Provider Number NONE Former Provider Name NONE

SECTION D: ADDITIONAL NPI - National Provider Identification #

41. NPI NONE NPI NONE NPI NONE
NPI NONE NPI NONE NPI NONE

SECTION E: PAYEE INFORMATION

42. Name NONE 43. Telephone NONE
44. DBA NONE
45. Street Address NONE
46. City NONE 47. State 48. Zip Code NONE 49. TIN Type Code
50. SSN/FEIN NONE 51. Billing Provider/Pay To NPI # NONE
52. Medicare Part B# NONE 53. PIN NONE 54. DMERC# NONE
Name NONE Telephone NONE
DBA NONE
Street Address NONE
City NONE State Zip Code NONE TIN Type Code
SSN/FEIN NONE Billing Provider/Pay To NPI # NONE
Medicare Part B# NONE PIN NONE DMERC# NONE

SECTION F: CERTIFICATION/SIGNATURE

I understand that knowingly falsifying or willfully withholding information may be cause for the denial or termination of participation in the Medical Assistance Program and such conduct may be prosecuted under applicable Federal and State laws.

Under penalties of perjury, I hereby certify that all of the information provided in this application process is true, correct and complete and that the enrolling provider is in compliance with all applicable federal and state laws and regulations. I further certify that neither I, nor any of the following provider's employees, partners, officers, or shareholders owning at least five percent (5%) of said provider are currently barred, suspended, terminated, voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from participation in the Medicaid or Medicare programs, nor are any of the above currently under sanction for, or serving a sentence for conviction of any Medicaid or Medicare program violations. I further certify that none of the above are currently sanctioned by any federal agency for any reason. I authorize the Department of Healthcare and Family Services, to verify the information provided on this application with other state and federal agencies. I further certify that I will review and comply with the Department's policies, rules and regulations including but not limited to those found at the following websites:

Illinois HFS website address: http://www.hfs.illinois.gov/
Illinois HFS Handbook updates are available: http://www.hfs.illinois.gov/handbooks/
Illinois HFS Laws and Rule Regulations: http://www.hfs.illinois.gov/laws-rule/index.html

Check this box if you want a provider handbook mailed ☐

Signature: Date:
Printed name of person signing above:
Print Form

HFS 2243 (R-7-09) Page 2 of 2

What sections do I have to complete?

Please complete all applicable information above the dotted line on page one. You should be entering information in boxes 3-11 & your Social Security Number in Box 14. On page two, you must sign, date and print your name at the bottom of the form. All other areas have been pre-populated for you.

Phone: **(888) 866-0582** **Administrative Fax:** (866) 826-7287
TTY: **(800) 360-5899** **Timesheet Fax:** (866) 340-1653
Email: **ildd@pcgus.com** **Web:** **www.publicpartnerships.com**

State of Illinois
Department of Healthcare and Family Services

PROVIDER ENROLLMENT APPLICATION
ILLINOIS MEDICAL ASSISTANCE PROGRAM

(Must be Typed or Printed Legible and Do Not Use Highlighter On Any Documents.)
All fields must be completed or the application may be returned. If a field is Non-Applicable, the applicant should type or print NONE.

SECTION A: PROVIDER

1. New Enrollment ☒ Re-Enrollment ☐ Name Change ☐ Reinstatement Request ☐ 2. Provider Type 09

3. Provider Name

4. Primary Office Address

5. City 6. County

7. State 8. Zip Code 9. Telephone: 10. Fax:

11. E-mail Address (3) NONE NONE

12. National Provider Identification # - NPI NONE **Report Additional NPI's In Section D** 13. FEIN NONE

14. SSN 15. License/Certification NONE 16. DEA NONE

17. Medicare Part A# NONE 18. Organization Type 1 19. Control of Facility C 20. Fiscal Year NONE

21. CLIA # NONE NONE NONE

SECTION B: SERVICE/SPECIALTY

22. Category of Service 095

23. Provider Specialty: Primary Specialty N/A Secondary Specialties N/A

24. Physician UPIN No. NONE 25. OBRA Qualifications (Physicians Only) N/A

26. Hospital Admitting Privilege: (Physicians Only)

Hospital Name NONE Address NONE

Hospital Name NONE Address NONE

27. Pharmacy Location 28. Pharmacist In Charge NONE 29. License # NONE

30. Electronic Billing? Yes ☐ No ☐ 31. If Yes, Pharmacy Software Vendor Name NONE 32. Pharmacy NCPDP# NONE

33. Transportation: Taxi Base/Meter/Flag Rate NONE 34. Taxi Mileage Rate NONE 35. Medicar: Hydraulic Manual Lift or Ramp Yes ☐ No ☐

36. Long Term Care Medical Bed Capacity NONE 37. Long Term Care Medicare Fiscal Intermediary NONE

38. Long Term Care Building ID Code NONE

SECTION C: FORMER PARTICIPATION

39. Change of Ownership Yes ☐ No ☒ Effective Date NONE

40. Former Provider Number NONE Former Provider Name NONE

SECTION D: ADDITIONAL NPI - National Provider Identification #

41. NPI NONE NPI NONE NPI NONE

NPI NONE NPI NONE NPI NONE

SECTION E: PAYEE INFORMATION

42. Name NONE 43. Telephone: NONE

44. DBA NONE

45. Street Address NONE

46. City NONE 47. State 48. Zip Code NONE 49. TIN Type Code

50. SSN/FEIN NONE 51. Billing Provider/Pay To NPI # NONE

52. Medicare Part B# NONE 53. PIN NONE 54. DMERC# NONE

Name NONE Telephone: NONE

DBA NONE

Street Address NONE

City NONE State Zip Code NONE TIN Type Code

SSN/FEIN NONE Billing Provider/Pay To NPI # NONE

Medicare Part B# NONE PIN NONE DMERC# NONE

SECTION F: CERTIFICATION/SIGNATURE

I understand that knowingly falsifying or willfully withholding information may be cause for the denial or termination of participation in the Medical Assistance Program and such conduct may be prosecuted under applicable Federal and State laws..

