

**RESPITE  
CONSUMER  
PACKET**

## 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. (\*\*ALSO\*\* dates 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

**\*\*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 (2<sup>nd</sup> page)
    - **SIGNATURE MUST BE IN THE CHILD'S NAME**
4. Payment Options
  - **Must choose one option - Signature and date**

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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 it 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 form. **\*\* 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 your basic information and then 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 it 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 Curtis

201 Mulholland

Bay City, MI 48708

Fax: 1-989-497-1569 Or Email: [scurtis@babha.org](mailto:scurtis@babha.org)

Phone: 1-989-895-2277

**If you are in need of more provider packets please contact:**

Susan Curtis, 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!!!**



**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: \_\_\_\_\_

# What are these Tax Forms?

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## **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 Service 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 Powers 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.

**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](http://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

<b>Type or print clearly.</b>	<b>1</b> Legal name of entity (or individual) for whom the EIN is being requested			
	<b>2</b> Trade name of business (if different from name on line 1)	<b>3</b> Executor, administrator, trustee, "care of" name		
	<b>4a</b> Mailing address (room, apt., suite no. and street, or P.O. box)	<b>5a</b> Street address (if different) (Don't enter a P.O. box.)		
	<b>4b</b> City, state, and ZIP code (if foreign, see instructions)	<b>5b</b> City, state, and ZIP code (if foreign, see instructions)		
	<b>6</b> County and state where principal business is located			
	<b>7a</b> Name of responsible party	<b>7b</b> SSN, ITIN, or EIN		
	<b>8a</b> Is this application for a limited liability company (LLC) (or a foreign equivalent)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>8b</b> If 8a is "Yes," enter the number of LLC members . . . . . ▶				
<b>8c</b> If 8a is "Yes," was the LLC organized in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>9a</b> <b>Type of entity</b> (check only one box). <b>Caution:</b> If 8a is "Yes," see the instructions for the correct box to check.				
<input type="checkbox"/> Sole proprietor (SSN) _____ <input type="checkbox"/> Estate (SSN of decedent) _____ <input type="checkbox"/> Partnership _____ <input type="checkbox"/> Plan administrator (TIN) _____ <input type="checkbox"/> Corporation (enter form number to be filed) ▶ _____ <input type="checkbox"/> Trust (TIN of grantor) _____ <input type="checkbox"/> Personal service corporation _____ <input type="checkbox"/> Military/National Guard <input type="checkbox"/> State/local government _____ <input type="checkbox"/> Church or church-controlled organization _____ <input type="checkbox"/> Farmers' cooperative <input type="checkbox"/> Federal government _____ <input type="checkbox"/> Other nonprofit organization (specify) ▶ _____ <input type="checkbox"/> REMIC <input type="checkbox"/> Indian tribal governments/enterprises _____ <input type="checkbox"/> Other (specify) ▶ _____ <b>Group Exemption Number (GEN) if any ▶</b> _____				
<b>9b</b> If a corporation, name the state or foreign country (if applicable) where incorporated	State _____ Foreign country _____			
<b>10</b> <b>Reason for applying</b> (check only one box)				
<input type="checkbox"/> Started new business (specify type) ▶ _____ <input type="checkbox"/> Banking purpose (specify purpose) ▶ _____ <input type="checkbox"/> Hired employees (Check the box and see line 13.) <input type="checkbox"/> Changed type of organization (specify new type) ▶ _____ <input type="checkbox"/> Compliance with IRS withholding regulations <input type="checkbox"/> Purchased going business _____ <input type="checkbox"/> Other (specify) ▶ _____ <input type="checkbox"/> Created a trust (specify type) ▶ _____ <input type="checkbox"/> _____ <input type="checkbox"/> Created a pension plan (specify type) ▶ _____				
<b>11</b> Date business started or acquired (month, day, year). See instructions.	<b>12</b> Closing month of accounting year			
<b>13</b> Highest number of employees expected in the next 12 months (enter -0- if none). If no employees expected, skip line 14.	<b>14</b> If you expect your employment tax liability to be \$1,000 or less in a full calendar year and want to file Form 944 annually instead of Forms 941 quarterly, check here. (Your employment tax liability generally will be \$1,000 or less if you expect to pay \$5,000 or less in total wages.) If you don't check this box, you must file Form 941 for every quarter. <input type="checkbox"/>			
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%; text-align:center;">Agricultural</td> <td style="width:33%; text-align:center;">Household</td> <td style="width:33%; text-align:center;">Other</td> </tr> </table>		Agricultural	Household	Other
Agricultural	Household	Other		
<b>15</b> First date wages or annuities were paid (month, day, year). <b>Note:</b> If applicant is a withholding agent, enter date income will first be paid to nonresident alien (month, day, year) . . . . . ▶				
<b>16</b> Check <b>one</b> box that best describes the principal activity of your business.				
<input type="checkbox"/> Construction <input type="checkbox"/> Rental & leasing <input type="checkbox"/> Transportation & warehousing <input type="checkbox"/> Health care & social assistance <input type="checkbox"/> Wholesale-agent/broker <input type="checkbox"/> Real estate <input type="checkbox"/> Manufacturing <input type="checkbox"/> Finance & insurance <input type="checkbox"/> Accommodation & food service <input type="checkbox"/> Wholesale-other <input type="checkbox"/> Retail <input type="checkbox"/> _____ <input type="checkbox"/> Other (specify) ▶ _____				
<b>17</b> Indicate principal line of merchandise sold, specific construction work done, products produced, or services provided.				
<b>18</b> Has the applicant entity shown on line 1 ever applied for and received an EIN? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If "Yes," write previous EIN here ▶ _____				
<b>Third Party Designee</b>	Complete this section <b>only</b> if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form.			
	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:70%;">Designee's name</td> <td>Designee's telephone number (include area code)</td> </tr> <tr> <td>Address and ZIP code</td> <td>Designee's fax number (include area code)</td> </tr> </table>	Designee's name	Designee's telephone number (include area code)	Address and ZIP code
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.				
Name and title (type or print clearly) ▶ _____				
Applicant's telephone number (include area code)				
Applicant's fax number (include area code)				
Signature ▶ _____	Date ▶ _____			

