



YOUR LIFE
YOUR CARE
YOUR PEOPLE

How to Complete Enrollment Paperwork

June 2026



PPL Enrollment Forms

- 01.** Participant/EOR Forms
- 02.** PSW Forms
- 03.** How to Return Paperwork
- 04.** Contact Us





Participant/Employer Forms

Employer Forms

Individual Personal Information Form


of pages: 1

Who needs to sign?: Employer only

What am I signing?: This form provides PPL with specific information about the person receiving services. This information helps ensure the program is providing services to a diverse community.

Where do I sign? PPL will put the Employers information into this form. Employer only need to sign and date at the bottom.

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INDIVIDUAL PERSONAL INFORMATION FORM

Use this form to tell Public Partnerships LLC (PPL) about your:

- Race (including ethnicity),
- Gender, and
- Preferred language.

PPL is asking you for this information on behalf of the Oregon Office of Developmental Disabilities Services (ODDS). ODDS asked PPL to gather this data and to report it to ODDS. **The answers you provide on this form will not impact your ability to get services.**

Individual Name

First: Last: PPL ID:

Employer Name (this must be completed)

First: Last:

Individual Information

Please select your primary ethnicity and race:

Hispanic or Latino Native Hawaiian or Pacific Islander White Asian

Black or African American American Indian or Alaska Native

Middle Eastern or Northern African Other Prefer not to disclose

Please select your gender:

Male Female Non-binary Prefer not to disclose

What is your preferred language?

Agree and Sign

I, the Employer, confirm:

- I have read all of this form.
- The details provided on behalf of the Individual are accurate and complete.

Employer Signature: **Date:**

Employer Name (please print)

www.pplfirst.com v.1.2, May 2025
Page 1 of 1



Employer Forms

Employment Agreement

of pages: 2

Who needs to sign?: Employer only

What am I signing?: This form identifies all the terms and conditions – it shares what PPL will do and then what an Employer must do as an Employer in this program. *Please read what you are signing.*

Where do I sign? PPL will put the Employer's information into this form. Employer only need to sign and date at the bottom.



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EMPLOYER AGREEMENT

Individual Name
First: Last: PPL ID:

Employer Name (this must be completed)
First: Last:

This agreement covers the responsibilities of the Employer. They are subject to federal and state laws.

Terms and Conditions

PUBLIC PARTNERSHIPS LLC (PPL) DUTIES:

1. Provide enrollment packets.
2. Pay Providers in accordance with the payroll schedule set by the Collective Bargaining Agreement between the SEIU503 Local and the state. For the Provider to be paid, timesheets must be approved by the Employer.
3. Deposit Employer-related taxes using the Employer's tax ID.
4. Follow all IRS and State guidelines.
5. Obtain all proper Federal and State Powers of Attorney.
6. Process all tax exemptions and withholdings.
7. Maintain records of all:
 - Withholdings
 - Filings
 - Payments
8. Supply the Provider with a paystub for each pay period.
9. Furnish the Provider with end of year statements for filing income tax returns.
10. Submit all claims to the Program on behalf of the Employer.
11. Will only pay for tasks approved in the Service Plan.
12. Upon the end of this Agreement PPL will complete all required federal and state filings.

EMPLOYER DUTIES:

1. Agrees that they a
2. The Employer will:
 - Meets program
 - Has complete
 - Passes a bac
3. Non-qualified Prov
4. The Employer:
 - Will set the te
 - Can end the e
 - Must follow al

Repeated dismissals b
The Employer must tel

If the Provider's emplo

Change of Employer
If a new Employer repl
continued to provide th
This includes the I-9.

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[Employer Agreement](#) Oregon | FMAS

Electronic Signatures
PPL supports electronic signing of forms if it is lawful and applies.

Electronic Visit Verification (EVV)
The Provider must clock in and clock out for their shift using an approved EVV method.

Agree and Sign

The Employer confirms:

- I have read all of this form.
- I understand my responsibilities.
- I agree to the terms of this Agreement.
- My records are protected under state and federal laws.
- I understand my records cannot be disclosed without my consent unless required by law.
- The details provided are accurate and complete.

Employer Signature: **Date:**

Employer Forms

IRS – SS-4 Application for Employer Identification Number (EIN)

of pages: 1

Who needs to sign?: Employer only

What am I signing?: This form will allow PPL to obtain the required EIN for the new Employer. You must have an active EIN filed with the IRS so that PPL can file taxes on your behalf.

Where do I sign? PPL will put the Employer's information into this form. Employer only need to sign and date at the bottom.

