WV ADW Personal Options
Phone: 304-381-3100 or 1-888-775-9801
TTY: 1-800-360-5599
Admin Fax: 1-866-388-1626

PCG Public Partnerships
Supporting Choice. Managing Costs.™

Employee Application for Difficulty of Care Federal Income Tax Exclusion

Employee Name: Employee ID:

Participant Name: Participant ID:

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

Certain payments received by an individual care provider for providing Medicaid services in the provider'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, PPL 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 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.**

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 an individual care provider 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*

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

SECTION B – Terminating Difficulty of Care Federal Income Tax 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*

Please mail the completed form to 601-3 East Brockway Ave., Suite E, Morgantown, WV 26501 or fax it to 1-866-388-1626.