## Power of Attorney and Declaration of Representative

OMB No. 1545-0150

▶ Go to [www.irs.gov/Form2848](http://www.irs.gov/Form2848) for instructions and the latest information.

**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. _____
<b>Check if to be sent copies of notices and communications</b> <input type="checkbox"/>	Check if new: Address <input type="checkbox"/> Telephone No. <input type="checkbox"/> Fax No. <input type="checkbox"/>
Name and address	CAF No. _____ PTIN _____ Telephone No. _____ Fax No. _____
<b>Check if to be sent copies of notices and communications</b> <input type="checkbox"/>	Check if new: Address <input type="checkbox"/> Telephone No. <input type="checkbox"/> Fax No. <input type="checkbox"/>
Name and address	CAF No. _____ PTIN _____ Telephone No. _____ Fax No. _____
(Note: IRS sends notices and communications to only two representatives.)	Check if new: Address <input type="checkbox"/> Telephone No. <input type="checkbox"/> Fax No. <input type="checkbox"/>
Name and address	CAF No. _____ PTIN _____ Telephone No. _____ Fax No. _____
(Note: IRS sends notices and communications to only two representatives.)	Check if new: Address <input type="checkbox"/> Telephone No. <input type="checkbox"/> Fax No. <input type="checkbox"/>

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**).

**Progress Note:** What was provided this day

**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 Curtis at 895-2277.

Respite Claims Detail Invoice

Parent/Guardian  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_

Stuart Wilson Contracted Through  
 Bay-Arenac Behavioral Health  
 Behavioral Health Center  
 201 Mulholland  
 Bay City, MI 48708  
 989-895-2300  
 (not implying a co-employment relationship)

I hereby certify that all RESPITE providers listed below have received training and/or all pertinent information and is qualified to provide care for Consumer/Employer: \_\_\_\_\_ 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 cannot be more than 3 months old and form must be filled out completely to be paid\*\***

Respite Care Worker PLEASE PRINT SIGNATURE ON FIRST LINE and SIGN THE REST	Date of Service (must fill out)	Start Time AM/PM (must fill out)	Stop Time AM/PM (must fill out)	Total hours (must fill out)	Hourly Rate (must fill out)	Total Reimbursement (must fill out)	Progress Note (must fill out)

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 Curtis at E-mail to: [scurtis@babha.org](mailto:scurtis@babha.org) **\*within three months of care.**

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Respite Claims Detail Invoice

Parent/Guardian

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Stuart Wilson Contracted Through  
 Bay-Arenac Behavioral Health  
 Behavioral Health Center  
 201 Mulholland  
 Bay City, MI 48708

989-895-2300

(not implying a co-employment relationship)

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Signature of Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Respite Claims Detail Invoice

Parent/Guardian

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Phone: \_\_\_\_\_

Stuart Wilson Contracted Through  
 Bay-Arenac Behavioral Health  
 Behavioral Health Center  
 201 Mulholland  
 Bay City, MI 48708

989-895-2300

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**\*within three months of care.**

Signature of Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_