SS-4 Application for Employer Identification Number <small>(For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, Indian tribal entities, certain individuals, and others.)</small> <small>Go to www.irs.gov/FormSS4 for instructions and the latest information.</small> <small>See separate instructions for each line. Keep a copy for your records.</small>		OMB No. 1545-0003 EIN
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 Public Partnerships LLC
4a Mailing address (room, apt., suite no. and street, or P.O. box) 8000 Avalon Blvd Suite 300		5a Street address (if different) (Don't enter a P.O. box.)
4b City, state, and ZIP code (if foreign, see instructions) Alpharetta, GA 30009		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)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		8b If 8a is "Yes," enter the number of LLC members <input type="checkbox"/> Yes <input type="checkbox"/> No
8c If 8a is "Yes," was the LLC organized in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No		
9a Type of entity (check only one box). Caution: 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 checked="" type="checkbox"/> Other (specify) ▶ HCSR Using Employer/Fiscal Agent 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)		
<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 checked="" type="checkbox"/> Other (specify) ▶ HCSR Using Employer/Fiscal Agent <input type="checkbox"/> Created a trust (specify type) ▶ _____ <input type="checkbox"/> Created a pension plan (specify type) ▶ _____		
11 Date business started or acquired (month, day, year). See instructions.		12 Closing month of accounting year December
13 Highest number of employees expected in the next 12 months (enter -0- if none). If no employees expected, skip line 14.		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. <input type="checkbox"/>
Agricultural _____ Household _____ Other _____		
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.		
<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 checked="" type="checkbox"/> Other (specify) ▶ HCSR Using Employer/Fiscal Agent <input type="checkbox"/> Wholesale-other <input type="checkbox"/> Retail		
17 Indicate principal line of merchandise sold, specific construction work done, products produced, or services provided. HCSR Household Employer Using Employer/Fiscal Agent		
18 Has the applicant entity shown on line 1 ever applied for and received an EIN? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes," write previous EIN here ▶ _____		
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.		
Third Party Designee Designee's name Shay McCool, David Goldberg		Designee's telephone number (include area code) 844-225-3659
Address and ZIP code 8000 Avalon Blvd Suite 300, Alpharetta, GA 30009		Designee's fax number (include area code) 866-260-6260
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) _____
Signature ▶ _____		Applicant's fax number (include area code) _____
Date ▶ _____		



Employer Forms

IRS 2678 Employer/Payer Appointment of Agent

of pages: 1

Who needs to sign?: Employer only

What am I signing?: This form will allow PPL to talk with the IRS on behalf of the Employer about their Employer Taxes ONLY.

Where do I sign? PPL will put the Employer's information into this form. Employer only need to sign and date at the bottom.

Form **2678** Employer/Payer Appointment of Agent
(Rev. December 2024) Department of the Treasury — Internal Revenue Service OMB No. 1545-0029

Use this form if you want to request approval to have an agent file returns and make deposits or payments of employment or other withholding taxes or if you want to revoke an existing appointment.

For IRS use:

- If you're an employer or payer who wants to request approval, complete Parts 1 and 2 and sign Part 2. Then give it to the agent. Have the agent complete Part 3 and sign it.

Note: This appointment isn't effective until we approve your request. See the instructions for more information.

- If you're an employer, payer, or agent who wants to revoke an existing appointment, complete all three parts. In this case, only one signature is required.

Part 1: Why you're filing this form.
(Check one)
 You want to **appoint** an agent for tax reporting, depositing, and paying.
 You want to **revoke** an existing appointment.

Part 2: Employer or Payer Information: Complete this part if you want to appoint an agent or revoke an appointment.

1 Employer identification number (EIN) -

2 Employer's or payer's name
(not your trade name)

3 Trade name (if any)

4 Address

Number	Street	Suite or room number	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
City	State	ZIP code	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Foreign country name	Foreign provincial/county	Foreign postal code	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

5 Forms for which you want to appoint an agent or revoke the agent's appointment to file. (Check all that apply.)

	For ALL employees/ payees/payments	For SOME employees/ payees/payments
Form 940, Employer's Annual Federal Unemployment (FUTA) Tax Return* (all 940 series)	<input type="checkbox"/>	<input type="checkbox"/>
Form 941, Employer's QUARTERLY Federal Tax Return (all 941 series)	<input type="checkbox"/>	<input type="checkbox"/>
Form 943, Employer's Annual Federal Tax Return for Agricultural Employees (all 943 series)	<input type="checkbox"/>	<input type="checkbox"/>
Form 944, Employer's ANNUAL Federal Tax Return (all 944 series)	<input type="checkbox"/>	<input type="checkbox"/>
Form 945, Annual Return of Withheld Federal Income Tax	<input type="checkbox"/>	<input type="checkbox"/>
Form CT-1, Employer's Annual Railroad Retirement Tax Return	<input type="checkbox"/>	<input type="checkbox"/>
Form CT-2, Employee Representative's Quarterly Railroad Tax Return	<input type="checkbox"/>	<input type="checkbox"/>

* Generally, you can't appoint an agent to report, deposit, and pay tax reported on Form 940, unless you're a home care service recipient.
 Check here if you're a home care service recipient, and you want to appoint the agent to report, deposit, and pay FUTA tax for you. See the instructions.