Under penalties of perjury, I hereby certify that all of the information provided in this application process is true, correct and complete and that the enrolling provider is in compliance with all applicable federal and state laws and regulations. I further certify that neither I, nor any of the following provider's employees, partners, officers, or shareholders owning at least five percent (5%) of said provider are currently barred, suspended, terminated, voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from participation in the Medicaid or Medicare programs, nor are any of the above currently under sanction for, or serving a sentence for conviction of any Medicaid or Medicare program violations. I further certify that none of the above are currently sanctioned by any federal agency for any reason. I authorize the Department of Healthcare and Family Services, to verify the information provided on this application with other state and federal agencies. I further certify that I will review and comply with the Department's policies, rules and regulations including but not limited to those found at the following websites:

Illinois HFS website address: http://www.hfs.illinois.gov/
Illinois HFS Handbook updates are available: http://www.hfs.illinois.gov/handbooks
Illinois HFS Laws and Rule Regulations: http://www.hfs.illinois.gov/lawsrules/index.html

Check this box if you want a provider handbook mailed ☐

Signature: Date

Printed name of person signing above

Print Form

PUBLIC PARTNERSHIPS

IL DHFS PROVIDER
Agreement for Participation

What is this form for?

This form is an agreement between you the Provider and the Department of Healthcare and Family Services. You are agreeing to comply with all department regulations and report time worked correctly.

What happens after PPL submits these forms?

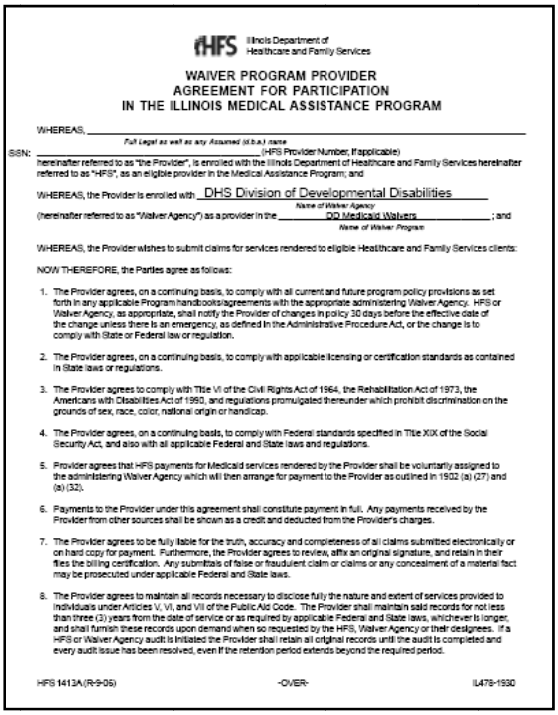
PPL sends these forms to the IL Department of Human Services for processing. PPL and DHS will retain copies of these forms.

What if I do not want to fill out these forms?

If you do not complete and sign these forms PPL cannot complete your Personal Support Worker registration. These processes are required in order to be employed by a participant in the IL DD program. If you do not complete or sign this form, you cannot be employed.

What sections do I have to complete?

You should print your name on the top line of page one and write in your Social Security Number on the line below. You then need to sign and date the Provider section at the bottom of page two and write in your SSN on the line labeled “Provider FEIN Number”.



IHFS Illinois Department of Healthcare and Family Services

WAIVER PROGRAM PROVIDER
AGREEMENT FOR PARTICIPATION
IN THE ILLINOIS MEDICAL ASSISTANCE PROGRAM

WHEREAS, _____
Full Legal as well as any Assumed (d.b.a.) name
SSN: _____ (HFS Provider Number, if applicable)
hereinafter referred to as "the Provider", is enrolled with the Illinois Department of Healthcare and Family Services hereinafter referred to as "HFS", as an eligible provider in the Medical Assistance Program; and

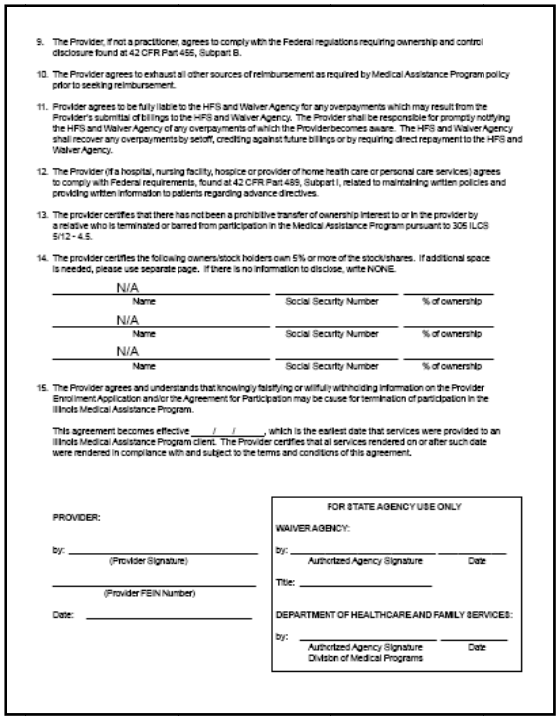
WHEREAS, the Provider is enrolled with DHS Division of Developmental Disabilities
Name of Waiver Agency
(hereinafter referred to as "Waiver Agency") as a provider in the DD Medicaid Waivers ; and
Name of Waiver Program

WHEREAS, the Provider wishes to submit claims for services rendered to eligible Healthcare and Family Services clients:

NOW THEREFORE, the Parties agree as follows:

