Premier
Financial Management Services

INDEPENDENT LIVING SUPPORTS PILOT (ILSP)
PARTICIPANT PAPERWORK CHECKLIST

DOCUMENT NAME	REQUIRED/OPTIONAL
ILSP Application	Required
ILSP Pre-Pilot Survey	Required
ILSP Service Plan	Required
Release of Information	*Optional*
ILSP Post-Pilot Survey (Completed at end of benefit)	Required
ILSP Participant Acknowledgement of Direct Hire Worker & Provider Eligibility for Employment	Required
Form SS-4 – Application for Employer Identification Number	Required
Legal Guardianship Papers	Required, if a Legal Guardian Has Been Appointed
Employer of Record	*Optional*
Direct Deposit Form	*Optional*

Note:

Please ensure all **REQUIRED** documents are filled out accurately before submitting them for processing.

INDEPENDENT LIVING SUPPORTS PILOT (ILSP) APPLICATION

Instructions and Important Information

Completing and signing this form is voluntary; however, no referral to enroll in the ILSP program can be processed without the completed signed form. To apply for this program, applicants must contact their local aging and disability resource center (ADRC). Contact information for local ADRCs can be found at www.dhs.wisconsin.gov/adrc/consumer/index.htm.

HOW TO USE THIS FORM

The ILSP Application form (F-03161) must accompany all referrals to enroll or in the ILSP program. All information must be complete and accurate. The participant's signature or the signature of a legal guardian, conservator, or activated power of attorney is required. If the applicant signs with a mark instead of a signature, two witness signatures are required. If the applicant is physically unable to sign, the applicant may direct another adult to sign the form in front of two witnesses. The person who signs on the applicant's behalf will indicate that they are signing at the direction of the applicant.

Aging and disability resource center (ADRC) staff complete and submit the form to DHS. The ADRC must retain the original signed ILSP Authorization Form or an electronically scanned copy of the signed form for ten years in the event of a records request.

ADDITIONAL INSTRUCTIONS

Section I

- Demographic information collected will be shared with the ILSP fiscal agent for enrollment in their systems. The fiscal agent will use this information to streamline participant enrollment and payment of claims.
- Demographics will also be shared with the pilot program evaluator to assess the impact of the ILSP program.
- A **Social Security Number** is requested to facilitate fiscal agent processing of participant employer paperwork and for program evaluation data purposes. It is not a required field.

Section II

- Per 8 U.S.C. 1621(a), only U.S. citizens, U.S. nationals, or certain documented immigrants may enroll in ILSP.
- A **certified or licensed facility** includes but is not limited to an adult family home (AFH), a community-based residential facility (CBRF), a skilled nursing facility, or a residential care apartment complex (RCAC).
- Living within the **ADRC's service area** is defined as residing in the county or counties to which the ADRC provides services. A person is considered to reside in a county if they are physically present in the county and living in a place of fixed habitation with an intent to remain voluntarily.
- **Long-term care Medicaid** programs include: Include, Respect, I Self-Direct (IRIS), Family Care, Family Care Partnership and Program of All-Inclusive Care for the Elderly (PACE).
    - Enrollment in a long-term care Medicaid program disqualifies applicants for ILSP.
    - Enrollment in Medicaid health insurance **does not** disqualify an applicant for ILSP.
- All applicants must provide a **primary diagnosis**. If an applicant is 55 or older and no primary diagnosis applies, the diagnosis of "Age 55+ with no primary diagnosis" may be entered.

  - To be eligible, a diagnosis must cause functional needs expected to last longer than 90 days from the date of the ILSP application.
  - Diagnoses in the Severe and Persistent Mental Illness (SPMI) category are not eligible as a primary diagnosis for ILSP.
  - Please consult the ILSP Diagnosis List for allowable diagnoses.
- **Additional diagnoses** are not required but may be helpful to add. Diagnoses in the SPMI target group are allowable in this category. If no additional diagnoses are expected to cause functional needs lasting longer than 90 days, N/A may be selected.
- All applicant **Income** should be included to reach a grand total. Applicants with a grand total income greater than 300% of the Federal Poverty Level are ineligible for the ILSP program. Spousal income and assets are not considered in application to the ILSP program.
- Applicants must answer "Yes" to at least one question in the **Functional Eligibility Screening Tool** to qualify for ILSP.
  - Answers of "Sometimes" should be marked as a "Yes."
  - Even if an applicant has answered "Yes" to a question, all remaining questions in the tool must be answered prior to enrollment in the ILSP program.
- A **valid ID** includes a U.S. passport, state driver's license or state identity card, school photo ID, employee photo ID, military dependent ID card, military ID or draft record, tribal records, such as a tribal ID card, a Certificate of Degree of Indian Blood, a tribal census document, or documents on tribal letterhead, or a United States Citizenship and Immigration Services (USCIS) photo ID.

