Representative Name (if exists): _____

Participant Name: _____

CONSUMER DIRECT CARE NETWORK

DIRECT SERVICE WORKER DATA FORM

Assistance with the hiring process: If you need assistance completing this packet, please call the Consumer Direct office at 1-877-270-9580.

Direct Service Worker Contact Information

Name: _____ _____ _____
First Middle Last

Mailing Address: _____

_____
City State Zip Code

Phone #: Home (___) _____ Work (___) _____ Cell (___) _____

Email: _____

Date of Birth: ____/____/_____ Social Security Number: _____ - ____ - _____

Emergency Contact: _____ _____ _____
Name Phone Relationship

Age and Education Requirements

Are you at least 18 years old? ☐ Yes ☐ No

RN or LPN license is mandatory for Attendant Care and Intermittent and Skilled Nursing Services. **Attach photocopy of your license if providing these services.**

Have you ever committed a felony? ☐ Yes ☐ No

Do you have a criminal record? ☐ Yes ☐ No If yes, explain:

Please Read Carefully: The employment relationship is with the Participant/Legal Guardian not Consumer Direct. The acceptance of the direct service worker (DSW) paperwork is to establish employment with the Participant/Legal Guardian.

I authorize investigation of all statements provided to the Participant/Designated Representative or contained in the DSW paperwork. I understand that misrepresentation or omission of facts called for is cause for dismissal at any time without notice.

I understand that employment remains conditional until the results of the criminal background check have been received and approved. I also understand that the results of the criminal background check or any future criminal background checks may be shared with the approving entity (MCO, county, etc.) and/or the Participant/Legal Guardian with whom I work.

Signature of Applicant: _____ Date: _____

CONSUMER DIRECT CARE NETWORK

FISCAL EMPLOYER AGENT

NEW DIRECT SERVICE WORKER ENROLLMENT CHECKLIST

Welcome to Consumer Direct!

*Please complete all of the forms on the list below including this New Direct Service Worker (DSW) Checklist. Send originals to Consumer Direct **before** the DSW begins work. The DSW may not begin work until all forms are completed, and are received and **approved** by Consumer Direct.*

Direct Service Worker Name	Participant Name	Representative Name (if applicable)

Forms required for all new DSWs

The Participant/Representative should check each item as it is completed. The Participant/Representative should keep a copy of each document and **send the originals to Consumer Direct**:

1. ☐ Direct Service Worker Data Form **(attachment may be required, see form)**
2. ☐ New Direct Service Worker Enrollment Checklist (this form)
3. ☐ Employment Relationship Disclosure
4. ☐ I-9 **(attachment may be required:** attach photocopy if any of the following documents are recorded in section 2 of the I-9: US Passport or Passport Card; Permanent Resident Card, Form I-551; Employment Authorization Document, Form I-766)
5. ☐ W-4
6. ☐ Pay Selection Form **(attachment may be required, see form)**
7. ☐ Participant/Direct Service Worker Agreement
8. ☐ Care Provider Background Screening – Privacy Policy Acknowledgement Form
9. ☐ Attestation of Compliance with Background Screening Requirements
10. ☐ Information Needed for Fingerprinting
11. ☐ Job Description (participant completes)
12. ☐ Health Questionnaire
13. ☐ Fingerprint Registration Procedure (review only)
14. ☐ Employment Handbook (review only)

We have reviewed and verified the above forms for completeness and all forms are readable. We understand that an applicant cannot be scheduled for work until all employment paperwork is approved, background checks are complete, and we have been notified by Consumer Direct that the Employee is approved to begin work.

_____ _____ _____ _____

Participant/Representative Signature *Date* *Direct Service Worker Signature* *Date*

For Office Use Only

DSW Start Date: _____ Packet Review Date: _____

03474

CONSUMER DIRECT CARE NETWORK

DIVULGACIÓN DE RELACIÓN DE TRABAJO

Nombre del trabajador de servicio directo	Nombre de Titular de FEIN (participante)

INSTRUCCIONES: Cada trabajador de servicio directo debe proporcionar la siguiente información acerca de su relación con el titular de FEIN antes de que comience el empleo. Debe revisar, completar todas las secciones que continúan y debe de firmar e imprimir la fecha en la parte inferior del formulario. Esta información es necesaria para comenzar el empleo.