1. The Provider agrees, on a continuing basis, to comply with all current and future program policy provisions as set forth in any applicable Program handbooks/agreements with the appropriate administering Waiver Agency. HFS or Waiver Agency, as appropriate, shall notify the Provider of changes in policy 30 days before the effective date of the change unless there is an emergency, as defined in the Administrative Procedure Act, or the change is to comply with State or Federal law or regulation.
2. The Provider agrees, on a continuing basis, to comply with applicable licensing or certification standards as contained in State laws or regulations.
3. The Provider agrees to comply with Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, and regulations promulgated thereunder which prohibit discrimination on the grounds of sex, race, color, national origin or handicap.
4. The Provider agrees, on a continuing basis, to comply with Federal standards specified in Title XIX of the Social Security Act, and also with all applicable Federal and State laws and regulations.
5. Provider agrees that HFS payments for Medicaid services rendered by the Provider shall be voluntarily assigned to the administering Waiver Agency which will then arrange for payment to the Provider as outlined in 1902 (a) (27) and (a) (32).
6. Payments to the Provider under this agreement shall constitute payment in full. Any payments received by the Provider from other sources shall be shown as a credit and deducted from the Provider's charges.
7. The Provider agrees to be fully liable for the truth, accuracy and completeness of all claims submitted electronically or on hard copy for payment. Furthermore, the Provider agrees to review, affix an original signature, and retain in their files the billing certification. Any submittals of false or fraudulent claim or claims or any concealment of a material fact may be prosecuted under applicable Federal and State laws.
8. The Provider agrees to maintain all records necessary to disclose fully the nature and extent of services provided to individuals under Articles V, VI, and VII of the Public Aid Code. The Provider shall maintain said records for not less than three (3) years from the date of service or as required by applicable Federal and State laws, whichever is longer, and shall furnish these records upon demand when so requested by the HFS, Waiver Agency or their designees. If a HFS or Waiver Agency audit is initiated the Provider shall retain all original records until the audit is completed and every audit issue has been resolved, even if the retention period extends beyond the required period.

HFS 1413A(R-9-05) -OVER- IL478-1930



9. The Provider, if not a practitioner, agrees to comply with the Federal regulations requiring ownership and control disclosure found at 42 CFR Part 455, Subpart B.
10. The Provider agrees to exhaust all other sources of reimbursement as required by Medical Assistance Program policy prior to seeking reimbursement.
11. Provider agrees to be fully liable to the HFS and Waiver Agency for any overpayments which may result from the Provider's submittal of billings to the HFS and Waiver Agency. The Provider shall be responsible for promptly notifying the HFS and Waiver Agency of any overpayments of which the Providerbecomes aware. The HFS and Waiver Agency shall recover any overpayments by setoff, crediting against future billings or by requiring direct repayment to the HFS and Waiver Agency.
12. The Provider (if a hospital, nursing facility, hospice or provider of home health care or personal care services) agrees to comply with Federal requirements, found at 42 CFR Part 489, Subpart I, related to maintaining written policies and providing written information to patients regarding advance directives.
13. The provider certifies that there has not been a prohibitive transfer of ownership interest to or in the provider by a relative who is terminated or barred from participation in the Medical Assistance Program pursuant to 305 ILCS 5/12-4.5.
14. The provider certifies the following owners/stock holders own 5% or more of the stock/shares. If additional space is needed, please use separate page. If there is no information to disclose, write NONE.

Name	Social Security Number	% of ownership
N/A		
N/A		
N/A		

15. The Provider agrees and understands that knowingly falsifying or willfully withholding information on the Provider Enrollment Application and/or the Agreement for Participation may be cause for termination of participation in the Illinois Medical Assistance Program.

This agreement becomes effective ___/___/___, which is the earliest date that services were provided to an Illinois Medical Assistance Program client. The Provider certifies that all services rendered on or after such date were rendered in compliance with and subject to the terms and conditions of this agreement.

PROVIDER:

by: _____ (Provider Signature)

_____ (Provider FEIN Number)

Date: _____

FOR STATE AGENCY USE ONLY

WAIVER AGENCY:

by: _____ Authorized Agency Signature _____ Date

Title: _____

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES:

by: _____ Authorized Agency Signature _____ Date
Division of Medical Programs

Phone:	**(888) 866-0582**	**Administrative Fax:**	(866) 826-7287
TTY:	**(800) 360-5899**	**Timesheet Fax:**	(866) 340-1653
Email:	**ildd@pcgus.com**	**Web:**	**www.publicpartnerships.com**

Illinois Department of
Healthcare and Family Services

WAIVER PROGRAM PROVIDER AGREEMENT FOR PARTICIPATION IN THE ILLINOIS MEDICAL ASSISTANCE PROGRAM

WHEREAS, _____
Full Legal as well as any Assumed (d.b.a.) name

SSN: _____ (HFS Provider Number, if applicable)

hereinafter referred to as "the Provider", is enrolled with the Illinois Department of Healthcare and Family Services hereinafter referred to as "HFS", as an eligible provider in the Medical Assistance Program; and

WHEREAS, the Provider is enrolled with DHS Division of Developmental Disabilities
Name of Waiver Agency

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1. The Provider agrees, on a continuing basis, to comply with all current and future program policy provisions as set forth in any applicable Program handbooks/agreements with the appropriate administering Waiver Agency. HFS or Waiver Agency, as appropriate, shall notify the Provider of changes in policy 30 days before the effective date of the change unless there is an emergency, as defined in the Administrative Procedure Act, or the change is to comply with State or Federal law or regulation.

2. The Provider agrees, on a continuing basis, to comply with applicable licensing or certification standards as contained in State laws or regulations.

3. The Provider agrees to comply with Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, and regulations promulgated thereunder which prohibit discrimination on the grounds of sex, race, color, national origin or handicap.