Section III

- **Signature** of the application form is legal consent to participate in the ILSP program.

Section IV

- The ADRC will mark eligible applicant forms with an enrollment date that is the same as the date of signature.
- The ADRC will mark ineligible applicant forms with the reason for ineligibility.
- This section provides notice to ILSP applicants of the outcome of their application.

Section V

- ADRC worker will enter their information.

INDEPENDENT LIVING SUPPORTS PILOT: APPLICATION

I. REFERRAL INFORMATION

Demographics

Name (Last, First, MI)	Date of Birth / /	Referring ADRC
Address	City	Zip Code
Phone Number	Email Address	Best Time to Contact

Established Guardianship	Activated Power of Attorney	Name – Guardian / POA	
☐ Guardian of Person ☐ Guardian of Estate ☐ N/A	☐ Healthcare ☐ Finance ☐ N/A	Email Address:	
		Phone Number	Best Time to Contact

Medical Insurance	Social Security Number
☐ Medicare ☐ Medicaid ☐ Private Insurance ☐ Uninsured	– –

Gender

☐ Female ☐ Male ☐ Transgender – Female ☐ Transgender – Male ☐ Other
☐ Prefer not to answer

Race/Ethnicity

☐ American Indian/Alaskan Native ☐ Asian ☐ Black or African American ☐ Hispanic Ethnicity
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ☐ Prefer not to answer

What is your preferred language?	Language Interpreter Needed ☐ N/A Language:

Designated Contact Person

(Complete only if applicant requests another individual to be primary contact)

Designated Contact Person – Name	Relationship	Phone Number	Best time to contact

II. ELIGIBILITY INFORMATION

☐ I am a U.S. citizen or qualified immigrant per 8 U.S.C. 1621(a).
☐ I do not live in a certified or licensed facility.
☐ I live within this ADRC's service area.
☐ I am not currently enrolled in a long-term care (LTC) Medicaid program.
☐ Valid ID provided:

Primary Diagnosis:

Additional Diagnoses:

Name (Last, First, MI)	Date of Birth / /	Referring ADRC

Income

For each item below, enter your total gross (Before deductions) expected annual income for 12 months. (Do not include your spouse's income)

Gross Social Security	$
Gross Wages	$
Interest, Dividends, and Capital Gains	$
Net Self-Employment Income	$
Retirement Income	$
Other Income	$
Grand Total	$

Functional Eligibility Screening Tool

Do you have difficulty or need help performing any of these daily activities?		
1. Bathing The ability to shower, bathe or take a sponge bath for the purpose of maintaining adequate hygiene. Including Getting in and out of the dub or shower, turning on and off the faucet, and adjusting temperature to a safe temperature. Washing and drying the body. Shampooing hair.	Yes ☐	No ☐
2. Dressing Ability to safely dress and undress. This includes both the top and bottom of the body, undergarments, socks, and shoes. Putting on and removing prostheses, orthotic devices, anti-embolism hose (TED hose), compression products or devices, and/or pressure relieving devices. The cognitive ability to choose weather-appropriate clothing.	Yes ☐	No ☐
3. Eating The act of getting food or drink from plate/bowl or cup to mouth (chewing if necessary and swallowing) using routine or adaptive utensils.	Yes ☐	No ☐
4. Mobility The ability to move between locations (including stairs) in the individual's living space. Living space is defined as kitchen, dining room, living room, bathroom, and sleeping area.	Yes ☐	No ☐
5. Toileting The ability to safely use the toilet, commode, bedpan, or urinal for bowel and/or bladder management in the home. Including locating the bathroom in your living space, transferring on and off the toilet, cleaning of the perineal area, changing of menstrual and/or incontinence products, or managing catheter or ostomy.	Yes ☐	No ☐
6. Transferring The ability to safely move between two surfaces. Including going from a sitting to a standing position and reverse.	Yes ☐	No ☐