I am authorizing the IRS to disclose otherwise confidential tax information to the agent relating to the authority granted under this appointment, including disclosures required to process Form 2678. The agent may contract with a third party, such as a reporting agent or certified public accountant, to prepare or file the returns covered by this appointment, or to make any required deposits and payments. Such contract may authorize the IRS to disclose confidential tax information of the employer/payer and agent to such third party. If a third party fails to file the returns or make the deposits and payments, the agent and employer/payer remain liable.

Sign your name here

Date / /

Print your name here

Print your title here

Best daytime phone

Now give this form to the agent to complete.

For filing instructions, see the separate instructions. www.irs.gov/Form2678 Cat. No. 18770D Form **2678** (Rev. 12-2024)



Employer Forms


OR Auth Rep Form 150-101-101

of pages: 1

Who needs to sign?: Employer only

What am I signing?: This form will allow PPL to talk with OR Dept of Employment on behalf of the Employer about their Employer Taxes ONLY.

Where do I sign? PPL will put the Employer's information into this form. Employer only need to sign and date at the bottom.

 **Form OR-AUTH-REP**
Authorization to Represent

Use this form to authorize the Oregon Department of Revenue to disclose your confidential tax information to the authorized representative you identify below and to allow that representative to make decisions on your behalf. The person you authorize must meet the qualifications listed in the instructions. If a tax matter concerns a year for which a joint return was filed, see additional instructions on Form OR-AUTH-REP Instructions.

- Print clearly. Use black or blue ink.
- This form will be rejected if it isn't signed by both you and your authorized representative, is incomplete, or has unreadable information.
- This form is invalid if modified or appended.
- See additional instructions on Form OR-AUTH-REP Instructions.
- Submit your completed form through your Revenue Online account at revenueonline.dor.oregon.gov, or by email to questions.dor@dor.oregon.gov, or by mail to Oregon Department of Revenue, 955 Center St. NE, Salem, OR 97301-2555.

Part 1 – Taxpayer information (Individual or Business entity)

Taxpayer name		Phone number ()		
Business name				
Business owner/Officer name (Required if taxpayer is a business entity)				
Social Security number (SSN) (Last 4)		Individual taxpayer identification number (ITIN) (Last 4)		
Business identification number (BIN)		Federal employer identification number (FEIN)		
Address		City	State	ZIP code

Part 2 – Authorization to represent, Representative's attestation and signature
I authorize the Department of Revenue to share my confidential tax information to the authorized representative named below. I authorize my representative to make decisions on my behalf. The authorized representative must meet the qualifications to represent me before the Oregon Department of Revenue. My authorized representative will represent me for **all** tax years and **all** tax programs unless the authorization is limited in Part 3.

Representative name Shay McCool		Phone number (844) 225-3659		
Firm, organization, or agency name Public Partnerships LLC				
Title (if applicable)		Email taxor@pplfirst.com		
Address 8000 Avalon Blvd Suite 300		City Alpharetta	State GA	ZIP code 30009
Relationship Fiscal Agent		CPA, State Bar Number, or Oregon License Number (LTC, LTC, Agent) 13736		
Signature of representative—By signing below as an authorized representative, I attest that I meet the qualifications to represent under Oregon law.				Date 01/01/2025

Part 3 – Authorization limitations
I limit the access and representation of my authorized representative to particular tax years or particular tax programs or both as follows:
Tax year(s):
Tax program(s):

Part 4 – Revocation of prior authorizations
Prior authorizations to represent remain in effect until revoked in writing. If you wish to revoke previous authorizations to represent, initial here.

Part 5 – Taxpayer declaration and signature
Your signature below acknowledges that your representative may receive your confidential tax information and that actions taken by your authorized representative are binding on you, even if an authorized representative isn't an attorney. Proceedings can't later be declared legally defective because your authorized representative was not an attorney. Corporate officers, partners, fiduciaries, or other qualified persons signing on behalf of the taxpayer: Under penalties for false swearing, I also certify and declare that I have the authority to execute this form.

Signature X	Date
Name	

150-101-101 (Rev. 10-29-24) Page 1 of 1 Form OR-AUTH-REP



Employer Forms

Authorized Representative Agreement – (optional)


of pages: 2

Who needs to sign?: Employer and Authorized Representative

What am I signing?: This form will allow PPL to talk with the identified Authorized Representative on behalf of the Employer or Participant. *A PSW cannot be an Authorized Representative.*

Where do I sign? PPL will put the Employer's and the Authorized Representative's information into this form. Employer only need to sign and date at the bottom.