1) DIVULGACIÓN DE RELACIÓN:

Antes de empleo, mi relación con el mencionado **FEIN titular** es:

Por favor marque uno:

☐ Padre/Madre (exento)
☐ Padrastro/Madrastra (exento)
☐ Cónyuge (exento)
☐ Menor de edad 21 (exenta)
☐ Ninguna relación
☐ Hermano
☐ Otro Por favor describa: _____

Nota: El trabajador de servicio directo no puede ser el tutor legal o representante del participante.

2) RECONOCIMIENTO SOBRE RELACIÓN Y EMPLEO:

Entiendo que independientemente de mi relación con el Titular de FEIN, estoy sujeto a todos los requisitos de empleo incluyendo antecedentes, entrenamiento y retención de impuestos federales. Además, tengo entendido que la aprobación de la entidad aprobadora (MCO o condado) puede requerirse antes de que el empleo pueda comenzar.

Si mi relación con el titular de FEIN indica exentos como declare encima, entiendo que estoy entrando en una relación de trabajo que está exenta de FICA (Seguro Social y Medicare) FUTA (desempleo Federal) y SUTA (estado desempleo).

Las reglas fiscales federales y estatales cambian con frecuencia. Por favor, consulte con su asesor fiscal de impuestos para evaluar el impacto de estas reglas en sus impuestos y complete su W-4 (y/o forma de estado aplicable) en conformidad. Si usted descubre que su situación fiscal ha cambiado durante el año usted puede present una versión reivsada de W-4 para los ajustes de rentención soble el pago furturo.

Al no pagar ciertos impuestos esto significa que no gano créditos históricos de trabajo de Seguro Social. Créditos de trabajo del Seguro Social — cuando trabaja y paga a el Seguro Social, usted gana créditos hacia los beneficios del Seguro Social. *Necesita un cierto número de créditos para ser elegible para beneficios de Seguro Social. El número que necesita depende de su edad y el tipo de beneficio para el cual usted está solicitando. Usted puede ganar un máximo de cuatro créditos cada año. La mayoría de las personas necesitan 40 créditos para tener derecho a beneficios de jubilación. Consulte la publicación del IRS 15-familia empleados en www.IRS.gov para obtener más información.*

_____ _____
Participante o Representante, Firma *Fecha*

_____ _____
Trabajador de Servicio Directo, Firma *Fecha*

Instructions for Completing Form I-9 Section 1

(On or before employee's first day of work for pay)

Employee: Complete Section 1 of Form I-9. This must be done no later than your first day of work for pay. Please print clearly, and sign and date when you are finished. Refer to the numbered explanations below for additional information.

Employer: Review Section 1, ensuring your employee has completed it properly.

Employee (steps 1-9)

① Print your full legal name: Last, First and Middle Initial. Provide any other names used, such as maiden name. Enter "N/A" if you have never had another name.

② Print your physical address. Entering a PO Box is not allowed. Enter "N/A" if you have no apartment number.

③ Print your date of birth (mm/dd/yyyy).

④ Print your Social Security Number.