Name (Last, First, MI)	Date of Birth	Referring ADRC

7. Meal Preparation The ability to safely obtain and prepare simple meals, including the task of grocery shopping. Including opening food containers, safely using kitchen appliances, safely placing food in a dish and carrying it to a table, cutting food, proper food preparation and sanitation. Obtaining groceries including retrieving food at store, getting bags into a vehicle and home, and putting groceries away.	Yes ☐	No ☐
8. Medication Administration: To take or be given a medication by any route (oral, topical, injectable etc.) except intravenously (IV) that is prescribed by a doctor and regularly taken. and/or Management: to set up or monitor a person's prescribed and regularly scheduled and used medications. This includes medication setup and medication monitoring.	Yes ☐	No ☐
9. Money Management The ability to handle money including paying bills and completing financial transactions for basic necessities (food, shelter, and clothing).	Yes ☐	No ☐
10. Household Chores Ability to complete one's personal laundry, routine housekeeping, and basic home maintenance tasks. This includes laundry, vacuuming, mopping, dishes, cleaning bathroom, wiping down surfaces, taking out the garbage, mowing the lawn, and snow removal.	Yes ☐	No ☐
11. Use of Telephone The physical and cognitive ability of a person to use a telephone or other device to exchange information with others, two-way communication.	Yes ☐	No ☐
12. Transportation The physical and cognitive ability to drive a regular or adaptive vehicle.	Yes ☐	No ☐

Name (Last, First, MI)	Date of Birth	Referring ADRC

III. AGREEMENT

I certify, under penalty of perjury and false swearing, that all my answers are correct and complete to the best of my knowledge, including information provided about citizenship or immigration status.

If I am found eligible, I consent to enrollment in the Independent Living Supports Pilot and to following all program rules found in the participant handbook.

I consent to sharing my demographic information with the fiscal agent to allow for coordination of financial benefit.

SIGNATURE – Applicant	Date
SIGNATURE – Legal Guardian, Conservator, or Activated Power of Attorney for Finance	Date
SIGNATURE – Legal Guardian, Conservator, or Activated Power of Attorney for Finance	Date
SIGNATURE – Witness (if applicable)	Date
SIGNATURE – Witness (if applicable)	Date

IV. ELIGIBILITY FINDINGS (to be completed by ADRC)

☐ Applicant is Eligible for ILSP program Enrollment Date: _____

☐ Applicant is Ineligible for ILSP program due to the following reason(s):

- ☐ Financially ineligible
- ☐ Does not meet functional need
- ☐ Does not have a qualifying diagnosis
- ☐ Enrolled in a LTC Medicaid program
- ☐ Lives in a certified or licensed facility
- ☐ Does not live in ADRC's service area
- ☐ Does not meet citizenship requirements

V. INFORMATION COMPLETED BY

Name – ADRC Worker	Date
Phone Number	Email Address

INDEPENDENT LIVING SUPPORTS PILOT (ILSP)
PRE-PILOT SURVEY

Instructions: Completion of this form is an ILSP program requirement.

Aging and disability resource center (ADRC) staff will complete this form with you and submit it to DHS. Information collected in this form will be shared with the ILSP program evaluator to assess impact of the program. This form is intended to be completed between enrollment and service plan development in the ILSP program.

I. Participant Information

Name (Last, First, MI)	Date of Birth	ILSP ID	ADRC

II. Survey

1. Does someone help you with any of these activities?

Bathing	Always ☐	Sometimes ☐	Never ☐
Dressing	Always ☐	Sometimes ☐	Never ☐
Eating	Always ☐	Sometimes ☐	Never ☐
Getting around your home	Always ☐	Sometimes ☐	Never ☐
Toileting	Always ☐	Sometimes ☐	Never ☐
Getting up from a bed, chair, or toilet	Always ☐	Sometimes ☐	Never ☐
Making meals	Always ☐	Sometimes ☐	Never ☐
Managing or taking medicine	Always ☐	Sometimes ☐	Never ☐
Money management	Always ☐	Sometimes ☐	Never ☐
Household chores	Always ☐	Sometimes ☐	Never ☐
Using the telephone	Always ☐	Sometimes ☐	Never ☐
Transportation	Always ☐	Sometimes ☐	Never ☐

