Program: OR FMAS
Phone: 1-888-419-7705 (English) 1-888-419-7720 (Español
Phone: 1-888-419-7734 (Русский) **TTY: 1-800-360-5899**
Administrative Fax: 1-844-399-6593
E-mail: PPLORFMAS@pcgus.com

PCG Public Partnerships
Supporting Choice. Managing Costs.™

Employee Application for Difficulty of Care Federal Income Tax Exclusion

Employee Name: Employee ID: PORF-

Individual Name: Participant ID: CORF-

SECTION A – Applying for a Difficulty of Care Federal Income Exclusion

Certain payments received by a personal support worker for providing Medicaid services in the worker's home are considered Difficulty of Care payments excludable from federal income tax. To determine if you are eligible for the income exclusion, complete the following steps. If you are eligible, the Office of Developmental Disabilities Services will not report the payments as income and will not withhold federal income taxes.

STEP 1: Review information regarding the Difficulty of Care Federal Income Tax Exclusion. Information is available on PPL's website at: http://www.publicpartnerships.com.

STEP 2: Check all that apply:

- ☐ **I provide services to the individual in my home.**
- ☐ **I do not have a separate home where I reside.**
- ☐ **This is the home where I reside and regularly perform the routines of private life, including shared meals and holidays with family.**

STEP 3: If all of the above do not apply, you are not eligible for the Difficulty of Care Federal Income Tax Exclusion. Do not send in this form.

STEP 4: If all of the above apply, you are eligible for the Difficulty of Care Federal Income Tax Exclusion. Complete the information below, sign, and return to PPL.

Under penalties of perjury, I declare that I am a personal support worker receiving payments under a state Medicaid Home and Community-Based Services program. I live in the home with, and I provide services to, the Individual listed at the top of this form.

Employee Signature / / Date

SECTION B – Terminating Difficulty of Care Federal Income Tax Exclusion

<Complete the below section ONLY if you are terminating your exclusion.>

Under penalties of perjury, I declare that I no longer reside with an individual that I provide services to and who is receiving payments under a state Medicaid Home and Community-Based Services program.

Employee Signature / / *Date that I no longer qualify for the exclusion.*

Mail Form to **OR FMAS Program ● PO Box 50040 Phoenix, AZ 85076 or Fax to 1-844-399-6593**