PCG Public Partnerships
Supporting Choice. Managing Cost.™

DIFFICULTY OF CARE FEDERAL INCOME EXCLUSION

Provider Information

First Name: _____ **Last Name:** _____ **PPL ID:** _____

Participant Information

First Name: _____ **Last Name:** _____ **PPL ID:** _____

Employer Information (complete this section even if the employer is the same as the participant)

First Name: _____ **Last Name:** _____

Some Employees may owe no taxes on their Self-Directed Services earnings. This is because they qualify for the Difficulty of Care Federal Income Exclusion. In that case, Public Partnerships will not report the payments as income and will not withhold applicable taxes. As a reminder, Public Partnerships LLC is not your Employer.

To determine if you qualify, read the following items below

For more information regarding the Difficulty of Care Federal Income Exclusion visit: **http://www.publicpartnerships.com**

Part 1: Applying for Difficulty of Care Federal Income Exclusion

Select all that apply:

☐ I provide services to the Participant 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.

! IMPORTANT:

- If all the above apply, you are eligible for the Difficulty of Care Federal Income Exclusion.
- If both the state taxing authority and program rules follow federal guidelines for the difficulty of care exclusion, the exclusion would also be applicable at the state level.
- You understand that if you no longer reside with the participant, you will no longer qualify and must terminate the Difficulty of Care Federal Income Exclusion by completing Part 2 below.

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

☐ None of the above.

Part 2: Terminating Difficulty of Care Federal Income Exclusion

Select if applies:

☐ I no longer reside with the participant that I provide services to.

Authorization and Signature

Under penalty of perjury, I declare that I am the Provider, of the Participant/Employer, receiving payments under a state Medicaid, Home and Community-Based Services program, and that the information and responses provided on this form are accurate and complete.

Provider Signature: _____ **Date:** _____