Name (Last, First, MI)	Date of Birth	ILSP ID	ADRC

2. Are you able to participate in social activities outside your home as often as you would like?	Very Often ☐	Somewhat Often ☐	Sometimes ☐	Rarely ☐	Never ☐
3. Are you able to move around safely in your current home? (For examples, can you safely access your bedroom, bathroom, kitchen, and entrance to your home or apartment?)	Very Often ☐	Somewhat Often ☐	Sometimes ☐	Rarely ☐	Never ☐
4. Do you have enough money to meet your basic needs?	Very Often ☐	Somewhat Often ☐	Sometimes ☐	Rarely ☐	Never ☐
5. Do you have adequate transportation to get to health care appointments or pick up prescriptions?	Very Often ☐	Somewhat Often ☐	Sometimes ☐	Rarely ☐	Never ☐
6. Do you have adequate transportation to get to work, grocery shopping, social activities, or running errands?	Very Often ☐	Somewhat Often ☐	Sometimes ☐	Rarely ☐	Never ☐
7. Are you able to afford enough food to eat?	Very Often ☐	Somewhat Often ☐	Sometimes ☐	Rarely ☐	Never ☐
8. Do you feel lonely or isolated from other people?	Very Often ☐	Somewhat Often ☐	Sometimes ☐	Rarely ☐	Never ☐
9. How likely are you to remain in your home for the next six months?	Very likely ☐	Somewhat likely ☐	Unsure ☐	Somewhat unlikely ☐	Very unlikely ☐
10. How likely are you to remain in your home for the next year?	Very likely ☐	Somewhat likely ☐	Unsure ☐	Somewhat unlikely ☐	Very unlikely ☐

III. INFORMATION COMPLETED BY

Name – ADRC Worker	Date Completed
Phone Number	Email Address

INDEPENDENT LIVING SUPPORTS PILOT (ILSP)
SERVICE PLAN

Completing and signing this form is voluntary; however, no referral to enroll in the ILSP Program can be processed without the completed signed form. To apply for this program, applicants must contact their local aging and disability resource center (ADRC). Contact information for local ADRCs can be found at www.dhs.wisconsin.gov/adrc/consumer/index.htm.

All information entered must be complete and accurate. The signature or signature of a legal guardian, conservator, or activated power of attorney for finance is required. If signing with a mark, two witness signatures are required. If physically unable to sign, the applicant may direct an adult to sign the form in front of two witnesses. The person who signs on the applicant's behalf should indicate that they are signing at the direction of the applicant.

Only Aging and Disability Resource Center (ADRC) staff is able to approve, finalize, or update the service plan. Information collected in this form will be provided to the ILSP fiscal agent to assist in provider onboarding and payment of claims. The ADRC must retain the originally signed ILSP Service Plan Form or an electronically scanned copy of the signed form for ten years in the event of a records request.

Service Plan

<table>
<tr><td colspan="2">Name (Last, First, MI)</td><td>ILSP ID</td><td colspan="2">Date of Birth
/ /</td><td>Referring ADRC</td></tr>
<tr><td>Equipment/Service</td><td>Service Type</td><td>Code</td><td>Units</td><td>Number of Units</td><td>Price (per unit)
$</td></tr>
<tr><td>Provider Name</td><td colspan="2">Address</td><td colspan="2">Phone Number</td><td>Total Cost
$</td></tr>
<tr><td>Equipment/Service</td><td>Service Type</td><td>Code</td><td>Units</td><td>Number of Units</td><td>Price (per unit)
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$</td></tr>
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$</td></tr>
<tr><td>Provider Name</td><td colspan="2">Address</td><td colspan="2">Phone Number</td><td>Total Cost
$</td></tr>
</table>

Name (Last, First, MI)		ILSP ID	Date of Birth		Referring ADRC
Equipment/Service	Service Type	Code	Units	Number of Units	Price (per unit) $
Provider Name	Address		Phone Number		Total Cost $
Equipment/Service	Service Type	Code	Units	Number of Units	Price (per unit) $
Provider Name	Address		Phone Number		Total Cost $
Equipment/Service	Service Type	Code	Units	Number of Units	Price (per unit) $
Provider Name	Address		Phone Number		Total Cost $
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Provider Name	Address		Phone Number		Total Cost $
Equipment/Service	Service Type	Code	Units	Number of Units	Price (per unit) $
Provider Name	Address		Phone Number		Total Cost $
Equipment/Service	Service Type	Code	Units	Number of Units	Price (per unit) $
Provider Name	Address		Phone Number		Total Cost $

Name (Last, First, MI)	Date of Birth / /	Referring ADRC

Authorization

Participant or legal representative is to initial below:

____ I understand that all service providers credentials must be verified by the fiscal agent prior to providing services. The fiscal agent will alert the provider and participant when approval is granted. Services may not be provided prior to this approval.

