CalPERS Long-Term Care Program

INDEPENDENT PROVIDER PACKET

This letter is in response to your request to use an Independent Provider (IP) for your home care services. Attached is an Independent Provider Packet. Please review the enclosed *Information Page* that contains the requirements to approve an IP.

Please return the completed forms to our office along with the necessary supporting documentation. You may return the completed forms to us via fax to 1-866-294-6967 (preferred) or mail to CalPERS Long-Term Care Program, P.O. Box 64902, St. Paul, MN 55164. We will advise you, in writing, when a decision is made concerning your eligibility for benefits, and whether coverage for the IP you have requested is approved.

An in-person assessment may be required. If this is the case, you will be contacted to schedule this visit. The assessment will be reviewed in conjunction with all other submitted information and claim proofs to determine benefit eligibility and coverage for the IP you have requested.

If coverage for the requested IP is approved, the following information will be needed from you for reimbursement of expenses incurred for IP services:

- Independent Provider Weekly Timesheet (attached)
- Valid proof of payment for each Weekly Timesheet
- Assignment of Benefits form with completed IRS form W-9 (if you choose to assign benefits to the provider)

The enclosed document, *Independent Provider Timesheet Instructions and Required Documentation*, provides instructions for completing the IP Weekly Timesheets and describes the required supporting documentation you must submit. We recommend you review this information with your IP(s) to ensure their understanding of these requirements.

Your Care Manager must be involved on an ongoing basis. All changes regarding your independent provider and your Plan of Care must be reported to your Care Manager. Changes include but are not limited to an increase or decrease in hours, services, or wages; ongoing provider changes; and additional proposed IP's. All changes must be pre-approved by your Care Manager to be considered for reimbursement under your plan.

Your Care Manager may also contact you periodically. For example:

- He/she may send you an IP Questionnaire to gather information necessary to monitor your Plan of Care.
- He/she may schedule an in-person assessment in order to ensure the services provided to you by your IP are appropriate to your needs and continue to meet the conditions noted in your plan.

If you have any questions regarding this request, please call our Claims Representatives at 1-800-982-1775, between 8:00 a.m. and 6:00 p.m. Pacific Time, or e-mail us at calpersltc@illumifin.com.

Sincerely,
Claims Department

illumifin - Administrator for CalPERS Long-Term Care Program

CalPERS Long-Term Care Program

INFORMATION PAGE

Required for Approval: *The following items are required to consider each Independent Provider as approved under your long-term care coverage*

❑	Independent Provider Personal and Professional History sheet	This form must be submitted for each caregiver for whom you are requesting reimbursement.
❑	Government Issued Photo ID	Copy of a government-issued photo identification card.
❑	Proof of Training or Licensure	Copy of licensure and/or certification of applicable training.
❑	I-9 Form	The blank form is available from the USCIS Web site at http://www.uscis.gov. If you are an employer, you must keep the original jointly signed form.

Required if IP is Approved: *The following forms are optional, please complete if applicable*

❑	Independent Provider Weekly Timesheet	As the employer, you are responsible for submitting completed timesheets for the services provided to you from an independent provider.
❑	Acknowledgement of Terms and Release of Liability for Independent Provider(s)	This form must be signed by both the Claimant and the IP, which demonstrates that they understand the responsibilities being undertaken as an employer and employee, as well as the Program's expectations.
❑	Proof of Payment	You will be required to submit proof of payment for services provided by your Independent Provider on a quarterly basis. Acceptable forms of proof of payment are as follows: • Original cancelled checks drawn from your bank account (If you do not have the original cancelled checks, you may provide copies produced by your financial institution) • Electronic funds transfer statement • Credit card transaction statement • Payroll service statement

Optional: *The following forms are optional, please complete if applicable*

❑	Assignment of Benefits Form	Fill this out along with a completed W-9 form if you want any payments to go directly to your provider.
❑	Direct Deposit Form	We encourage you to fill out if you would like your payment deposited directly into your bank account. This is the quickest way to get reimbursed, since it eliminates the time it takes us to cut and send out a check in the mail.

