ROBLAND
Home Healthcare Corporation

Employer Enrollment Packet - Consumer Support Grant Payroll Agent

Employer Name: _____

Consumer Name:_____

ISO Coordinator Name: _____

Start Date: _____

Return the following forms, along with this cover sheet to Robland HHC

- ❑ SS-4.****If you are signing this form on behalf of someone else you must include your social security # on or above the signature line.*
- ❑ MN ABR
- ❑ MN UI Registration Form
- ❑ Form 2678
- ❑ REV-184
- ❑ Acknowledgment of Receipt of Notice of Privacy Practices
- ❑ Consent for Release of Information

The following forms must be completed if the Employer is over the age of 18 AND is unable to sign the SS-4 form for themselves. Please contact your ISO Coordinator for these forms if this scenario applies

- ❑ 8821
- ❑ 2848