4. The Provider agrees, on a continuing basis, to comply with Federal standards specified in Title XIX of the Social Security Act, and also with all applicable Federal and State laws and regulations.

5. Provider agrees that HFS payments for Medicaid services rendered by the Provider shall be voluntarily assigned to the administering Waiver Agency which will then arrange for payment to the Provider as outlined in 1902 (a) (27) and (a) (32).

6. Payments to the Provider under this agreement shall constitute payment in full. Any payments received by the Provider from other sources shall be shown as a credit and deducted from the Provider's charges.

7. The Provider agrees to be fully liable for the truth, accuracy and completeness of all claims submitted electronically or on hard copy for payment. Furthermore, the Provider agrees to review, affix an original signature, and retain in their files the billing certification. Any submittals of false or fraudulent claim or claims or any concealment of a material fact may be prosecuted under applicable Federal and State laws.

8. The Provider agrees to maintain all records necessary to disclose fully the nature and extent of services provided to individuals under Articles V, VI, and VII of the Public Aid Code. The Provider shall maintain said records for not less than three (3) years from the date of service or as required by applicable Federal and State laws, whichever is longer, and shall furnish these records upon demand when so requested by the HFS, Waiver Agency or their designees. If a HFS or Waiver Agency audit is initiated the Provider shall retain all original records until the audit is completed and every audit issue has been resolved, even if the retention period extends beyond the required period.

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10. The Provider agrees to exhaust all other sources of reimbursement as required by Medical Assistance Program policy prior to seeking reimbursement.

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12. The Provider (if a hospital, nursing facility, hospice or provider of home health care or personal care services) agrees to comply with Federal requirements, found at 42 CFR Part 489, Subpart I, related to maintaining written policies and providing written information to patients regarding advance directives.

13. The provider certifies that there has not been a prohibitive transfer of ownership interest to or in the provider by a relative who is terminated or barred from participation in the Medical Assistance Program pursuant to 305 ILCS 5/12 - 4.5.

14. The provider certifies the following owners/stock holders own 5% or more of the stock/shares. If additional space is needed, please use separate page. If there is no information to disclose, write NONE.

Name	Social Security Number	% of ownership
N/A		
N/A		
N/A		

15. The Provider agrees and understands that knowingly falsifying or willfully withholding information on the Provider Enrollment Application and/or the Agreement for Participation may be cause for termination of participation in the Illinois Medical Assistance Program.

    This agreement becomes effective ____/___/_____, which is the earliest date that services were provided to an Illinois Medical Assistance Program client. The Provider certifies that all services rendered on or after such date were rendered in compliance with and subject to the terms and conditions of this agreement.

PROVIDER:

by: _____
(Provider Signature)

_____
(Provider FEIN Number)

Date: _____

FOR STATE AGENCY USE ONLY

WAIVER AGENCY:

by: _____ _____
Authorized Agency Signature Date

Title: _____

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES:

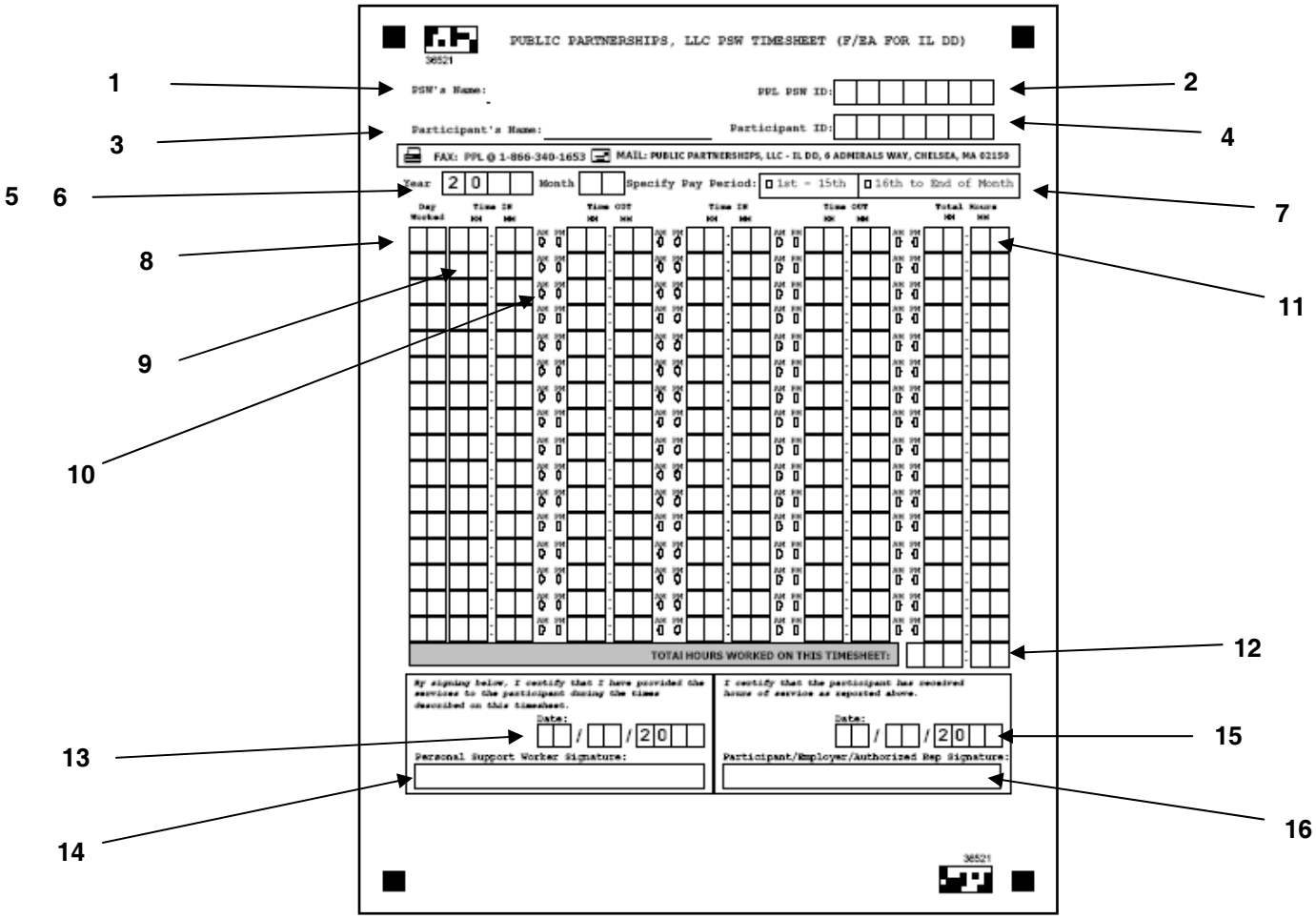
by: _____ _____
Authorized Agency Signature Date
Division of Medical Programs