Informational Only: *The following items are information only, please do not return*

	Choosing an Independent Provider	Provides guidelines and recommendations for Independent Providers, including proof of training.
	Independent Provider Weekly Timesheet Instructions	Provides instructions for completing the IP Weekly Timesheets and describes the required supporting documentation you must submit. We recommend you review this information with your IP(s) to ensure their understanding of these requirements.
	Fraud Warning Statements	Please review the applicable warning for the state where you reside and the state where your insurance policy was issued.

Choosing an Independent Provider (page 1 of 2)

(INFORMATIONAL DOCUMENT NOT FOR COMPLETION)

Choosing an Independent Provider is an important decision. The caregiver must be someone who can be trusted and that you can count on to provide necessary assistance. The following are a few suggestions of where you might begin looking for a qualified provider:

- **Home Care Registry or Employment Agency:** usually listed in the yellow pages of your local phone book. These agencies may have already screened the applicants and may charge a finder's fee or monthly service charge.
- **Churches/ Synagogues:** they often have community bulletin boards, newsletters, senior groups or other programs that may be a referral source.
- **Newspaper Advertisements:** you may consider placing an ad in your local community paper.
- **Community Colleges, Vocational/Technical Schools:** schools that offer nursing classes, Home Health Aide/Nurses aide training may be excellent referral sources.

Ineligible Independent Providers

Due to potential conflict of interest or policy exclusion, we will not approve the following as Independent Providers:

- **Family members** or other individuals who already reside with you
- **Your attorney-in-fact** or other legal representative

Interviewing a Potential Independent Provider

An in-person interview is a crucial part of the selection process. Before you start interviewing people for the job, you may wish to develop a list of the tasks the provider will be expected to perform and your expectations as an employer.

Suggested Interview Questions:

- What interests you about this job?
- Tell me about your current and past home care experiences.
- Why did you leave your last job?
- What would you do in case of an emergency such as (I) fall?
- What salary and benefits are you looking for?
- What days and during what time of day are you available?
- What qualifications and training do you bring to this job?

While interviewing the person, observe for the following:

- ➔ Is this a personality I think I can work with?
- ➔ Do they appear to have the attributes needed to do the job, i.e. do they look like they can transfer me if needed?
- ➔ Can I communicate easily with this person?

References, Training, Education and Skills

Reference checks are a critical step when selecting an employee, since this individual will be in your home. The more you know of their background and qualifications the better able you will be to select a competent employee who can be entrusted to provide care. It is recommended you call and check at least two personal or professional references.

Choosing an Independent Provider (page 2 of 2)

(INFORMATIONAL DOCUMENT NOT FOR COMPLETION)

Suggested Reference Questions:

- How long did this person work for you?
- How long have you known this person?
- Why did they leave your employment?
- Were they reliable when they worked for you, did they arrive on time, leave on schedule?
- How was their attendance while employed for you? Did they call when they were not able to work, etc.?
- Would you rehire this person?

Proof of Training

For individuals who require assistance with Activities of Daily Living, i.e., bathing, dressing, toileting, transfers, continence cares, and eating (not meal preparation), a caregiver should have proper training to ensure the safety of both the individual and the caregiver. The following are considered adequate training:

- Evidence of current or expired license or certification as a CNA (certified nursing assistant), NA (nursing assistant), HHA (home health aide), PCA (personal care assistant/personal care attendant).
- Completion of a training course for home care which includes course work in safe transfers and providing personal care to persons with physical disabilities. Evidence in the form of a Certificate of Completion or letter from an official at the school or training center is required.
- Proof of training in the provision of personal care through prior employment in a long-term care facility as a Personal Care Attendant or similar position.
- Written verification from a current agency employer that describes the training received.

NOTE: CPR certification or First Aid or Red Cross training without specific training in providing physical assistance is not considered adequate training for persons who require assistance with Activities of Daily Living, since such courses do not include training in providing safe transfers.