____ I understand that the service plan is an authorization to pay the provider after approval by the fiscal agent. Claims exceeding the approved amounts or maximum budget of $7,200 will not be authorized and will be the responsibility of the participant.

_____ I understand that my service plan is valid only while I am actively enrolled in the ILSP program. My enrollment will end 12 months from the date of enrollment on my application form.

_____ I understand that if I do not respond to calls from the ADRC and Fiscal Agent and do not use my services for three months, I will be disenrolled from the ILSP program.

SIGNATURE – Participant	Date Signed
SIGNATURE – Legal Guardian, Conservator, or Activated Power of Attorney for Finance	Date Signed
SIGNATURE – Legal Guardian, Conservator, or Activated Power of Attorney for Finance	Date Signed
SIGNATURE – Witness (if applicable)	Date Signed
SIGNATURE – Witness (if applicable)	Date Signed

Premier
Financial Management Services

Release of Confidential Information Authorization Form

This form authorizes Premier Financial Management Services (PFMS) to disclose any information regarding the services you receive, wages and payment information for your workers and/or anything else related to your Independent Living Supports Pilot (ILSP) service plan. You have the right to revoke this Authorization by providing PFMS ILSP with written notice of revocation.

AUTHORIZATION

I, _____, hereby authorize PFMS or any of its staff to disclose, by any acceptable means, information regarding the services I receive, wages and payment information for my workers, including fax or email, and/or anything else related to my service plan described as follows:

_____

_____

_____

_____

_____

I, _____, hereby authorize the release of the above-mentioned information to the following person:

Name: _____

Address: _____ Phone Number: _____

***This authorization does not grant the individual authority to sign off on any ILSP Program-related documents.**

Participant or Legal Representative Name (*Please Print*): _____

Participant or Legal Representative Signature: _____

Participant Date of Birth: ____/____/_____ Form Completion Date: ____/____/_____

Authorization Form Submission:

Mail:
10425 W North Ave
Suite 320
Milwaukee, WI 53226

Drop Off:
10425 W North Ave.
Suite 345
Milwaukee, WI 53226

Email:
ilsp@premier-fms.com

Fax:
1-877-334-2573

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-03154A (07/2023)

STATE OF WISCONSIN

ILSP PARTICIPANT ACKNOWLEDGEMENT

OF DIRECT-HIRE WORKER AND PROVIDER ELIGIBILITY FOR EMPLOYMENT

INSTRUCTIONS: Completion of this form is an ILSP program requirement.
Completed forms should be submitted to the ILSP third-party administrator.

ILSP Program Policy:

Direct-hire workers (DHWs) and providers are ineligible for employment through the ILSP program if they have been convicted of a serious crime, as defined in Wis. Stat. § 50.065. This includes first or second-degree homicide, felony murder, assisting suicide, battery, physical abuse of an elder or child, abuse of individuals at risk, residents of penal facilities, neglect of patients or residents, or sexual assault.

DHS strongly recommends participants obtain a criminal and caregiver background check for all DHWs and individual providers before hire. Individual providers are professionals who are not associated with an agency.

An ILSP participant can opt to have the third-party administrator initiate a background check on a DHW or individual provider prior to hire. The cost of any background checks will not be deducted from the participant's ILSP budget.

If a background check reveals a conviction for a serious crime, the service will not be approved, and the participant and worker will be notified.

If a participant hires a DHW or individual provider who is ineligible for employment through the ILSP due their criminal record, the participant may be directly responsible for any payments to that worker.

Organizations are responsible for conducting background checks on their own staff. Participants are not able to request a background check for agency providers.

Acknowledgement:

By signing below, I acknowledge that I have reviewed and understand the ILSP program policy on eligibility for employment.

SIGNATURE – Participant Employer/Guardian/POA	Date Signed

Name – Participant Employer/Guardian/POA (Last, First, MI)

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
Premier Financial Management Services

4a Mailing address (room, apt., suite no. and street, or P.O. box)
10425 W North Ave Ste 320

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

4b City, state, and ZIP code (if foreign, see instructions)
Milwaukee, WI 53226

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

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)
888 890-2286

Address and ZIP code
10425 W North Ave Ste 320, Milwaukee WI 53226

Designee's fax number (include area code)
877 337-2573

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 ►

Do I Need an EIN?

