RESPITE CONSUMER PACKET

What is needed for a **Respite Provider Packet or **Consumer Packet** (you may receive one or both packets) PLEASE follow instructions below.

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*What is needed from you as (parent/guardian or self), the **Employer** to complete the **Respite CONSUMER Packet:**

1. Fiscal Intermediary Respite Program – Respite Referral Sheet
   - Completely fill out this form
2. SS-4 Form
   - **Signature and date only**
     - Parent/guardian can sign the SS-4 form but it **MUST BE IN THE CHILD'S NAME**
     - If child's name is not signed then you must supply documentation stating you have guardianship
3. 2848 Form
   - Signature and date only (2nd page)
     - **SIGNATURE MUST BE IN THE CHILD'S NAME**

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*What is needed from you as (parent/guardian or self), the **Employer** and the respite care provider the **Employee** to complete the **Respite PROVIDER Packet:**

1. Employment Agreement
   - You as (parent/guardian or self) fill out top section of this form
   - You as (parent/guardian or self) then sign and date where is says – **Employer**
   - Have the person you would like to provide the respite care sign and date where it says – **Employee**
2. Criminal Background Check Authorization Form
   - The person providing the respite care (**Employee**) must complete, sign and date this from.
     *** The Provider (**Employee**) can't start working until the background check is cleared.*
     - *A copy of the employee's driver's license and social security card **MUST** be provided along with this form*
3. W-4 Form
   - Respite care provider (**Employee**) - Fill out section 1 and then sign and date section 5
4. Employment Eligibility Verification Form/Dept. of Homeland Security
   - Respite care provider (**Employee**) – fill out top section with you basic information and the sign and date where it says signature of employee (page 1)
   - You as (parent/guardian or self), the (**Employer**) only need to sign and date under the certification section (page 2) of the Employment Eligibility Verification form where is says - signature of Employer or authorized representative
   - You do NOT have to complete the X out sections
5. Trainings
   - Read all training sections and take test
   - Sign, date and return test

Once your packet(s) are completely filled out please mail or fax them to:
Bay Arenac Behavioral Health
Attn: Susan Leix
201 Mulholland
Bay City, MI 48708
Fax: 1-989-497-1569
Phone: 1-989-895-2277

If you are in need of more provider packets please contact:
Susan Leix, Secretary at 1-989-895-2277
or
Chelli Harless, Respite Care Coordinator
at 1-989-895-2212

If you return an incomplete packet it WILL delay the process!!!
Please call Susan if you have questions at 895-2277

Respite fund guidelines for amounts/payments

**Respite care allotment amounts vary and are determined by the Respite Care Coordinator or Client Services Specialist. You will receive a letter in the mail to notify you of your approved respite care allotment for the year.

The maximum respite allotment per **calendar year** is $1,999.99 (January through December) to eliminate all payroll tax reporting requirements. *This does not mean you will receive this amount, please refer to your letter for your approved amount.

*The respite funds granted are attached to the person's **Person Centered Plan (PCP) dates** that will fall within a calendar year.*

A respite care provider can only be paid $999.99 **per quarter in the calendar year** – the quarters per calendar year are as follows:

January, February, March
April, May, June
July, August, September
October, November, December

Respite providers cannot reside in the same home of the person receiving the respite services. Respite checks under **no** circumstances will be mailed to the address of the respite consumer for a provider. Provider checks will only be mailed to the provider's home address.

Each consumer (employer) completes a respite invoices (voucher), has employee sign and then it must be submitted to Bay Arenac Behavioral Health for payment authorization. Upon authorization, the invoice (voucher) will be forwarded to the fiscal intermediary, Stuart Wilson for payment. *Please allow two weeks before calling to check on the status of your payment.

All** respite invoices (vouchers) submitted must have dates **within three months** on when it was received. (**ALSOdates on the invoice submitted must fall between the PCP beginning and end dates)

ALL respite claims invoices (vouchers) must be mailed or faxed to:
Bay Arenac Behavioral Health
Respite Services
Attn: Susan or Chelli
201 Mulholland
Bay City, MI 48708
Or
Fax: 1-989-497-1569

STUART T. WILSON CPA, PC
CERTIFIED PUBLIC ACCOUNTANT
FISCAL INTERMEDIARY

Fiscal Intermediary Respite Referral Form

Participant Information
Participant name is always the individual receiving services, even if they are a minor.

Participant Name: _____

Participant Address: _____

_____

Participant Phone Number: _____

Participant DOB: _____/_____/_____ Participant SSN: _____-_____-_____

Case Manger Information

Case Manager: _____ Organization: _____

Case Manager Email: _____

Participant Case #:_____

Responsible Party Contact Information
Please provide contact information for the responsible party.