Individuals who require supervision to ensure their safety (i.e. individuals with a cognitive impairment) should consider a caregiver who understands the needs of individuals with dementia. The following are considered proof of training:

- Evidence of completion of a caregiver training course, or
- Evidence of completion of a training course for home care which includes working with persons with dementia or memory loss, or
- Verification of experience providing safe supervision of persons with dementia by virtue of the caregiver's prior employment in a facility or for an individual.

Setting Expectations with the Independent Provider

After you have selected your candidate, you may wish to express your expectations to your employee(s) regarding the following:

- Schedule: days needed, hours needed
- Rate of pay, method of payment
- Payday
- Illness/absences
- Paid vacation, holidays, make-up time
- Emergencies or reimbursement in the event you are hospitalized
- Care fare, gas reimbursement or mileage
- Meals, food and/or housing provided
- What to do in case of an emergency
- Record keeping
- Supervision procedures
- Taxes
- Notice or termination of employment

Note: The above are suggestions for your personal use in employing an Independent Provider and do not change or expand the definition of covered services under your long-term care insurance policy.

CalPERS Long-Term Care Program

INDEPENDENT PROVIDER PERSONAL AND PROFESSIONAL HISTORY

Instructions: *This form must be completed, in full, by the claimant or the claimant's representative for the Independent Provider (IP) named below to be considered as a provider under the claimant's long-term care insurance policy. The information should be completed with the assistance of the IP. Both the claimant and the IP must sign and date the form, and are responsible for the accuracy of the information provided. Complete and accurate information will help to avoid unnecessary delay in the review of the claim. CalPERS Long-Term Care Program and its Administrator recommend you keep a copy of this application and all other documents submitted.*

You may return the completed form via fax to 1-866-294-6967 (preferred) or mail to: CalPERS Long-Term Care Program, P.O. Box 64902, St. Paul, MN 55164.

Claimant Name: _____ Email: _____
Coverage ID Number: _____

Service Location (where care will be provided by the IP)
Address: _____

City: _____ State: ____ Zip: _____

Independent Provider Information *(Please attach a copy of the Independent Provider's Government issued photo ID)*:
Name: _____ Phone: (_____)_____

Address: _____ Email: _____

City: _____ State: ____ Zip: _____

Independent Provider's Tax ID, Social Security #, or Driver License number: _____

Is this provider related to you? ❑ Yes ❑ No If yes please specify relation: _____

Does this Independent Provider live in your home? ❑ Yes ❑ No

Is this provider replacing a previous provider? ❑ Yes ❑ No If yes please specify who: _____

Does this IP hold Power of Attorney or other legal authorization to act on your behalf? ❑ Yes ❑ No
If Yes, please describe: _____

Is this IP currently receiving Social Security Disability Income or any other disability benefits or income? ❑ Yes ❑ No
If Yes, please describe: _____

Is this IP employed by anyone other than/in addition to you? ❑ Yes ❑ No If Yes, by who? (please provide name and phone number of other employer: _____

Does this IP provide assistance or service to anyone else in your household? ❑ Yes ❑ No
If Yes, please explain: _____

When did this IP start providing services to you? Date: _____

Is this IP able to physically assist you with your Activities of Daily Living? ❑ Yes ❑ No
If No, please provide details: _____

Training/Education/Skills *(please enclose a copy of any license/certification):*
Type of license/certification: _____
Insured: ❑ Yes ❑ No *(if yes, please enclose copy)* Expiration date:_____
Bonded: ❑ Yes ❑ No *(if yes, please enclose copy)* Expiration date:_____

Describe pertinent education or skills and why you want to hire this person *(reference checks are recommended; if obtained, please attach copies)*:

_____

_____

Schedule: Which days per week will the IP work? Report all days that IP will provide services and indicate what hours will be worked in the following table.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Time In (Specify AM/PM)							
Time Out (Specify AM/PM)							
Total Hours Per Day							

What is the rate per hour you will be paying this IP? (Daily and weekly rates are not accepted.) $_____

Do you intend to withhold any payment of taxes owed to state, local or federal governments? ❑ Yes ❑ No

If yes, does the rate per hour above include the taxes owed to state, local or federal governments? ❑ Yes ❑ No

Note: All applicable federal, state and/or other taxes owed by you as the employer are not eligible for reimbursement under your plan.