File Form SS-4 if the applicant entity doesn't already have an EIN but is required to show an EIN on any return, statement, or other document.[1] See also the separate instructions for each line on Form SS-4.

IF the applicant...	AND...	THEN...
started a new business	doesn't currently have (nor expect to have) employees	complete lines 1, 2, 4a–8a, 8b–c (if applicable), 9a, 9b (if applicable), and 10–14 and 16–18.
hired (or will hire) employees, including household employees	doesn't already have an EIN	complete lines 1, 2, 4a–6, 7a–b, 8a, 8b–c (if applicable), 9a, 9b (if applicable), 10–18.
opened a bank account	needs an EIN for banking purposes only	complete lines 1–5b, 7a–b, 8a, 8b–c (if applicable), 9a, 9b (if applicable), 10, and 18.
changed type of organization	either the legal character of the organization or its ownership changed (for example, you incorporate a sole proprietorship or form a partnership)[2]	complete lines 1–18 (as applicable).
purchased a going business[3]	doesn't already have an EIN	complete lines 1–18 (as applicable).
created a trust	the trust is other than a grantor trust or an IRA trust[4]	complete lines 1–18 (as applicable).
created a pension plan as a plan administrator[5]	needs an EIN for reporting purposes	complete lines 1, 3, 4a–5b, 7a–b, 9a, 10, and 18.
is a foreign person needing an EIN to comply with IRS withholding regulations	needs an EIN to complete a Form W-8 (other than Form W-8ECI), avoid withholding on portfolio assets, or claim tax treaty benefits[6]	complete lines 1–5b, 7a–b (SSN or ITIN as applicable), 8a, 8b–c (if applicable), 9a, 9b (if applicable), 10, and 18.
is administering an estate	needs an EIN to report estate income on Form 1041	complete lines 1–7b, 9a, 10–12, 13–17 (if applicable), and 18.
is a withholding agent for taxes on nonwage income paid to an alien (that is, individual, corporation, or partnership, etc.)	is an agent, broker, fiduciary, manager, tenant, or spouse who is required to file Form 1042, Annual Withholding Tax Return for U.S. Source Income of Foreign Persons	complete lines 1, 2, 3 (if applicable), 4a–5b, 7a–b, 8a, 8b–c (if applicable), 9a, 9b (if applicable), 10, and 18.
is a state or local agency	serves as a tax reporting agent for public assistance recipients under Rev. Proc. 80-4, 1980-1 C.B. 581[7]	complete lines 1, 2, 4a–5b, 7a–b, 9a, 10, and 18.
is a single-member LLC (or similar single-member entity)	needs an EIN to file Form 8832, Entity Classification Election, for filing employment tax returns and excise tax returns, or for state reporting purposes[8], or is a foreign-owned U.S. disregarded entity and needs an EIN to file Form 5472, Information Return of a 25% Foreign-Owned U.S. Corporation or a Foreign Corporation Engaged in a U.S. Trade or Business	complete lines 1–18 (as applicable).
is an S corporation	needs an EIN to file Form 2553, Election by a Small Business Corporation[9]	complete lines 1–18 (as applicable).

[1] For example, a sole proprietorship or self-employed farmer who establishes a qualified retirement plan, or is required to file excise, employment, alcohol, tobacco, or firearms returns, must have an EIN. A partnership, corporation, REMIC (real estate mortgage investment conduit), nonprofit organization (church, club, etc.), or farmers' cooperative must use an EIN for any tax-related purpose even if the entity doesn't have employees.

[2] However, don't apply for a new EIN if the existing entity only (a) changed its business name, (b) elected on Form 8832 to change the way it is taxed (or is covered by the default rules), or (c) terminated its partnership status because at least 50% of the total interests in partnership capital and profits were sold or exchanged within a 12-month period. The EIN of the terminated partnership should continue to be used. See Regulations section 301.6109-1(d)(2)(iii).

[3] Don't use the EIN of the prior business unless you became the "owner" of a corporation by acquiring its stock.

[4] However, grantor trusts that don't file using Optional Method 1 and IRA trusts that are required to file Form 990-T, Exempt Organization Business Income Tax Return, must have an EIN. For more information on grantor trusts, see the Instructions for Form 1041.

[5] A plan administrator is the person or group of persons specified as the administrator by the instrument under which the plan is operated.