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AUTHORIZED REPRESENTATIVE AGREEMENT

Individual Name

First: Last: PPL ID:

Employer Name (this must be completed)

First: Last:

An Individual and/or their Guardian has the right to choose an Authorized Representative (AR). An AR may take some control for the Individual and/or Employer. The AR will involve the Individual and/or Employer as much as possible. Fill out the sections below only if you want to appoint an AR.

AR Name

First: Middle: Last:

Maiden or Previous:

Mailing

Address: Address 2 (APT., STE.):

City: State:

Personal Details

Date of Birth: Social Security Number: Gender: Male Female

Relationship to Individual:

Spouse Parent/Step-parent Child Sibling
 Grandparent Grandchild Non-relative Legal G

Contact Details

We need to have 2 ways of reaching you. Email is preferred.

Email:

Cell Phone: Home or Other Phone:

PPL can text me using the cell phone number above. Yes No
I understand that carrier charges may apply.

www.pplfirst.com Fax: 1-844-399-8593

Authorized Representative Agreement Oregon | FMAS

Terms and Conditions

An AR must:

- Understand the Individual and Employer's wishes
- Follow through on the Individual's care choices
- Be available to the Individual and Employer
- Be available to program managers
- Be at least 18 years old
- Submit to background checks, if required
- Keep Individual and Employer personal information private.

An AR may:

- Complete and sign program related forms, paperwork, and timesheets
- Perform employer related duties, such as:
 - Review Provider payroll
 - Assist in managing Provider(s)
 - Manage service authorizations

Repeated dismissals by the Employer may make replacing staff harder. This could raise state unemployment tax rates. The Employer must tell PPL when an Employee has been let go. This information will be saved by PPL.

If the Provider's employment stops for 18 months or longer, they may have to complete new paperwork.

The AR cannot also be a paid provider for the Individual.

The AR is not paid for representing the Individual.

This agreement can end any time by either party.

Change of Employer

If a new Employer replaces the previous Employer, they become the successor employer. The Provider must have continued to provide the same services to the same Individual. The new employer is required to keep completed forms. This includes the I-9.

Electronic Signatures

PPL supports electronic signing of forms if it is lawful and applies.

Agree and Sign

The AR, Individual, and/or Employer confirm:

- We have read all of this form.
- The details provided are accurate and complete.
- Any false statement may result in the AR's dismissal.
- This document is not a contract between the signing parties, PPL, or the State.

Authorized Representative Signature: **Date:**

Individual or Employer Signature: **Date:**





PSW Forms

Employee/PSW Forms

Provider Enrollment Form

of pages: 3

Who needs to sign?: PSW

What am I signing?: This form collects all of the PSW demographic information. It tells PPL how the PSW wishes to be paid. It confirms to PPL that the PSW has read the form prior to signing it.

Where do I sign? PPL will auto filled any demographic information we have into the document. PSW will complete pay option information. PSW only need to sign and date at the bottom.

PROVIDER ENROLLMENT

This form is the first step in the enrollment and onboarding process with Public Partnerships LLC (PPL). The details you provide on this form will be used for both employment and payment choices. Please complete this form.

Provider Name

First: [] Middle: [] Last: []
Maiden or Previous Last: []

Provider Address (where you live)

Street (no PO Box): [] Street 2 (APT., STE., etc.): []
City: [] State: [] Zip Code: []
County: [] Municipality: []

Select if address where you live is the same as mailing. If not, complete the Mailing Address section below.

Mailing Address

Address: []
City: [] State: []

Provider Personal Details

Date of Birth: [] Age: [] Social Security: []
Race: [] Primary Language: []
Select One: [] Select One: []

Provider Contact Details

We need to have 2 ways of reaching you. Email is preferred.

Email: []
Cell Phone: []

PPL can text me using the cell phone number above. I understand that carrier charges may apply. Yes No

Payment Information

Direct Deposit to Bank Account
Account Type (select one): Checking Account Savings Account
Banking Institution Name: []
Routing Number: []
Account Number: []

Deposit to Debit Card
If you select Debit Card as your payment method, you must provide PPL with an address where you live. If you work for more than one individual, all payments will be on one pay card.

Pay Stub

Your pay stub is available through the web port the checkbox below.
 Please send my pay stub in the mail.
 Please send my pay stub in the mail.

Provider Directory Opt-In

If available, would you like to be added to a directory?
 Yes, please list my name and basic contact info.
 No, I would prefer not to be listed in a Provider Directory.