Contact Name: _____

Address: _____

_____

Email: _____

Phone Number: _____

Stuart T. Wilson CPA, PC 6300 Schade Dr. Midland, MI 48640
P: 989-832-5400 F: 989-832-5404

What are these Tax Forms?

→SS-4 Application for EIN
This form allows our office to apply for an Employment Identification Number (EIN). The EIN is used to file for payroll taxes.

IRS Form 2678 – Employer Appointment of Agent
The 2678 form allows our office to pay the necessary payroll taxes on the consumer's behalf.

→IRS Form 2848 – Power of Attorney
This form is used to inform the IRS that our office is representing the consumer in any payroll tax matter related to their employees and gives the IRS permission to discuss these matters with our office. It is also used to inform the IRS that our office will be signing payroll tax returns on the consumer's behalf. It can only be used for these purposes. **It does not affect guardianship, personal income taxes, or other Powers of Attorney in any way.**

IRS Form 8821 – Tax Information Authorization
The 8821 allows our office to receive the consumer's payroll tax information from the IRS.

IRS 8822 – Change of Address
This form changes the consumer's mailing address for IRS payroll tax documents to our office's address. Once the address is changed, our office will receive any IRS payroll tax notices.

MI Form 3683 & 1488 – Payroll Services Provider Combined Power of Attorney Authorization
The 3683 form allows our office to file payroll tax returns, make payroll tax payments, and receive confidential payroll tax information. In addition, it changes the Michigan Treasury mailing address from the consumer's address to ours, ensuring that our office receives any Michigan Treasury payroll tax documents.

UIA Form 151 – Power of Attorney
This form allows our office to speak on the consumer's behalf to the Michigan Unemployment Agency. **It does not affect guardianship, personal income taxes, or other Power of Attorney in any way.**

Form 163 – Notice of Change
This form changes the address for all tax letters and bills to be sent directly to our office. We will answer all letters and pay the necessary bills.

Form **SS-4** (Rev. December 2019)

Department of the Treasury
Internal Revenue Service

Application for Employer Identification Number

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

▶ **Go to *www.irs.gov/FormSS4* for instructions and the latest information.**

▶ **See separate instructions for each line.** ▶ **Keep a copy for your records.**

OMB No. 1545-0003

EIN

Type or print clearly.

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

2 Trade name of business (if different from name on line 1)

3 Executor, administrator, trustee, "care of" name

4a Mailing address (room, apt., suite no. and street, or P.O. box)

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

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

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

6 County and state where principal business is located

7a Name of responsible party

7b SSN, ITIN, or EIN

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

8b If 8a is "Yes," enter the number of LLC members . . . . . ▶

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

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

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

Group Exemption Number (GEN) if any ▶

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

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

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

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

12 Closing month of accounting year

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

Agricultural	Household	Other

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

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

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

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

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

18 Has the applicant entity shown on line 1 ever applied for and received an EIN? ☐ Yes ☐ No

If "Yes," write previous EIN here ▶

Third Party Designee

Complete this section **only** if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form.

Designee's name — Designee's telephone number (include area code)

Address and ZIP code — Designee's fax number (include area code)

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

Applicant's telephone number (include area code)

Name and title (type or print clearly) ▶

Applicant's fax number (include area code)

Signature ▶ Date ▶

Form **2848**
(Rev. February 2020)
Department of the Treasury
Internal Revenue Service

Power of Attorney and Declaration of Representative

▶ **Go to *www.irs.gov/Form2848* for instructions and the latest information.**

OMB No. 1545-0150

For IRS Use Only
Received by:
Name
Telephone
Function
Date / /

Part I Power of Attorney

Caution: A separate Form 2848 must be completed for each taxpayer. Form 2848 will not be honored for any purpose other than representation before the IRS.

1 Taxpayer information. Taxpayer must sign and date this form on page 2, line 7.

Taxpayer name and address	Taxpayer identification number(s)	
	Daytime telephone number	Plan number (if applicable)

hereby appoints the following representative(s) as attorney(s)-in-fact:

2 Representative(s) must sign and date this form on page 2, Part II.

Name and address	CAF No. PTIN Telephone No. Fax No.
Check if to be sent copies of notices and communications ☐	Check if new: Address ☐ Telephone No. ☐ Fax No. ☐
Name and address	CAF No. PTIN Telephone No. Fax No.
Check if to be sent copies of notices and communications ☐	Check if new: Address ☐ Telephone No. ☐ Fax No. ☐
Name and address	CAF No. PTIN Telephone No. Fax No.
(**Note:** IRS sends notices and communications to only two representatives.)	Check if new: Address ☐ Telephone No. ☐ Fax No. ☐
Name and address	CAF No. PTIN Telephone No. Fax No.
(**Note:** IRS sends notices and communications to only two representatives.)	Check if new: Address ☐ Telephone No. ☐ Fax No. ☐

to represent the taxpayer before the Internal Revenue Service and perform the following acts:

3 Acts authorized (you are required to complete this line 3). With the exception of the acts described in line 5b, I authorize my representative(s) to receive and inspect my confidential tax information and to perform acts that I can perform with respect to the tax matters described below. For example, my representative(s) shall have the authority to sign any agreements, consents, or similar documents (see instructions for line 5a for authorizing a representative to sign a return).