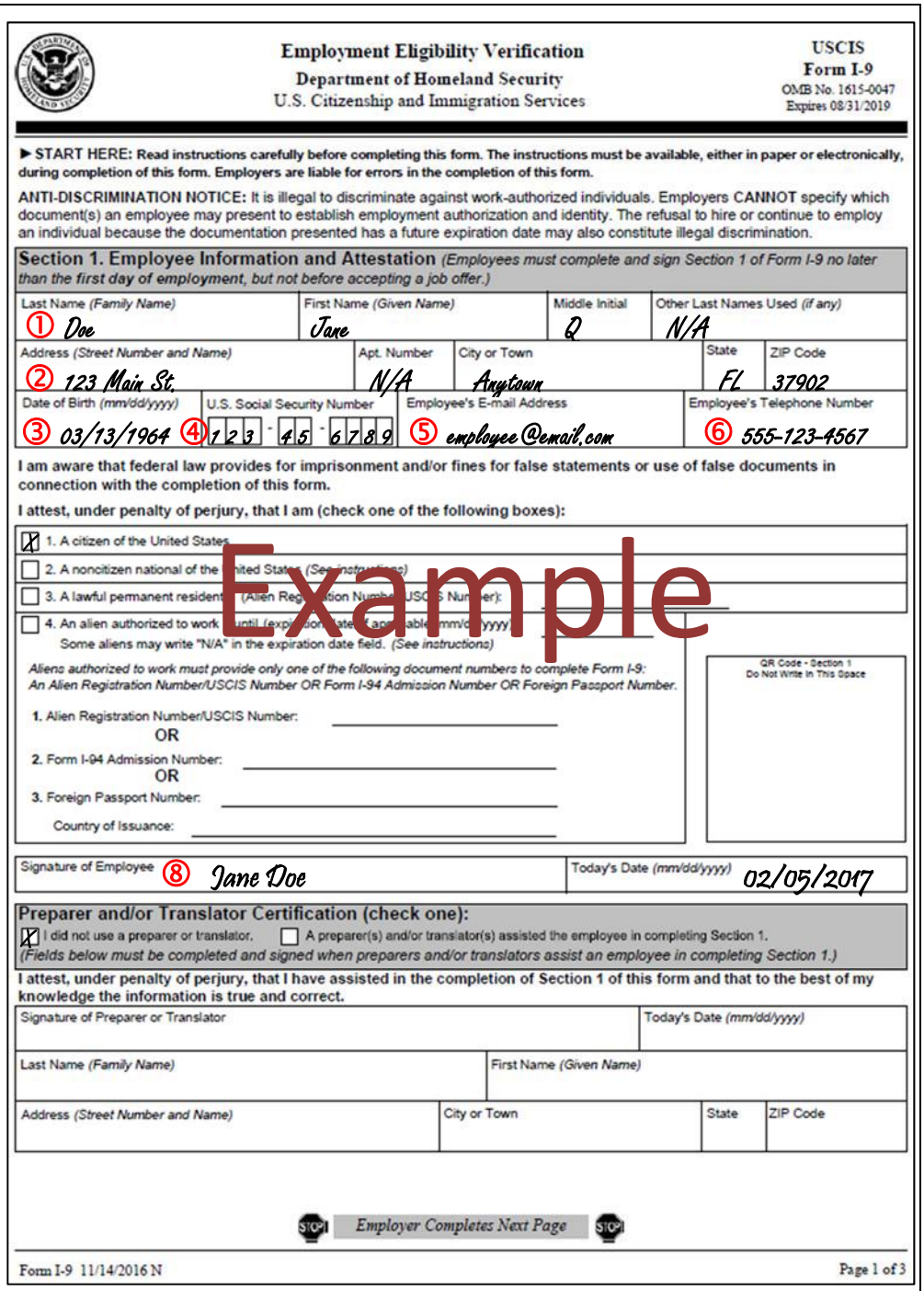
⑤ Print your email address or print "N/A" if you choose to not provide it.

⑥ Print your telephone number or print "N/A" if you choose to not provide it.

⑦ Check the one box that best describes your citizenship or immigration status in the United States.

⑧ Sign and print the date you completed the form. **No later than first day of work for pay.**

⑨ Check the box that indicates whether or not you were assisted by a preparer or translator.



Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS Form I-9
OMB No. 1615-0047
Expires 08/31/2019

▶ START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

Last Name (Family Name)	First Name (Given Name)	Middle Initial	Other Last Names Used (if any)
① Doe	Jane	Q	N/A

Address (Street Number and Name)	Apt. Number	City or Town	State	ZIP Code
② 123 Main St.	N/A	Anytown	FL	37902

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
③ 03/13/1964	④ 123-45-6789	⑤ employee@email.com	⑥ 555-123-4567

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

⑦
- [X] 1. A citizen of the United States
- [ ] 2. A noncitizen national of the United States (See instructions)
- [ ] 3. A lawful permanent resident (Alien Registration Number/USCIS Number):
- [ ] 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy)
  Some aliens may write "N/A" in the expiration date field. (See instructions)