PPL Terms and Conditions

I understand and accept:

- PPL is not my employer.
- PPL will help my employer collect my pay (FEA (Fiscal Employer Agent), will support).
- Information provided to PPL on behalf of my employer is required under Federal/State and S.
- I am solely responsible for providing PP changes in my direct deposit account.
- PPL will collect my account numbers on []
- PPL will process my payment only after []
- Through PPL, I can select my preferred [] and regular mail with details provided to []
- If I want to find out other ways PPL might []

Agree and Sign

The Provider confirms:

- I have read all of this form.
- The details I have provided are accurate and complete.
- Any false statement on this form may result in my dismissal.
- This document is not a contract between the Provider, PPL, or the State.
- Employment depends on verifying my right to work in the US.
- PPL can deposit my payment directly into my bank account based on my choice above.
- 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.
- PPL can withdraw from the designated account all amounts deposited electronically in error.
- If my account is closed, or does not have enough money to allow withdrawal, PPL can withhold any payment owed to me until the incorrect deposited amounts are repaid.
- If I want to cancel direct deposit, I will contact PPL customer service and provide both the account and routing number.

Provider Signature: [] Date: []



Employee/PSW Forms

Employment Agreement

of pages: 2

Who needs to sign?: Employer & PSW

What am I signing?: This is the employment contract between the PSW and the Employer. *PPL is not the employer.*

Where do I sign? PPL will auto-fill the document with names and PPL IDs. PSW & Employer need to sign and date at the bottom.

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EMPLOYMENT AGREEMENT

Provider Name
First: _____ Last: _____ PPL ID: _____

Individual Name
First: _____ Last: _____ PPL ID: _____

Employer Name (this must be completed)
First: _____ Last: _____

This agreement explains the responsibilities between the Individual, Employer, and Provider. Read this form in full so you understand what is required of you and others.

Terms and Conditions

- I am an employee of the employer. I am not an employee of Public Partnerships LLC (PPL).
- I must have a background screening before I am employed. The screening is through the OR Office of Developmental Disability Services (ODDS). Results may be shared with:
 - Oregon Financial Management Agent Services (OR FMAS)
 - Affiliated agencies
- I cannot start work until the results of the screening are reviewed.
- I have provided the required proof of my credentials.
- I have completed all trainings.
- This agreement does not promise a certain number of hours of work.
- I will be covered by:
 - Worker's compensation
 - Unemployment Insurance
- Information shared with me by my Individual, Employer, and am I
- I will carry out duties and jobs assigned to me by my Individual
- I will let all affiliated agencies know if I cannot contact my Individual
- My employer will coordinate with their Case Management Entity
 - Tell me if I am hired
 - Tell me my start date
 - Set the terms of my employment
 - Explain what I will be doing on the job
 - Explain my work schedule
 - Approve my service shifts
- I can be terminated if:
 - I abuse, neglect, or misuse funds or property of the Individual
 - I commit fraud or violate the terms of this agreement
- I must report possible:
 - Neglect
 - Abuse
 - Misuse of funds or property
- My service shift time must be correct and approved to be paid for
- I will be paid in accordance with the payroll schedule set by the SEIU503 Local and the state.
- I cannot submit service shifts or be paid through the program if:
 - My Individual no longer has Medicaid
- Services, tasks, or hours are not authorized
- I work before PPL issues a "Good-to-Go" notice
- I am no longer eligible under program rules to provide services
- The Individual is hospitalized
- The Individual is in a nursing home or similar facility

17. I will let PPL and the Provider Relations Unit know if my personal information changes.
18. I am paid with federal and/or state funds. Submitting accurate information is required by law.
19. If I am paid for the work I did not do, I will have to pay it back. The Program through PPL will pursue all legal means to recover this amount.

If my employment stops for 18 months or longer, I may have to complete new paperwork.

Medicaid Fraud
Medicaid Fraud is a crime. It can lead to penalties and/or jail time. I can report any suspected fraud to PPL, the Case Management Entity (CME), and/or the State.

Overtime
Any overtime worked without approval will not be paid by the Program.

Change of Employer
If a new Employer replaces the previous Employer, they become the successor employer. The Provider must have continued to provide the same services to the same Individual. The new employer is required to keep completed forms. This includes the 1-9.

Electronic Signatures
PPL supports electronic signing of forms if it is lawful and applies.

Agree and Sign
The Provider, Individual, and Employer confirm:

- We have read all of this form
- The details we have provided are accurate and complete
- We agree to follow the policies and procedures of the OR FMAS program
- If employed, any false statement or violation of terms on this agreement may result in dismissal and further actions
- This form is not meant to be a contract of employment
- Employment depends upon verifying my right to work in the US
- We will hold harmless, release, and forever discharge OR ODDS and PPL from any claims and/or damages that might arise out of any action or omissions by the:
 - Provider
 - Employer
 - Representative

Provider Signature: _____ Date: _____

Individual or Employer Signature: _____ Date: _____

www.ppltrst.com Fax: 1-844-399-6593



Employee/PSW Forms

Employment Eligibility Verification I-9

of pages: 1 + 3 instructional pages

Who needs to sign?: Employer & PSW

What am I signing?: This is a Federal form that collects identification that proves the PSW is eligible to work in the United States.