What care will this person be providing to you?

_____
_____
_____
_____

Please specify if someone, other than the claimant, will be managing the Independent Provider

Name:_____ Phone: (_____)_____

Address: _____City: _____ State:_____ Zip:_____

Email: _____ Relationship: _____

Power of Attorney or conservatorship information must be submitted for the individual named above.

By signing below, I declare that the information provided is true and correct to the best of my knowledge and understand this Independent Provider must be a part of the approved Plan of Care developed by the Care Manager.

Claimant/Representative Signature: _____ Date: _____

Claimant/Representative Printed Name: _____

If Representative, give relationship to Claimant: _____

Independent Provider Signature: _____ Date: _____

CalPERS Long-Term Care Program

ACKNOWLEDGEMENT OF TERMS AND RELEASE OF LIABILITY FOR INDEPENDENT PROVIDER(S)

Instructions: *This form must be signed by both the Claimant and the Independent Provider (IP), which demonstrates that they understand the responsibilities being undertaken as an employer and employee, as well as the Program's expectations. Please return the completed form via fax to 1-866-294-6967 (preferred) or mail to: CalPERS Long-Term Care Program, P.O. Box 64902, St. Paul, MN 55164.*

1. Any employer/employee relationship or contractual relationship concerning the provisions of care is strictly limited to you and the Independent Provider. Neither CalPERS Long-Term Care Program, nor its Administrator, nor the assigned Care Advisory Agency is a party to such relationship.
2. Payment for services to the IP is entirely the Claimant's responsibility, regardless of whether the Program is liable for reimbursement of the claim.
3. Any expenses the Claimant incurs acting as an employer, which may include payment of taxes to state, local or federal government in addition to those amounts withheld from my salary, are the Claimant's responsibility. The Claimant will contact his/her tax accountant or attorney with any employer tax questions.
4. The Claimant is obligated to abide by any local, state, or federal laws and regulations applicable to any employer-employee relationship. The Program reserves the right to request proof of compliance with such laws and regulations.
5. The Program can offer an Assignment of Benefits to the IP. This means payment could be made directly to the IP upon receipt of timesheets and other documentation of the services provided. The Claimant and IP must agree and sign an Assignment of Benefit form, and the IP must submit a completed W-9 form.
6. A Care Manager must approve the IP prior to the start of care and has the right to review the IP's eligibility on an on-going basis. Services provided by the IP must be consistent with the approved Plan of Care. I understand that the Program reserves the right to terminate approval of a Plan of Care and/or an IP at any time if the Care Manager determines that use of an IP is no longer appropriate.
7. The Claimant and IP have reviewed the IP Packet. Both the Claimant and IP understand their responsibilities as employer and employee.
8. I have read and understand the IP Weekly Timesheet instructions. It is the IP's responsibility to complete original, not copied, timesheets for each week of service. Timesheets must be filled out completely and reflect the specific services provided to the Claimant. The Claimant is responsible for completion of this packet and the submission of all required documentation for the Program's review in order to process claims. Required documents include, but are not limited to, IP Weekly Timesheets and proof of payment corresponding to each IP Weekly Timesheet.
9. I understand the Program reserves the right to conduct a criminal background investigation on the IP at any time.
10. CalPERS Long-Term Care Program and its Administrator are not responsible for the quality of care provided by this IP, and have no liability regarding the acts or omissions of the Claimant or the IP.

I have read and understand the above Independent Provider Acknowledgement of Terms and Release of Liability.