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
   OR
2. Form I-94 Admission Number: _____
   OR
3. Foreign Passport Number: _____
   Country of Issuance: _____

QR Code - Section 1 Do Not Write In This Space

Signature of Employee	Today's Date (mm/dd/yyyy)
⑧ Jane Doe	02/05/2017

⑨ **Preparer and/or Translator Certification (check one):**

- [X] I did not use a preparer or translator.
- [ ] A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date (mm/dd/yyyy)

Last Name (Family Name)	First Name (Given Name)

Address (Street Number and Name)	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Form I-9 11/14/2016 N — Page 1 of 3

Note: These instructions are for informational purposes only. Refer to pages 1 and 2 of Form I-9 Instructions for detailed information.

Instructions for Completing Form I-9 Section 2

(Any time after employee has accepted job offer, but no later than 3 days after employee's first day of work)

Employee: Present original, unexpired documents to your employer to verify your identity and authorization to work in the United States. The LIST OF ACCEPTABLE DOCUMENTS is found after the Form I-9.

Employer (FEIN holder): Examine the documents your employee provides and record them in Section 2. The employee must be present while you examine them. Refer to the numbered explanations below for additional information.

Employer (steps 1-10)

① Print employee's name from Section 1: Last, First, and Middle Initial.

② Enter the number representing employee's citizenship status checked in Section 1.

③ Examine each document and note the details in the appropriate List column.

<u>one document from List A</u>

OR

<u>one from List B and one from List C</u>

If accepting a List B document, it must bear a photograph.

<u>If accepting a List A document, provide a photocopy when submitting the I-9 to Consumer Direct.</u>

Only accept unexpired, original documents (no photocopies).

④ Print the date of the employee's first day of work.

⑤ Sign the form.

⑥ Print the date you signed the form. **Must be completed and signed within 3 days of employee's first day of work.**

⑦ If not pre-populated, print your title as "Employer."

⑧ Print your last then first name.

⑨ Print your first and last name.

⑩ Print physical address where services are provided: street, city, state and zip code.

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
	① Doe	Jane	Q	② 1

List A Identity and Employment Authorization	List B Identity	List C Employment Authorization
Document Title	③ Document Title: Driver's License	Document Title: Social Security Card
Issuing Authority	Issuing Authority: State of Residence	Issuing Authority: SSA
Document Number	Document Number: 0123456789abcde	Document Number: 123-45-6789
Expiration Date (if any)(mm/dd/yyyy)	Expiration Date (if any)(mm/dd/yyyy): 08/17/2020	Expiration Date (if any)(mm/dd/yyyy): N/A
Document Title	Additional Information	QR Code - Sections 2 & 3 Do Not Write In This Space
Issuing Authority		
Document Number		
Expiration Date (if any)(mm/dd/yyyy)		
Document Title		
Issuing Authority		
Document Number		
Expiration Date (if any)(mm/dd/yyyy)		

Example

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: ④ 02/05/2017 *(See instructions for exemptions)*

Signature of Employer or Authorized Representative	Today's Date(mm/dd/yyyy)	Title of Employer or Authorized Representative
⑤ Ronald Smith	⑥ 02/05/2017	⑦ Employer

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
⑧ Smith	Ronald	⑨ Ronald Smith

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code
⑩ 500 Fictional St.	Anytown	FL	33353

Submit form I-9 to Consumer Direct with the Employee Packet

Note: These instructions are for informational purposes only. Refer to pages 6 through 12 of Form I-9 Instructions for detailed information.

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
/ /	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

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Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	**OR**	**List B** Identity	**AND**	**List C** Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
		Employer

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			**B.** Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Examples of many of these documents appear in the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

00540

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

► **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
► **Give Form W-4 to your employer.**
► **Your withholding is subject to review by the IRS.**

OMB No. 1545-0074

2020

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	**(b) Social security number**
Address		► **Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single or Married filing separately**
☐ **Married filing jointly** (or Qualifying widow(er))
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the online estimator, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ► ☐

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents

If your income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 ► $ _____

Multiply the number of other dependents by $500 . . . . ► $ _____

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

► _____ **Employee's signature** (This form is not valid unless you sign it.) ► _____ **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505.