[6] Entities applying to be a Qualified Intermediary (QI) need a QI-EIN even if they already have an EIN. See Rev. Proc. 2000-12.

[7] See also *Household employer agent* in the instructions. **Note:** State or local agencies may need an EIN for other reasons, for example, hired employees.

[8] See *Disregarded entities* in the instructions for details on completing Form SS-4 for an LLC.

[9] An existing corporation that is electing or revoking S corporation status should use its previously-assigned EIN.

Premier
Financial Management Services

Designated Represntative Form

Instructions: *An individual who wants to self-direct but is unable or unwilling to perform employer duties themselves may appoint a representative to serve as the employer on their behalf. The Employer of Record can assist with decision-making, hiring staff, managing staff, approving invoices, etc. It will be important to complete a Release of Information form to ensure that Premier staff can partner with your representative.*

Please fill out any information in Sections 1 and 2, where applicable. The participant and Employer of Record are required to sign and date at the bottom of the form. Please submit the completed form to Premier Financial Management Services ILSP Program via one of the following options below:

Mail:
10425 W North Ave.
Suite 320
Milwaukee, WI 53226

Phone:
1-888-890-2286

Email:
ilsp@premier-fms.com

Fax:
1-877-334-2573

Participant's Information

First Name: _____ Middle Initial: ____ Last Name: _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Email Address: _____

Employer of Record's Information

First Name: _____ Middle Initial: ____ Last Name: _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Email Address: _____

Date of Birth: ____ / ____ / _____ Social Security Number: _____ - _____ - _____

By signing below, you certify that the information on this form is accurate. Both parties agree that the above individual will act on the participant's behalf as the employer of record.

Participants Signature: _____ Date: ____ /____ /_____

Employer of Record Signature: _____ Date: ____ /____ /_____

Premier
Financial Management Services

Direct Deposit Agreement Form

Instructions: *Please fill out the information, as applicable, then select the appropriate box below. After entering the Financial Institution information, please attach the required documentation as listed. Review the* ***Authorization for Set-Up*** *then sign and date. Please submit the completed form to* ***Premier Financial Management Services ILSP Program*** *via one of the following options:*

Mail:
10425 W North Ave.
Suite 320
Milwaukee, WI 53226

Drop Off:
10425 W North Ave.
Suite 345
Milwaukee, WI 53226

Email:
ilsp@premier-fms.com

Fax:
1-877-334-2573

Note: Please print clearly.

Participant Name: _____

Direct-hired Worker/Vendor Name: _____

Effective Date: ____ /____/ _____ Last 4 Digits of SSN/Vendor EIN: _____

Check one box ONLY: ☐ New DD Set Up ☐ New Paycard Set-Up

Name of Financial Institution: _____

Type of Account: ☐ Checking Percentage: _____ % ☐ Savings Percentage: _____ %

Name of Financial Institution: _____

Type of Account: ☐ Checking Percentage: _____ % ☐ Savings Percentage: _____ %

Name of Financial Institution: _____

Type of Account: ☐ Checking Percentage: _____ % ☐ Savings Percentage: _____ %

Name of Financial Institution: _____

Type of Account: ☐ Checking Percentage: _____ % ☐ Savings Percentage: _____ %

For Checking account: Tape a voided check here. *(No starter check or deposit slip.)*

For Savings Account: Attach letter from bank with routing and account numbers.
(Letter must be typed on bank's letterhead.)

For Multiple Accounts: Please attach additional verification of account and routing numbers to the other side of this page.

Authorization for Set-Up:

☐ I hereby authorize Premier Financial Management Services (PFMS) to **deposit** any amount owed to me for wages and/or reimbursements. PFMS is not responsible for any erroneous information provided. Also, I grant PFMS permission to correct and/or adjust any electronic funds transfer resulting from an erroneous overpayments by debiting my account. This authorization is to remain in full force and effect until PFMS receives written notification from me to terminate the agreement.

☐ I hereby elect and consent to recieve my wages to a **paycard** by electronic transfer. I also grant Premier Financial Management Services (PFMS) permission to correct and/or adjust any electronic funds transfer resulting from an erroneous overpayment by debiting my account. I acknowledge I have received a copy of the terms, conditions, and fees associated with using the aforementioned paycard. This authorization is to remain in full force and effect until PFMS recieves written notification from me to terminate the agreement.

Signature: _____ Date: ___/___/_____

Paycard Number:
(For office use only)