IL DD Paper Timesheet Instructions

If you cannot submit your timesheets by using the Web Portal, you can submit a paper timesheet via fax or mail. If you submit via paper, timesheets are read by a machine (like the ones that read standardized tests) so it is important that you fill out the timesheets clearly and completely.

Whether you have used other timesheets or not, you are probably wondering, "How in the world am I supposed to fill out this timesheet?" This worksheet should provide you with clear instructions for doing so.

There are 16 required fields on our timesheet. These are described below:



Required Fields

All of these fields MUST be completed for the timesheet to be paid.

Phone:	**(888) 866-0582**	**Administrative Fax:**	(866) 826-7287
TTY:	**(800) 360-5899**	**Timesheet Fax:**	(866) 340-1653
Email:	**ilddd@pcgus.com**	**Web:**	**www.publicpartnerships.com**

IL DD PAPER TIMESHEET INSTRUCTIONS

For assistance, call Customer Service at (888) 866-0582.

This list corresponds to the picture on the previous page.

1. **PSW's Name.** Enter the name of the person providing services.
2. **PPL PSW ID.** This is the PPL ID given to the provider. It begins with the letter E and is followed by 4-6 digits. Please call Customer Service to verify your Provider ID.
3. **Participant's Name.** Enter the name of the person receiving services.
4. **Participant ID.** This is the Participant's ID number. It can be found on the participant's Individual Service Plan. Customer Service can also verify this ID number.
5. **Year:** The year in which you worked.
6. **Month:** The two digit number of the month.
7. **Specify Pay period.** There are two different pay periods: the one that runs from the first to the 15th of the month, and the one that runs from the 16th to the end of the month. Select the appropriate one.
8. **Day Worked:** Enter the date you worked. (Example, for the 1st of the month write, "01". for the 22nd write, "22".)
9. **Time In/Time Out.** Enter in the time you started working and the time you finished working. Please see instructions below for entering overnight time and multiple times per day
10. **AM/PM.** Fill in the circle indicating if you worked in the AM or PM.
11. **Total Hours Worked.** This is the total number of hours (both shifts combined) that you worked on that day.
12. **Total Hours Worked**. Enter the total hours worked as reported on this timesheet.
13. **Date of PSW Signature.** This is the date that the PSW signed the timesheet.
14. **PSW Signature.** This is the signature of the PSW.
15. **Date of Participant Signature.** This is the date the Participant/Employer signed the timesheet.
16. **Participant Signature.** This is the Participant/Employer's signature. An 'X' or a mark is accepted as a signature.

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TTY:	**(800) 360-5899**	**Timesheet Fax:**	(866) 340-1653
Email:	**ildd@pcgus.com**	**Web:**	**www.publicpartnerships.com**

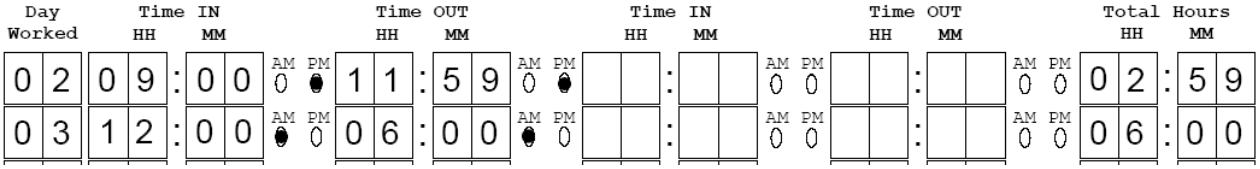
IL DD PAPER TIMESHEET INSTRUCTIONS

For assistance, call Customer Service at (888) 866-0582.

Special Situations

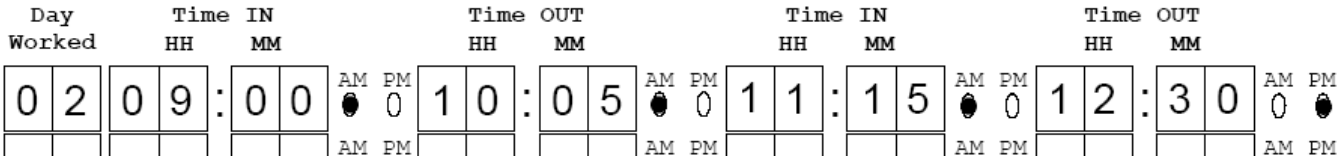
1. **Working overnight.** When you work overnight, there are special instructions for completing the timesheet. You must complete one line for work you did before midnight and another line for work you did after midnight.