Exemption from withholding. You may claim exemption from withholding for 2020 if you meet both of the following conditions: you had no federal income tax liability in 2019 **and** you expect to have no federal income tax liability in 2020. You had no federal income tax liability in 2019 if (1) your total tax on line 16 on your 2019 Form 1040 or 1040-SR is zero (or less than the sum of lines 18a, 18b, and 18c), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2020 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1a, 1b, and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2021.

Your privacy. If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

1. Expect to work only part of the year;

2. Have dividend or capital gain income, or are subject to additional taxes, such as the additional Medicare tax;

3. Have self-employment income (see below); or

4. Prefer the most accurate withholding for multiple job situations.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

Nonresident alien. If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

If you (and your spouse) have a total of only two jobs, you may instead check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

Multiple jobs. *Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.*

Step 3. Step 3 of Form W-4 provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2020 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . **1** $

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . **2a** $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . **2b** $

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . **2c** $

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3**

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . **4** $

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1 Enter an estimate of your 2020 itemized deductions (from Schedule A (Form 1040 or 1040-SR)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 10% of your income . . . . . **1** $

2 Enter:
- $24,800 if you're married filing jointly or qualifying widow(er)
- $18,650 if you're head of household
- $12,400 if you're single or married filing separately

. . . . . **2** $

3 If line 1 is greater than line 2, subtract line 2 from line 1. If line 2 is greater than line 1, enter "-0-" . . **3** $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Schedule 1 (Form 1040 or 1040-SR)). See Pub. 505 for more information . . . **4** $

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . **5** $

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Married Filing Jointly or Qualifying Widow(er)

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$220	$850	$900	$1,020	$1,020	$1,020	$1,020	$1,020	$1,210	$1,870	$1,870
$10,000 - 19,999	220	1,220	1,900	2,100	2,220	2,220	2,220	2,220	2,410	3,410	4,070	4,070
$20,000 - 29,999	850	1,900	2,730	2,930	3,050	3,050	3,050	3,240	4,240	5,240	5,900	5,900
$30,000 - 39,999	900	2,100	2,930	3,130	3,250	3,250	3,440	4,440	5,440	6,440	7,100	7,100
$40,000 - 49,999	1,020	2,220	3,050	3,250	3,370	3,570	4,570	5,570	6,570	7,570	8,220	8,220
$50,000 - 59,999	1,020	2,220	3,050	3,250	3,570	4,570	5,570	6,570	7,570	8,570	9,220	9,220
$60,000 - 69,999	1,020	2,220	3,050	3,440	4,570	5,570	6,570	7,570	8,570	9,570	10,220	10,220
$70,000 - 79,999	1,020	2,220	3,240	4,440	5,570	6,570	7,570	8,570	9,570	10,570	11,220	11,240
$80,000 - 99,999	1,060	3,260	5,090	6,290	7,420	8,420	9,420	10,420	11,420	12,420	13,260	13,460
$100,000 - 149,999	1,870	4,070	5,900	7,100	8,220	9,320	10,520	11,720	12,920	14,120	14,980	15,180
$150,000 - 239,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,190	16,050	16,250
$240,000 - 259,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,520	17,170	18,170
$260,000 - 279,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	13,120	15,120	17,120	18,770	19,770
$280,000 - 299,999	2,040	4,440	6,470	7,870	9,190	10,720	12,720	14,720	16,720	18,720	20,370	21,370
$300,000 - 319,999	2,040	4,440	6,470	8,200	10,320	12,320	14,320	16,320	18,320	20,320	21,970	22,970
$320,000 - 364,999	2,720	5,920	8,750	10,950	13,070	15,070	17,070	19,070	21,290	23,590	25,540	26,840
$365,000 - 524,999	2,970	6,470	9,600	12,100	14,530	16,830	19,130	21,430	23,730	26,030	27,980	29,280
$525,000 and over	3,140	6,840	10,170	12,870	15,500	18,000	20,500	23,000	25,500	28,000	30,150	31,650