_____

*Signature of Claimant or *Legal Representative* *Date signed (Month, Day, Year)*

_____

Printed Claimant's or Legal Representative's Name

_____

If Representative, give relationship to Claimant

**If you are signing as a legal representative, describe the scope of your authority to act on the Claimant's behalf and include a copy of the documentation of your legal authority.*

_____

Signature of Independent Provider *Date signed (Month, Day, Year)*

_____

Printed Name of Independent Provider

Independent Provider Timesheet Instructions and Required Documentation

(INFORMATIONAL DOCUMENT NOT FOR COMPLETION**)**

Completion of Weekly Timesheets

As the employer, you are responsible for submitting completed timesheets for the services provided to you from an IP. A timesheet must be submitted weekly, bi-monthly, or monthly. Following are instructions for completion of the weekly timesheets.

- Timesheets must be completed accurately and reflect all services provided to you. A new timesheet must be completed for each week of care. While you may make photocopies of blank timesheets for future submissions, all information you and your caregiver enter must be originally created each week.
- Only services outlined in your Plan of Care and listed as covered by the Plan are eligible for reimbursement.
- If there is a difference between the check amount and the amount charged on the timesheet, you must provide an explanation in the 'Comments' section of the timesheet.
- Reimbursement is provided for tax withholdings from the employee's gross wage. Reimbursement is not provided for amounts you, as the employer, pay for local, state or federal taxes, including but not limited to unemployment, Social Security and/or Workers' Compensation or similar programs. If there are employee tax withholdings, please check the appropriate box and indicate the dollar amount withheld. The sum of the withholdings and the proof of payment must equal the weekly charge amount. Documented evidence of the employee withholdings must also be provided. *We do not provide tax advice. Please contact your tax accountant or attorney with any employer/employee tax questions.*
- No benefits will be provided for expenses claimed on timesheets which are incomplete or which contain copied information from prior weeks.
- It is the IP's responsibility to sign only completed timesheets. By signing and dating each timesheet, the IP agrees the information you are submitting is accurate.
- You have the option to request that benefits payable for the services of your IP be assigned to that individual. This means that we will issue benefit payments directly to your caregiver, then issue an IRS Form 1099 to that individual at the end of each year. If you wish to assign benefits directly to your IP, please complete and submit an Assignment of Benefits form, and have the IP complete and submit IRS form W-9.
- If benefits are not assigned, you must maintain acceptable proof of payment and provide that to us with each timesheet.

Description of Services

On the timesheet, use the following guide to indicate the level of assistance provided with each ADL (Activities of Daily Living) for each date of service. Leave the section blank for the activities for which no assistance was provided.

1 = No assistance is provided, resident is Independent
2 = Claimant uses equipment, does not receive assistance from another person
3 = Receives cueing/prompting to initiate or complete the ADL due to memory loss
4 = Receives stand-by assistance (person within arm's reach) from another person to complete the ADL
5 = Receives hands-on assistance from another person to complete some or all of the ADL
6 = Unable to participate in any part of the ADL

Please refer to your policy for complete definitions of each ADL as well as other personal care needs.

Proof of Payment

If you do not assign benefits to your IP, must submit proof of payment for IP services with each claims submission. Proof of payment must match information found on the timesheet. If there is a difference between what you pay your caregiver and the amount shown on the timesheet, you must explain the basis for the difference.

Acceptable forms of proof of payment are as follows:

- Original or copies of cancelled checks that are written to the IP that would include the specific dates of service that are applicable for the charges in the memo portion of the check. (If copies, they must be processed by your financial institution and include both the front and back of each check);
- Electronic funds transfer statements;
- Credit card transaction statements;
- Payroll service statements;
    - Copy of the live cashier's check that is written to the IP (**before cashed by the IP**) that would include the specific dates of service that are applicable for the charges in the memo portion of the check; or
    - Copy of the live money order that is written to the IP (**before cashed by the IP**) that would include the specific dates of service that are applicable for the charges in the memo portion of the order.

