Statement of Compliance To
IRS Section 131 Notice 2014-7
(Difficulty of Care)

This form is to inform Acumen that I ☐ qualify ☐ no longer qualify for Difficulty of Care.

INDIVIDUAL CARE PROVIDER (EMPLOYEE):
Per the above rules, the undersigned hereby declares:

Under penalties of perjury, I declare that I am an individual care provider receiving payments under a qualifying state Medicaid program as defined in IRS Notice 2014-7 for care I provide to _____(Participant), who lives in my home under a plan of care.

I am not required to report income earned under this program. Federal, and if my state allows, state income taxes should not be withheld from my paycheck.

If non-taxable wages have been reported by Acumen Fiscal Agent in Box 1 of my Form W-2, I can deduct the nontaxable wages from my taxable income as directed in IRS Notice 2014-7 when I file my tax return.

If I no longer qualify for IRS Notice 2014-7, I will notify Acumen Fiscal Agent in advance of the change. At that time, the federal and state income tax withholding, if applicable, will resume. By signing below, I understand it is my responsibility to notify Acumen Fiscal Agent within three (3) business days of moving; if I move from the home or the Participant no longer lives with me.

I agree that Acumen Fiscal Agent will stop federal and state income withholding, if applicable, on all time submitted after this form is signed and provided to Acumen Fiscal Agent. By signing below, I attest that the Participant lives in my home. All of the following information is required:

Printed Name:_____

Signature:_____ Date:_____

Employee ID#:_____ Social Security # (last 4):_____

EMPLOYER or DESIGNATED REPRESENTATIVE:
As the individual receiving care from _____(Employee), I am familiar with the laws supporting this Notice. I agree with my individual care provider's statement and signature above. I also agree that this is an accurate representation of the facts regarding services performed on my behalf.

Printed Name:_____

Signature:_____ Date:_____

Participant Name:_____ FEIN# (optional): _____

State:_____ Program (optional): _____

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