Section 1 is filled in by the PSW includes their signature and date.

Section 2 is filled in by the Employer and includes their signature and date.

Where do I sign?

PSW in the bottom of red section 1

Employer in the bottom of blue section 2

Only return page one of this document – PPL does not need all 4 pages.

Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the [instructions](#).

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in Section 1, or specify which acceptable documentation employees must present for Section 2 or Supplement B, *Reverification and Rehire*. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

Section 1. Employee Information and Attestation: Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.

Last Name (Family Name) First Name (Given Name) Middle Initial (If Any) Other Last Names Used (If Any)

Address (Street Number and Name) Apt. Number (If Any) City or Town State ZIP Code

Date of Birth (mm/dd/yyyy) U.S. Social Security Number Employee's Email Address Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

1. A citizen of the United States

2. A noncitizen national of the United States (See instructions.)

3. A lawful permanent resident (Enter USCIS or A-Number.)

4. A noncitizen (other than item numbers 2 and 3, above) authorized to work until (exp. date, if any)

If you check item number 4, enter one of these:

USCIS A-Number or Form I-94 Admission Number or Foreign Passport Number and Country of Issuance

Signature of Employee Today's Date (mm/dd/yyyy)

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional information.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)	Additional Information				
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative Signature of Employer or Authorized Representative Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete [Supplement B, *Reverification and Rehire*](#) on Page 4.

Form I-9 Edition 08/01/23 Page 1 of 4



Employee/PSW Forms

Federal W-4

of pages: Page 1 is all that is needs to be returned to PPL

Who needs to sign?: PSW only

What am I signing?: Complete this form so that PPL can withhold the correct federal income tax from your pay on behalf of your employer. Confirm that all information is stated correctly.

Where do I sign?

PSW only need to sign and date at the bottom.

Form W-4		Employee's Withholding Certificate		OMB No. 1545-0074
Department of the Treasury Internal Revenue Service		Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Give Form W-4 to your employer. Your withholding is subject to review by the IRS.		2025
Step 1: Enter Personal Information	(a) First name and middle initial _____ Last name _____	(b) Social security number _____		
	Address _____	Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov.		
	City or town, state, and ZIP code _____			
	(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)			
<p>TIP: Consider using the estimator at www.irs.gov/W4App to determine the most accurate withholding for the rest of the year if: you are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.</p> <p>Complete Steps 2-4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at www.irs.gov/W4App.</p>				
Step 2: Multiple Jobs or Spouse Works	Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs. Do only one of the following. (a) Use the estimator at www.irs.gov/W4App for the most accurate withholding for this step (and Steps 3-4). If you or your spouse have self-employment income, use this option; or (b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; or (c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate. <input type="checkbox"/>			
<p>Complete Steps 3-4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3-4(b) on the Form W-4 for the highest paying job.)</p>				
Step 3: Claim Dependent and Other Credits	If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly): Multiply the number of qualifying children under age 17 by \$2,000 \$ _____ Multiply the number of other dependents by \$500 \$ _____ Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here 3 \$ _____			
Step 4 (optional): Other Adjustments	(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income 4(a) \$ _____			
	(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here 4(b) \$ _____			
	(c) Extra withholding. Enter any additional tax you want withheld each pay period 4(c) \$ _____			
Step 5: Sign Here	Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.			
	Employee's signature (This form is not valid unless you sign it.) _____		Date _____	
Employers Only	Employer's name and address _____	First date of employment _____	Employer identification number (EIN) _____	

For Privacy Act and Paperwork Reduction Act Notice, see page 3. Cat. No. 10220Q Form **W-4** (2025)