For example, say you worked overnight on the 2nd from 9:00 PM to 6:00 AM. Enter the start time on the 2nd as 9:00 PM as seen below. Enter the end time for that day as 11:59 PM. Now, you did not finish working at 11:59 PM, you just finished working on the 2nd at that time. Enter the rest of your time on the 3rd as shown below – 12:00 AM to 6:00 AM.

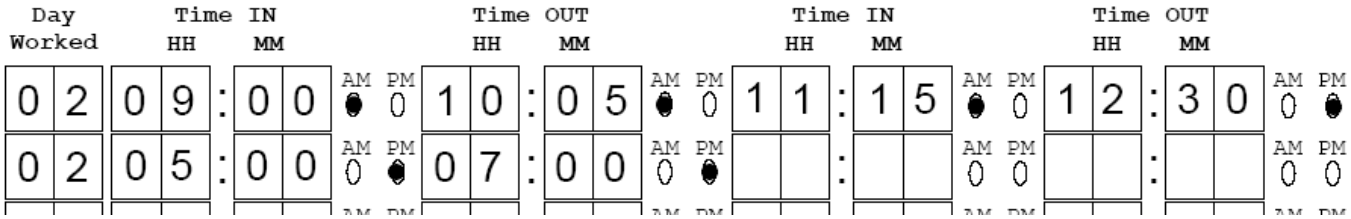


2. **Working multiple times in one day.** Many PSWs work with someone several times in a day. You can enter as many in and out times as you want but you are limited to two shifts per line.

For example, say you started working for Sally at 9:00 AM. You helped her until 10:05 AM. You left to run an errand, came back at 11:15 AM, and stayed until 12:30 PM. You would enter these shifts as shown below.



If you came back a third time that evening from 5pm – 7 pm, you would need to move down to the next line as shown below to record all three shifts for that day.



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36521

PUBLIC PARTNERSHIPS, LLC PSW TIMESHEET (F/EA FOR IL DD)

PSW's Name: ____________________ **PPL PSW ID:** [ ][ ][ ][ ][ ][ ][ ]

Participant's Name: ____________________ **Participant ID:** [ ][ ][ ][ ][ ][ ][ ]

FAX: PPL @ 1-866-340-1653 **MAIL: PUBLIC PARTNERSHIPS, LLC - IL DD, 6 ADMIRALS WAY, CHELSEA, MA 02150**

Year 2 0 [ ][ ] **Month** [ ][ ] **Specify Pay Period:** ○ 1st - 15th ○ 16th to End of Month

Day Worked	Time IN HH : MM		Time OUT HH : MM		Time IN HH : MM		Time OUT HH : MM		Total Hours HH : MM
	:	AM ○ PM ○	:	AM ○ PM ○	:	AM ○ PM ○	:	AM ○ PM ○	:
	:	AM ○ PM ○	:	AM ○ PM ○	:	AM ○ PM ○	:	AM ○ PM ○	:
	:	AM ○ PM ○	:	AM ○ PM ○	:	AM ○ PM ○	:	AM ○ PM ○	:
	:	AM ○ PM ○	:	AM ○ PM ○	:	AM ○ PM ○	:	AM ○ PM ○	:
	:	AM ○ PM ○	:	AM ○ PM ○	:	AM ○ PM ○	:	AM ○ PM ○	:
	:	AM ○ PM ○	:	AM ○ PM ○	:	AM ○ PM ○	:	AM ○ PM ○	:
	:	AM ○ PM ○	:	AM ○ PM ○	:	AM ○ PM ○	:	AM ○ PM ○	:
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	:	AM ○ PM ○	:	AM ○ PM ○	:	AM ○ PM ○	:	AM ○ PM ○	:

TOTAl HOURS WORKED ON THIS TIMESHEET: [ ][ ][ ] : [ ][ ]

By signing below, I certify that I have provided the services to the participant during the times described on this timesheet.

Date: [ ][ ] / [ ][ ] / 2 0 [ ][ ]

Personal Support Worker Signature:

I certify that the participant has received hours of service as reported above.

Date: [ ][ ] / [ ][ ] / 2 0 [ ][ ]

Participant/Employer/Authorized Rep Signature:

36521

Public Partnerships, LLC

IL DD Payment Schedule

Calendar Year 2012

6 Admirals Way
Chelsea, MA 02150
Phone: (888) 866-0582
Fax: (866) 826-7287
Timesheet Fax: (866) 340-1653

NOTE: Payments are issued twice monthly.
Direct Deposit (EFT) payments are issued to the bank twice monthly; payment should be received in your account one to two days later.

Pay Period		Timesheets must be Received by:	Checks Mailed/EFT Issued on:
Start (1st or 16th)	**End (15th or Last)**	**Deadline**	**Payroll Date**
December 16, 2011	December 31, 2011	January 1, 2012	January 5, 2012
January 1, 2012	January 15, 2012	January 16, 2012	January 20, 2012
January 16, 2012	January 31, 2012	February 1, 2012	February 7, 2012
February 1, 2012	February 15, 2012	February 16, 2012	February 22, 2012
February 16, 2012	February 29, 2012	March 1, 2012	March 7, 2012
March 1, 2012	March 15, 2012	March 16, 2012	March 22, 2012
March 16, 2012	March 31, 2012	April 1, 2012	April 6, 2012
April 1, 2012	April 15, 2012	April 16, 2012	April 20, 2012
April 16, 2012	April 30, 2012	May 1, 2012	May 7, 2012
May 1, 2012	May 15, 2012	May 16, 2012	May 22, 2012
May 16, 2012	May 31, 2012	June 1, 2012	June 6, 2012
June 1, 2012	June 15, 2012	June 16, 2012	June 21, 2012
June 16, 2012	June 30, 2012	July 1, 2012	July 6, 2012
July 1, 2012	July 15, 2012	July 16, 2012	July 20, 2012
July 16, 2012	July 31, 2012	August 1, 2012	August 6, 2012
August 1, 2012	August 15, 2012	August 16, 2012	August 22, 2012
August 16, 2012	August 31, 2012	September 1, 2012	September 6, 2012
September 1, 2012	September 15, 2012	September 16, 2012	September 21, 2012
September 16, 2012	September 30, 2012	October 1, 2012	October 5, 2012
October 1, 2012	October 15, 2012	October 16, 2012	October 22, 2012
October 16, 2012	October 31, 2012	November 1, 2012	November 7, 2012
November 1, 2012	November 15, 2012	November 16, 2012	November 21, 2012
November 16, 2012	November 30, 2012	December 1, 2012	December 6, 2012
December 1, 2012	December 15, 2012	December 16, 2012	December 21, 2012

IL DD PAPER TIMESHEET INSTRUCTIONS

For assistance, call Customer Service at (888) 866-0582.