Note: payment by any other method, including cash, is not acceptable.

CalPERS Long-Term Care Program

INDEPENDENT PROVIDER WEEKLY TIMESHEET

Instructions: *Please submit a separate weekly time sheet for each IP. All information must be original. Documentation of care, hours worked, amount paid, signatures and signature dates copied from other timesheets (i.e. from week to week) are unacceptable. A column must be completed for each day of provided services with the hours worked and dollars paid for each day documented. Please refer to the instructions for further information. You may return the completed form via fax to 1-866-294-6967 (preferred) or mail to: CalPERS Long-Term Care Program, P.O. Box 64902, St. Paul, MN 55164.*

Claimant Name: _____	IP Name: _____
Coverage ID Number: _____	IP Phone: _____

*Use the following guide to indicate the **level of assistance provided** with the following Activities of Daily Living (ADLs) for each day of service. Leave the section blank for the activities for which no assistance was provided.*

1 = No assistance is provided, resident is Independent
2 = Claimant uses equipment, does not receive assistance from another person
3 = Receives cueing/prompting to initiate or complete the ADL due to memory loss
4 = Receives stand-by assistance (person within arm's reach) from another person to complete the ADL
5 = Receives hands-on assistance from another person to complete some or all of the ADL
6 = Unable to participate in <u>any</u> part of the ADL

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Month/Day/Year							
Time In (specify am/pm)							
Time Out (specify am/pm)							
Activities of Daily Living *(Use key above and enter level of assistance provided)*							
Bathing							
Dressing							
Toileting							
Transferring							
Incontinence Care							
Eating (feeding, not meal prep)							
Additional Care Needs							
Mobility							
Medication Administration							
Homemaker Services *(check box if any services listed below are provided)*							
Housekeeping	❑	❑	❑	❑	❑	❑	❑
Laundry	❑	❑	❑	❑	❑	❑	❑
Meal Preparation	❑	❑	❑	❑	❑	❑	❑
Medication Reminders	❑	❑	❑	❑	❑	❑	❑
Money Management	❑	❑	❑	❑	❑	❑	❑
Shopping	❑	❑	❑	❑	❑	❑	❑
Social Companionship	❑	❑	❑	❑	❑	❑	❑
Telephone Use	❑	❑	❑	❑	❑	❑	❑
Transportation	❑	❑	❑	❑	❑	❑	❑
Other: _____	❑	❑	❑	❑	❑	❑	❑
Supervision to Ensure Safety							
Supervision	❑	❑	❑	❑	❑	❑	❑
Hours Worked							
Dollars Paid	$	$	$	$	$	$	$

General Comments/Observations/Changes in condition or services explanation of weekly charge not matching proof of payment (please add additional pages as needed): _____

_____

❑ Check this box if you are withholding employee taxes. Please indicate weekly amount withheld. _____
Sum of withholding and proof of payment must equal the weekly charge.

Total hours worked this period (from Sun-Sat): _____ Hourly Rate: $_____ Total Weekly Charge: $_____

I declare that all of the above information is complete and true to the best of my knowledge. I understand that CalPERS Long-Term Care Program reserves the right to require further proof of services and/or payment.

Claimant/Representative Signature: _____ Date: _____

Independent Provider Signature: _____ Date: _____

The IP and Claimant/Representative must not sign or date the timesheet until the week is over, all services have been rendered, and the timesheet is completed in full.

CLAIM FRAUD WARNING STATEMENTS

AL: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

AK: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

AZ: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

AR, LA, RI, TX and WV: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CA: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DE, FL, ID, IN and OK: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DC: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

KY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

ME, TN, VA and WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MD: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MN: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NH: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NJ and NM: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OH and OR: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, files a claim containing a false or deceptive statement material to the risk may be guilty of insurance fraud.