Description of Matter (Income, Employment, Payroll, Excise, Estate, Gift, Whistleblower, Practitioner Discipline, PLR, FOIA, Civil Penalty, Sec. 4980H Shared Responsibility Payment, etc.) (see instructions)	Tax Form Number (1040, 941, 720, etc.) (if applicable)	Year(s) or Period(s) (if applicable) (see instructions)

4 Specific use not recorded on Centralized Authorization File (CAF). If the power of attorney is for a specific use not recorded on CAF, check this box. See *Line 4. Specific Use Not Recorded on CAF* in the instructions . . . . . ▶ ☐

5a Additional acts authorized. In addition to the acts listed on line 3 above, I authorize my representative(s) to perform the following acts (see instructions for line 5a for more information): ☐ Access my IRS records via an Intermediate Service Provider;
☐ Authorize disclosure to third parties; ☐ Substitute or add representative(s); ☐ Sign a return;

☐ Other acts authorized:

b **Specific acts not authorized.** My representative(s) is (are) not authorized to endorse or otherwise negotiate any check (including directing or accepting payment by any means, electronic or otherwise, into an account owned or controlled by the representative(s) or any firm or other entity with whom the representative(s) is (are) associated) issued by the government in respect of a federal tax liability.
List any other specific deletions to the acts otherwise authorized in this power of attorney (see instructions for line 5b): _____

6 **Retention/revocation of prior power(s) of attorney.** The filing of this power of attorney automatically revokes all earlier power(s) of attorney on file with the Internal Revenue Service for the same matters and years or periods covered by this document. If you **do not** want to revoke a prior power of attorney, check here . . . . . ▶ ☐
YOU MUST ATTACH A COPY OF ANY POWER OF ATTORNEY YOU WANT TO REMAIN IN EFFECT.

7 **Signature of taxpayer.** If a tax matter concerns a year in which a joint return was filed, each spouse must file a separate power of attorney even if they are appointing the same representative(s). If signed by a corporate officer, partner, guardian, tax matters partner, partnership representative (or designated individual, if applicable), executor, receiver, administrator, or trustee on behalf of the taxpayer, I certify that I have the legal authority to execute this form on behalf of the taxpayer.
▶ **IF NOT COMPLETED, SIGNED, AND DATED, THE IRS WILL RETURN THIS POWER OF ATTORNEY TO THE TAXPAYER.**

Signature	Date	Title (if applicable)
Print name		Print name of taxpayer from line 1 if other than individual

Part II Declaration of Representative

Under penalties of perjury, by my signature below I declare that:

- I am not currently suspended or disbarred from practice, or ineligible for practice, before the Internal Revenue Service;
- I am subject to regulations contained in Circular 230 (31 CFR, Subtitle A, Part 10), as amended, governing practice before the Internal Revenue Service;
- I am authorized to represent the taxpayer identified in Part I for the matter(s) specified there; and
- I am one of the following:

a Attorney—a member in good standing of the bar of the highest court of the jurisdiction shown below.
b Certified Public Accountant—a holder of an active license to practice as a certified public accountant in the jurisdiction shown below.
c Enrolled Agent—enrolled as an agent by the IRS per the requirements of Circular 230.
d Officer—a bona fide officer of the taxpayer organization.
e Full-Time Employee—a full-time employee of the taxpayer.
f Family Member—a member of the taxpayer's immediate family (spouse, parent, child, grandparent, grandchild, step-parent, step-child, brother, or sister).
g Enrolled Actuary—enrolled as an actuary by the Joint Board for the Enrollment of Actuaries under 29 U.S.C. 1242 (the authority to practice before the IRS is limited by section 10.3(d) of Circular 230).
h Unenrolled Return Preparer—Authority to practice before the IRS is limited. An unenrolled return preparer may represent, provided the preparer (1) prepared and signed the return or claim for refund (or prepared if there is no signature space on the form); (2) was eligible to sign the return or claim for refund; (3) has a valid PTIN; and (4) possesses the required Annual Filing Season Program Record of Completion(s). ***See* Special Rules and Requirements for Unenrolled Return Preparers *in the instructions for additional information.***
k Qualifying Student—receives permission to represent taxpayers before the IRS by virtue of his/her status as a law, business, or accounting student working in an LITC or STCP. See instructions for Part II for additional information and requirements.
r Enrolled Retirement Plan Agent—enrolled as a retirement plan agent under the requirements of Circular 230 (the authority to practice before the Internal Revenue Service is limited by section 10.3(e)).