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$460	$940	$1,020	$1,020	$1,470	$1,870	$1,870	$1,870	$1,870	$2,040	$2,040	$2,040
$10,000 - 19,999	940	1,530	1,610	2,060	3,060	3,460	3,460	3,460	3,640	3,830	3,830	3,830
$20,000 - 29,999	1,020	1,610	2,130	3,130	4,130	4,540	4,540	4,720	4,920	5,110	5,110	5,110
$30,000 - 39,999	1,020	2,060	3,130	4,130	5,130	5,540	5,720	5,920	6,120	6,310	6,310	6,310
$40,000 - 59,999	1,870	3,460	4,540	5,540	6,690	7,290	7,490	7,690	7,890	8,080	8,080	8,080
$60,000 - 79,999	1,870	3,460	4,690	5,890	7,090	7,690	7,890	8,090	8,290	8,480	9,260	10,060
$80,000 - 99,999	2,020	3,810	5,090	6,290	7,490	8,090	8,290	8,490	9,470	10,460	11,260	12,060
$100,000 - 124,999	2,040	3,830	5,110	6,310	7,510	8,430	9,430	10,430	11,430	12,420	13,520	14,620
$125,000 - 149,999	2,040	3,830	5,110	7,030	9,030	10,430	11,430	12,580	13,880	15,170	16,270	17,370
$150,000 - 174,999	2,360	4,950	7,030	9,030	11,030	12,730	14,030	15,330	16,630	17,920	19,020	20,120
$175,000 - 199,999	2,720	5,310	7,540	9,840	12,140	13,840	15,140	16,440	17,740	19,030	20,130	21,230
$200,000 - 249,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
$250,000 - 399,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
$400,000 - 449,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,450	19,940	21,240	22,540
$450,000 and over	3,140	6,230	8,810	11,310	13,810	15,710	17,210	18,710	20,210	21,700	23,000	24,300

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$830	$930	$1,020	$1,020	$1,020	$1,480	$1,870	$1,870	$1,930	$2,040	$2,040
$10,000 - 19,999	830	1,920	2,130	2,220	2,220	2,680	3,680	4,070	4,130	4,330	4,440	4,440
$20,000 - 29,999	930	2,130	2,350	2,430	2,900	3,900	4,900	5,340	5,540	5,740	5,850	5,850
$30,000 - 39,999	1,020	2,220	2,430	2,980	3,980	4,980	6,040	6,630	6,830	7,030	7,140	7,140
$40,000 - 59,999	1,020	2,530	3,750	4,830	5,860	7,060	8,260	8,850	9,050	9,250	9,360	9,360
$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,780	10,980	11,180	11,580	12,380
$80,000 - 99,999	1,900	4,300	5,710	7,000	8,200	9,400	10,600	11,180	11,670	12,670	13,580	14,380
$100,000 - 124,999	2,040	4,440	5,850	7,140	8,340	9,540	11,360	12,750	13,750	14,750	15,770	16,870
$125,000 - 149,999	2,040	4,440	5,850	7,360	9,360	11,360	13,360	14,750	16,010	17,310	18,520	19,620
$150,000 - 174,999	2,040	5,060	7,280	9,360	11,360	13,480	15,780	17,460	18,760	20,060	21,270	22,370
$175,000 - 199,999	2,720	5,920	8,130	10,480	12,780	15,080	17,380	19,070	20,370	21,670	22,880	23,980
$200,000 - 249,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
$250,000 - 349,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
$350,000 - 449,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,900	25,200
$450,000 and over	3,140	6,840	9,560	12,140	14,640	17,140	19,640	21,530	23,030	24,530	25,940	27,240

CONSUMER DIRECT CARE NETWORK

PAY SELECTION FORM

Name: _____
(please print)

Consumer Direct recommends every employee select direct deposit, either to a prepaid debit card issued through US Bank or to another account you specify. Direct deposits avoid all possible delays associated with delivery of mail - and that helps you access your pay on pay day. Your pay stub (summary of your pay) will be sent by first class mail to your address on file. First class mail terms and limitations apply.