General Suggestions

- Fill in the timesheet clearly. Remember, it is being read by a machine. If it cannot read your timesheet, it may delay your payment.
- Fill in all the required fields. You will not be paid unless all of the fields are filled in.
- Do not use colored ink. The machine has trouble reading light colors.
- Do not use markers or pencil. Markers tend to bleed and can cause timesheet errors. Pencil is not always read by scanner and can smudge.
- Use separate timesheets for different participants. If you work with more than one participant, make sure you use separate timesheets.
- Do not round time. Write the exact time. Our machines will round your time.
- Do not cross out information. The machine will not read it. Use a new timesheet.
- Do not use white-out. Timesheets with white-out will be rejected.
- Make sure the timesheets are good copies. The four black boxes at the corners of the timesheet must always be completely visible.

Obtaining New Timesheets

We have included a timesheet with this packet. You can make copies of the timesheets we give you but make sure they are full-size and not tilted or our machine will not read them.

You can print copies of blank timesheets from the Web Portal. (See Web Portal Instruction packet). You can also call customer service and ask them to send you timesheets.

Phone:	**(888) 866-0582**	**Administrative Fax:**	(866) 826-7287
TTY:	**(800) 360-5899**	**Timesheet Fax:**	(866) 340-1653
Email:	**ildd@pcgus.com**	**Web:**	**www.publicpartnerships.com**

DIRECT DEPOSIT INFORMATION GUIDE

Direct Deposit, also known as Electronic Funds Transmission (EFT), is the fastest and safest way to receive your paycheck from PPL on behalf of your employer. Your payment can be deposited directly into your ***checking account***, ***savings account***, or to a ***pay card*** of your choice. To sign up, review the steps below and complete the Direct Deposit application.

1. Meet Direct Deposit Requirements

- ❑ **Complete the Direct Deposit Application.**
- ❑ **Agree to immediately notify PPL in writing if you change your bank, account number, account type, ABA routing number, or contact information.** You may need to submit a new Direct Deposit Application form. Failure to comply with this may result in delay of payment.

2. Submit Direct Deposit Application to PPL

Once you have completed the Direct Deposit application, you must gather and submit account verification documents to PPL. This differs depending on where you want your funds to go:

- **Checking account**: Submit a voided check or a letter from your bank that states the checking account number where your funds should be deposited.
- **Savings account:** Submit a letter from your bank that states your savings account number where your funds should be deposited.
- **Pay card/debit card:** Submit documentation from the pay card's enrollment process or the pay card's financial entity that verifies the account and the routing numbers.

NOTE: *If you choose this option, please note that PPL does **not** support any particular pay card/debit card financial institution and is **not** responsible for any fees established by the financial institution. PPL recommends you review all pertaining to your pay card prior to enrolling and activating it.*

3. Await confirmation from PPL

Your Direct Deposit account will become active after PPL verifies your account number with your bank or pay card. The whole process will take 1 to 2 **pay cycles** from the time we receive your completed and signed application.

If there is a change in bank account information, your PPL payment account will be taken off Direct Deposit status until the new bank account information is verified. Verification may take a few weeks. You will receive paper checks in the interim period.

The Direct Deposit payment is sent on the check date (see Payroll Schedule) and should be in your bank account 24-48 hours afterwards. Please note that bank holidays may delay posting. After considering bank holidays, contact PPL if you don't receive your payment on time.

That's it! Once your Direct Deposit becomes active, you will receive a summary of your gross wages, tax withholding, etc. on a document called a "Remittance Advice" that is mailed to you. **Thank you for signing up – we hope you enjoy having faster access to your payments!**

Phone:	**(888) 866-0582**	**Administrative Fax:**	(866) 826-7287
TTY:	**(800) 360-5899**	**Timesheet Fax:**	(866) 340-1653
Email:	ildd@pcgus.com	**Web:**	www.publicpartnerships.com

PUBLIC PARTNERSHIPS

FREQUENTLY ASKED QUESTIONS ABOUT PAY CARDS

1. **Do I need a bank account to obtain a pay card?**
   No, you do not need a bank account to obtain a pay card.

2. **What is a pay card?**
   A pay card is an easy way to have your money deposited each payday without having a bank account. You are able to use this pay card at any ATM or it can be used just like a debit card to make purchases directly.

3. **Where can I obtain a pay card?**
   A pay card can be obtained at a local merchant store (Wal-Mart, CVS, Walgreens, etc) for a nominal fee or via the pay card company's website.

4. **Is a new pay card needed for each pay cycle?**
   No, the same pay card is used every pay cycle and the pay amount is directly transferred onto the card.

5. **What if all the money on the pay card is not used before the next pay cycle?**
   The remaining balance on your pay card will carry over with your next deposit.

6. **How do I know the balance on my pay card?**
   For many pay cards, there will be a customer service number for the financial institution on the back of your pay card that you can call to obtain your card balance. Simply follow the directions provided to obtain your balance. If there is not a phone number for balances indicated on your card, refer back to your pay card enrollment paperwork for more information.