Employee/PSW Forms

OR State W-4

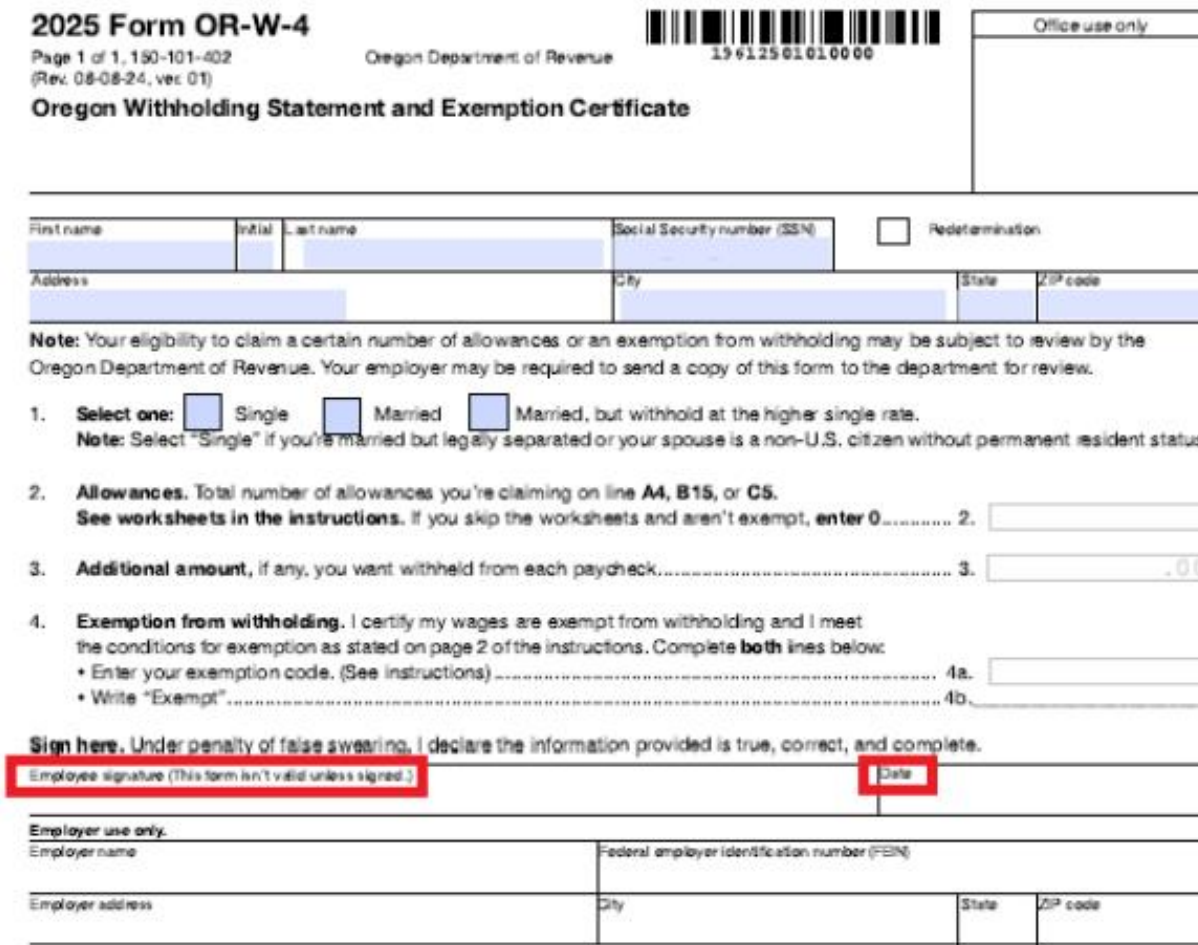
of pages: 1

Who needs to sign?: PSW only

What am I signing?: Complete this form so that PPL can withhold the correct Oregon state income tax from your pay on behalf of your employer. Confirm all the information is stated correctly.

Where do I sign?

PSW only need to sign and date at the bottom.



2025 Form OR-W-4
Page 1 of 1, 150-101-402 (Rev. 08-08-24, ver. 01) Oregon Department of Revenue 19#125 01010000

Office use only

Oregon Withholding Statement and Exemption Certificate

First name Initial Last name Social Security number (SSN) Redetermination

Address City State ZIP code

Note: Your eligibility to claim a certain number of allowances or an exemption from withholding may be subject to review by the Oregon Department of Revenue. Your employer may be required to send a copy of this form to the department for review.

1. **Select one:** Single Married Married, but withhold at the higher single rate.
Note: Select "Single" if you're married but legally separated or your spouse is a non-U.S. citizen without permanent resident status.

2. **Allowances.** Total number of allowances you're claiming on line A4, B15, or C5.
See worksheets in the instructions. If you skip the worksheets and aren't exempt, enter 0..... 2.

3. **Additional amount,** if any, you want withheld from each paycheck..... 3.

4. **Exemption from withholding.** I certify my wages are exempt from withholding and I meet the conditions for exemption as stated on page 2 of the instructions. Complete **both** lines below:
• Enter your exemption code. (See instructions) 4a.
• Write "Exempt" 4b.

Sign here. Under penalty of false swearing, I declare the information provided is true, correct, and complete.

Employee signature (This form isn't valid unless signed.) Date

Employer use only.

Employer name Federal employer identification number (FEIN)

Employer address City State ZIP code

— Submit this form to your employer —



Employee/PSW Forms

Difficulty of Care

of pages: 1


Who needs to sign?: PSW only

What am I signing?: PPL will auto-fill the names and PPL IDs. PSW will answer the questions regarding their living situation to the Participant.