▶ **IF THIS DECLARATION OF REPRESENTATIVE IS NOT COMPLETED, SIGNED, AND DATED, THE IRS WILL RETURN THE POWER OF ATTORNEY. REPRESENTATIVES MUST SIGN IN THE ORDER LISTED IN PART I, LINE 2.**

Note: For designations d–f, enter your title, position, or relationship to the taxpayer in the "Licensing jurisdiction" column.

Designation—Insert above letter **(a–r).**	Licensing jurisdiction (State) or other licensing authority (if applicable)	Bar, license, certification, registration, or enrollment number (if applicable)	Signature	Date

BAY-ARENAC BEHAVIORAL HEALTH
FAMILY SUPPORT SERVICES

RESPITE CLAIMS DETAIL INSTRUCTIONS

Parent:	Parent/Guardian first and last name
Address:	Address of parent
Phone:	Telephone number of parent
Consumer Name:	Provide name of consumer receiving respite care
Family Friend Signature	Signature of respite care provider (PRINT Signature on 1 line and sign the rest) ***If the Respite Care Provider has a change of address it MUST be indicated on the Respite Invoice!**
Date of Service:	Date(s) respite care was provided (**dates submitted can't be more than 3 months old and fall in between the PCP beginning and end dates**)
Start Time:	Enter the time the respite care begins
Stop Time:	Enter the time the respite care ends
Total Hours:	Enter the total hours of respite care provided
Hourly Rate:	Enter the rate paid to the respite care provider per hour or a daily rate for 10 or more consecutive hours
Reimbursement Amt:	Enter the total amount of expected reimbursement for each date of care. **(*dates submitted can't be more than 3 months old old and fall in between the PCP beginning and end dates).**
Signature of Parent/ Guardian:	Parent/Guardian signature is required

***Forms must be filled out completely** in order to receive reimbursement, or they will be returned to be completed. If you have any questions, please call Chelli Harless at 895-2212 or Susan Leix at 895-2277.

RESPITE CLAIMS DETAIL INVOICE

Parent/Guardian Name: _____

Address: _____

_____

Phone: _____

****RETURN THESES INVOICES TO****

Bay-Arenac Behavioral Health
Behavioral Health Center
201 Mulholland, 3rd Floor
Bay City, MI 48708
989-895-2300

RESPITE PROVIDER QUALIFICATIONS

Each respite provider and parent/guardian certifies that the below qualifications have been met at the time of, or before, the respite service is provided.

1.) The Respite Aide is trained in the special care needs of the respite participant by the parent.

2.) The Respite Aide is at least 18 years of age.

3.) The Respite Aide is able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary-specific procedures, and to report on activities performed.

4.) The Respite Aide is in good standing with the law (i.e. not a fugitive from justice, a convicted felon, or an illegal alien).

5.) The Respite Aide is able to perform basic first aid procedures.

6.) The Respite Aide is able to prevent transmission of any communicable diseases from self to others in the environment in which they are providing supports.

I hereby certify that all RESPITE providers listed below have received training and/or all pertinent information and is qualified to provide care for: _____ . I understand that Bay-Arenac Behavioral Health is not responsible for the actions of the worker or the child/adult while care is being provided. ***If the Respite provider has an address change it must be indicated on the Respite invoice!**

****Dates submitted can't be more than 3 months old**** and must fall between PCP beginning and end dates**

Respite Care Worker Signature PLEASE PRINT SIGNATURE ON FIRST LINE and SIGN THE REST	Date of Service	Start Time AM/PM	Stop Time AM/PM	Total Hours	Hourly Rate	Total Reimbursement

I understand and assume full responsibility for the accuracy and legitimacy of all hours listed above. I further declare that respite is not being used for the primary reason of care during my regular hours of employment. Respite care invoices can be returned to Susan Leix at BABH ***within three months of care**.

_____

Signature of Parent/Guardian

RESPITE CLAIMS DETAIL INVOICE

Parent/Guardian Name: _____

Address: _____

_____

Phone: _____

****RETURN THESES INVOICES TO****

Bay-Arenac Behavioral Health
Behavioral Health Center
201 Mulholland, 3rd Floor
Bay City, MI 48708
989-895-2300

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_____

Signature of Parent/Guardian

RESPITE CLAIMS DETAIL INVOICE

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Bay-Arenac Behavioral Health
Behavioral Health Center
201 Mulholland, 3rd Floor
Bay City, MI 48708
989-895-2300

Parent/Guardian Name: _____
Address: _____
_____
Phone: _____

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_____
Signature of Parent/Guardian