PA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

PR: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

CalPERS Long-Term Care Program

ASSIGNMENT OF BENEFITS FORM

Instructions: *Please complete and sign this form if you and your provider have agreed to establish an Assignment of Benefits. You must first establish if the provider is willing to consider this Assignment of Benefits. The service provider will need to submit their Tax Identification Number (Social Security Number if service provider is an independent provider) and attach a completed W-9 form so the payments will be made directly to the service provider.*

The Assignment of Benefits will not be in effect until CalPERS Long-Term Care Program has received the completed form. The Assignment of Benefits may be terminated in the future upon receipt of a written request stating you or the provider wishes to revoke the Assignment of Benefits.

You may return the completed form via fax to 1-866-294-6967 (preferred) or mail to: CalPERS Long-Term Care Program, P.O. Box 64902, St. Paul, MN 55164.

Claimant Name: _____
Coverage ID Number: _____

I, _____ , the Claimant or the guardian or other legal Representative of the Claimant (legal documentation of guardianship or other representative capacity, if appropriate, is attached), hereby authorize direct payment to _____ (provider) of any long-term care benefits otherwise payable to or on behalf of the Claimant for the services provided at a rate not to exceed the Provider's regular charges. It is agreed that payment to the Provider, pursuant to this Assignment of Benefits, by the plan administrator shall discharge CalPERS Long-Term Care Program of any and all obligation under the plan to the extent of such payments. It is understood by the undersigned that he/she is financially responsible for any charges not covered by this Assignment of Benefits. This Assignment of Benefits is valid for CalPERS Long-Term Care Program.

_____ _____ *Service Provider Representative Signature* *Date*	_____ _____ *Claimant/Legal Representative Signature* *Date*
_____ *Printed Name of Service Provider Representative*	_____ *Printed Name of Claimant/Legal Representative** **If you are signing as a legal representative, describe the scope of your authority to act on the Claimant's behalf and include a copy of the documentation of your legal authority.*

Provider's Federal Tax ID Number/Social Security Number: _____

_____
Name of Service Provider

_____
Street Address City State Zip Code

Form **W-9**
(Rev. November 2017)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▸ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▸ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▸

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any)

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–		–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person** ▸ **Date** ▸

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

CalPERS Long-Term Care Program

DIRECT DEPOSIT FORM

for Long-Term Care Claim Reimbursements

Instructions: *Please complete and sign this form if you wish to use direct deposit for your long-term care benefit payments. You must also attach a copy of a* ***Voided Check or Savings Account Withdrawal slip****.*

If you are anyone other than the Claimant requesting a direct deposit, a completed Assignment of Benefits form and current W-9 are required for the direct deposit request to be completed.

You may return the completed form via fax to 1-866-294-6967 (preferred) or mail to: CalPERS Long-Term Care Program, P.O. Box 64902, St. Paul, MN 55164.

Claimant Name: _____

Coverage ID Number: _____

Section I – Name for Direct Deposit Setup

_____

Payee Name

_____

Social Security # or Federal Tax ID #

Section II – Direct Deposit Information

Check off one: ❑ Initial Setup ❑ Account Change

Enter the account where payment should be disbursed. The nine-digit transit number and account number is encoded at the bottom of your check. A copy of a VOIDED CHECK or SAVINGS ACCOUNT WITHDRAWAL SLIP ***must*** be attached to ensure the correct numbers are obtained. Please allow six weeks for setup of direct deposit.

Account Type: ❑ Checking ❑ Savings

Bank Name	**Transit Number**	**Account Number**

Section III – Authorization

I hereby authorize CalPERS Long-Term Care Program to initiate credit entries to the Bank indicated by the Transit Number on this form. If necessary, I also authorize debit entries and adjustments for any credit entries in error to my account indicated on this form. The authority is to remain in full force and effect until CalPERS Long-Term Care Program has received written notification from me of its termination in such time and in such manner as to afford CalPERS Long-Term Care Program and the Bank a reasonable opportunity to act on it.

_____ _____

Signature of Account Holder *Date*

_____ _____

Account Holder Name *Account Holder Phone Number*