Where do I sign?

PSW only need to sign and date at the bottom.

OREGON | FMAS



DIFFICULTY OF CARE FEDERAL INCOME EXCLUSION

Provider Name
First: Last: PPL ID:

Individual Name
First: Last: PPL ID:

Employer Name (this must be completed)
First: Last:

Some Employees may not owe taxes on their Self-Directed Services earnings. This is because they qualify for the Difficulty of Care Federal Income Exclusion (DOC). In that case, Public Partnerships LLC (PPL) will not report the payments as income and will not withhold applicable taxes. As a reminder, PPL is not your Employer.

To determine if you qualify, read the items below.

For more information please visit: <http://www.pplfirst.com>

Part 1: Applying for Difficulty of Care Federal Income Exclusion
Select all that apply:

- I provide services to the Individual in my home.
- I do not have a separate home where I live.
- This is the home where I live and perform the routines of private life, including shared meals and holidays.

! IMPORTANT:

- If all the above apply, you qualify for the DOC.
- If both the state taxing authority and program rules follow federal guidelines for DOC, the exclusion would also apply at the state level.
- You understand that if you no longer live with the Individual, you will no longer qualify. You must cancel the DOC by completing Part 2 below.

If none of the above apply, select the option below.

None of the above.

Part 2: Cancelling Difficulty of Care Federal Income Exclusion
Select if applies:

- I no longer live with the Individual that I provide services to.

Agree and Sign
I confirm:

- I have read all of this form.
- I am providing services to the Individual receiving payments under a state Medicaid, Home and Community-Based Services program.
- The details provided are accurate and complete.

Provider Signature: **Date:**

www.pplfirst.com Fax: 1-844-399-6593 v.1



Employee/PSW Forms

Tax Exemption


of pages: 1

Who needs to sign?: PSW only

What am I signing?: PPL will auto-fill the names and PPL IDs. PSW will answer the questions regarding relationship to the Employer.

Where do I sign?
PSW only need to sign and date at the bottom.

OREGON | FMS



TAX EXEMPTIONS

Provider Name

First: Last: PPL ID:

Individual Name

First: Last: PPL ID:

Employer Name (this must be completed)

First: Last:

The statements below are used to determine the tax exemptions that may apply to you and the Employer, based on IRS regulations and applicable Federal/State tax laws. As a reminder, Public Partnerships LLC is not your Employer.

Please complete Part 1 and Part 2.

Part 1 (you must select one of the following statements)

I am the spouse of the employer.

I am the parent of the employer (including legally adopted children).

Select all that apply:

I also provide care for my grandchild or step-grandchild in my child's home.

My grandchild or step-grandchild is under 18 or has a physical or mental condition that requires personal care of an adult for at least four weeks in a row during the calendar quarter in which services are performed.

My child (son or daughter) is widowed, divorced, not remarried or living with a spouse who has a mental or physical condition so the spouse cannot care for my grandchild for at least four weeks in a row during the calendar quarter in which services are performed.

I am the child of the employer (including legally adopted children).

I am not the spouse, parent, or child of the employer.

Part 2 (select all that apply)

I am a full-time student.

This job of performing household services (respite) is my primary job.

I am 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 providing domestic services.

: IMPORTANT: If your information changes you must report it.

Agree and Sign

The Provider confirms:

- I read all of this form.
- The details provided are accurate and complete.
- Any false statement on this form may result in the Provider's dismissal.
- This document is not a contract between the signing Parties, PPL or the State.
- Employment depends on my right to work in the US.

Provider Signature: Date:

www.pplfirst.com Fax: 1-844-399-6593 v.1





How to Return Paperwork

How to Return Enrollment Paperwork

Paperwork can be returned in a number of ways – choose the one that is best for the Employer and/or PSW.

- ❖ AdobeSign – when you complete this packet on Adobesign the packet will automatically be sent to PPL – you do not need to do anything.
- ❖ Email: pplorfmas@pplfirst.com
- ❖ Turn it back into the Case Manager
- ❖ Fax: 844-399-6593
- ❖ Mail:
PPL-OR FMAS
17 Plaza Drive Suite 300
Latham, NY 12110
- ❖ Upload directly into the PPL BetterOnline® Portal
 - ❖ You will need to create a user account prior to using this option.



Contact Us

Contact Us!

We Are Here to Help

Hours of Operations: 8am-5pm PT
English Customer Service: 1-888-419-7705
Spanish Customer Service: 1-888-419- 7720
Russian Customer Service: 1-888-419-7734
TTY: 1-800-360-5899
Fax: 1-844-399-6593
Email Customer Service:
PPLORFMAS-CS@PPLFIRST.COM





YOUR LIFE
YOUR CARE
YOUR PEOPLE

Thank you!