

EMPLOYEE INFORMATION

Complete and submit this form to APD with employee's IRS Form W-4 and DHS Form I-9.

Employer (Participant)'s Name:	
Participant's CDC+ ID Number:	Date:

Employee Information (name must be written as it appears on SS card):

Last Name:		First Name:	
Phone: ()			
Address:			
City:	State:	Zip:	SSN:
Email Address:			DOB:

WHO CAN WE CONTACT IF YOUR MAIL IS RETURNED?

Last Name:		First Name:	
Phone: ()		Relationship:	

The following information determines whether the employee is exempt from employment taxes. NOTE: Employment taxes are **NOT** federal income tax; the information you provide on IRS Form W-4 determines how much federal income tax the CDC+ participant will pay, if any.

Employee's relationship to the employer (participant) is as follows. This Employee is (check one):

	The participant's parent or step-parent.
	The participant's child or step-child, <u>and</u> the employee is under age 21.
	The participant's spouse.
	Under age 18 and still in high school (and is NOT the participant's child or step-child).
	None of the above.

Provide the following information, which is required for program reporting (check one).

Employee's Relationship to CDC+ Participant: <input type="checkbox"/> None <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandparent <input type="checkbox"/> Grandchild (includes step-relationships)
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To determine if the employee can claim LIVE-IN status, respond to the following statement:

Employee's legal residence is the same as the participant's residence.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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You must verify the status of the employee's background screening. Proof of clear screen must be provided before employee can be enrolled in F/EA and issued a provider number.

1. Employee is a Medicaid-enrolled provider.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Employee has a current professional license from FL Dept of Health	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. Employee has been unemployed for 90 days or more	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If No to 1 & 2 above, a level 2 background screening clearance letter is attached.	YES <input type="checkbox"/>	
If Yes to 3 above, a level 2 background screening clearance letter is attached.	YES <input type="checkbox"/>	
4. Employee signed an affidavit confirming that the provider has complied with section 402.3057, Florida Statutes	Yes <input type="checkbox"/>	No <input type="checkbox"/>

I certify that the above information is true and correct.

Participant/Representative Signature: _____ Employee Signature: _____