7. **Are there any fees with the pay card?**
   Your particular pay card may have transaction fees. PPL is not responsible for any fees established by the pay card's financial institution.

8. **Can I use my pay card at an ATM and will there be surcharges?**
   Pay cards are usually accepted at any ATM. If the ATM charges a surcharge, you will be notified before the transaction is completed. You can accept the charge or you will have the option of canceling the transaction if you do not want to pay the fee.

9. **Can I use my pay card to make online purchases?**
   Usually, your pay card can be used to make online purchases. Refer to your pay card enrollment paperwork for additional information.

There are many websites where you can get free general information and/or information regarding pay cards such as, www.consumer-action.org or www.usapaycard.com.

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Public Partnerships, LLC (PPL)

DIRECT DEPOSIT APPLICATION

FORM - DD2
Revised 05/2010

Section 1

CREATE/CHANGE PPL Direct Deposit Account or CLOSE Existing PPL Direct Deposit Account

Check the appropriate box below based on your request.

- ☐ New Direct Deposit Set-up
- ☐ Change Account Number
- ☐ Cancellation Request
- ☐ New Pay Card/Debit Card Set-up
- ☐ Change Account Type
- ☐ Change Financial Institution

Section 2

PAYEE INFORMATION

Disclosure of your Social Security Number (SSN) is voluntary pursuant to 42 USC 405c2C. PPL will use to file required information returns to IRS.

1. Social Security Number (SSN) ☐☐☐ – ☐☐ – ☐☐☐☐

2. Payee Name

3. Phone

4. Payee Address

5. City

6. State

7. Zip

Section 3

AUTHORIZATION FOR SET-UP, CHANGE OR CANCELLATION

I authorize Public Partnerships, LLC (PPL) to process payments owed to me for services authorized by the Illinois Department of Human Services Division of Developmental Disabilities Home-based support program. Per my request, PPL will deposit my payment directly to my bank or pay card account indicated below using an Automated Clearing House (ACH) transaction. I recognize that if I fail to provide complete and accurate information on this form, processing may be delayed or made impossible, or my electronic payments may be erroneously made.

I authorize PPL to withdraw from the designated account all amounts deposited electronically in error. If the designated account is closed or has an insufficient balance to allow withdrawal, then I authorize PPL to withhold any payment owed to me by PPL until the erroneous deposited amounts are repaid. If I decide to change or revoke this authorization, I recognize that I must forward such notice to PPL. The change or revocation is effective on the day PPL processes the request. I certify that I have read and agree to comply with PPL rules governing payments and electronic transfers as they exist on the day of my signature on this form or as subsequently adopted, amended, or repealed.

I authorize PPL to stop making electronic transfers to my account without advance notice. If I choose to have my payments deposited to a pay card or debit card, I accept all responsibility for all terms, conditions and/or fees that may be applicable to my chosen pay card/debit card.

I certify that I am authorized to contract for the entity receiving deposits per this agreement, and that all information provided is accurate.

8. Signature (Required)

9. Title

10. Date

Section 4

ACCOUNT DETAIL INFORMATION

11. Financial Institution Name (My Bank or my Pay Card Bank's Name)

12. Bank Address

☐☐☐☐ – ☐☐☐☐☐
13. Bank Routing Number

14. Account Type: ☐ Checking ☐ Savings ☐ Pay Card/ Debit Card

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
15. My Account Number

16. Bank City

17. Bank State

18. Bank Zip

Send with VOIDED CHECK or ACCOUNT VERIFICATION to:

PPL IL DD, 6 Admirals Way, Chelsea, MA 02150
-or-
PPL IL DD Administrative Fax: (866) 826-7287

Illinois Department of Revenue

IL-W-5-NR Employee's Statement of Nonresidence in Illinois

Must I complete this form?

You must complete Part 1 of this form if

- you are a resident of Iowa, Kentucky, Michigan, or Wisconsin, or
- your spouse is in the military, you and your spouse are both residents of the same state (other than Illinois) and you are in Illinois only because your spouse is stationed here by the military,

and your wages are exempt from withholding of Illinois Income Tax under the reciprocal withholding agreements between Illinois and these states or under the Military Spouses Residency Relief Act. You must file your completed Form IL-W-5-NR with your Illinois employer. If you change your state of residence, you must notify your employer within ten days.

To employers:

You are required to have a copy of this form on file for each employee who

- is a resident of Iowa, Kentucky, Michigan, or Wisconsin; receives compensation paid in Illinois; and elects to claim exemption from withholding of Illinois Income Tax under the reciprocal withholding agreements between Illinois and these states, OR
- is exempt from Illinois Income Tax on compensation under the Military Spouses Residency Relief Act.

Part 1: Employee information

_____ _____ _____ - _____ _____ - _____ _____ _____ _____

Social Security number

Name

Mialing address

City State ZIP

I declare under penalties of perjury that

I am a resident of the state of:

☐ Iowa ☐ Kentucky ☐ Michigan ☐ Wisconsin, OR

☐ My spouse and I are residents of (write the 2-letter abbreviation for your state of residency) ____ and I am in Illinois only because my spouse is a member of the US military who is stationed in Illinois.

Employee's signature Date

IL-W-5-NR (R-12/09)

Part 2: Employer information

_____ _____ - _____ _____ _____ _____ _____ _____ _____

Federal employer identification number

Name

Mialing address

City State ZIP

This form is authorized as outlined by the Illinois Income Tax Act. Disclosure of this information is required. Failure to provide information may result in a penalty. This form has been approved by the Forms Management Center. IL-492-0052

**Only complete and return this form to PPL if you are a resident of Iowa, Kentucky, Michigan, Wisconsin or if you are in Illinois only because your spouse is a member of the US military who is stationed in Illinois.