Consumer Direct offers the following pay options. Please select <u>one</u> option below.

☐ **US Bank Focus Card Direct Deposit** – I authorize Consumer Direct to issue me a US Bank Focus Card using my Social Security Number and other identification on file and to initiate payroll deposits to my card account. You should receive your debit card in approximately two weeks.

☐ **Bank or Credit Union Direct Deposit** – I authorize Consumer Direct to initiate payroll deposits to (name of bank or financial institution): _____

Account Type (check one): ☐ Checking ☐ Savings

For Checking Accounts:

Attach (tape) a voided check here

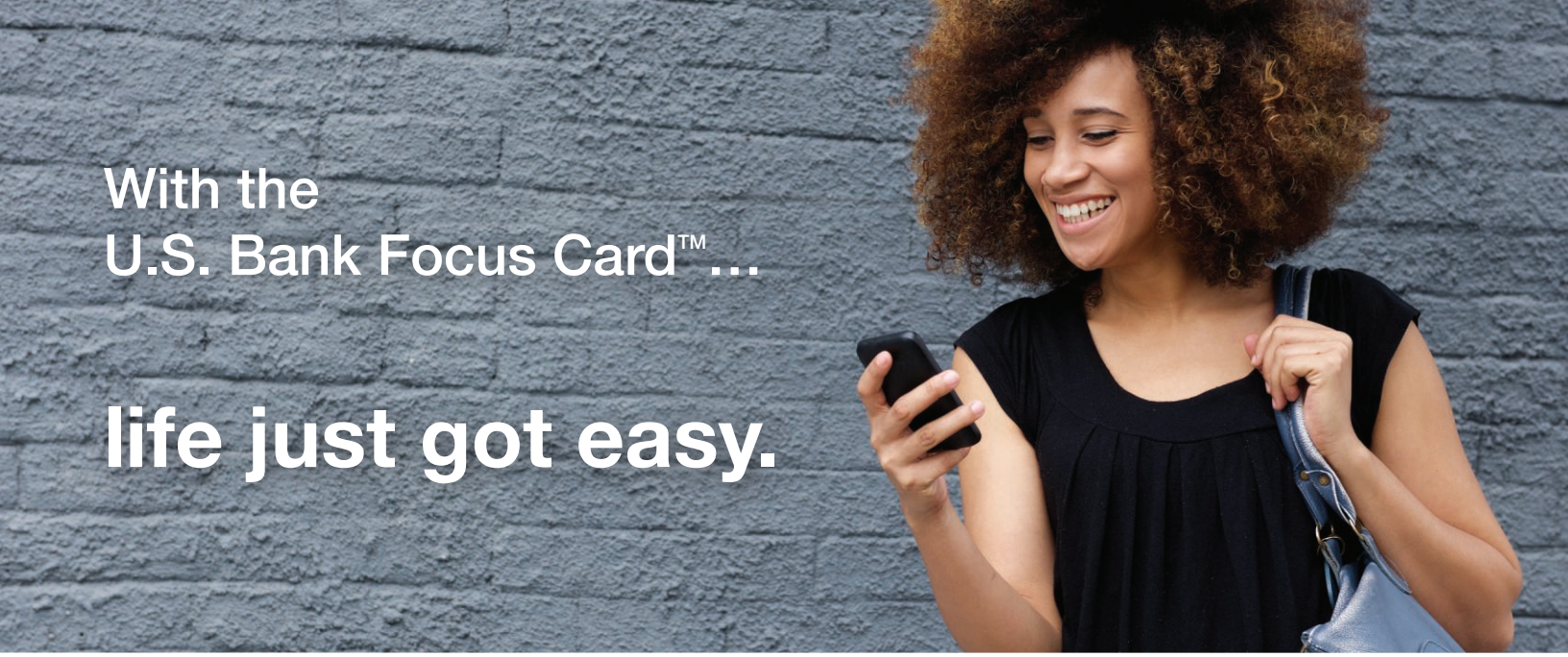
Do not attach a deposit slip.

For Savings Accounts: provide a document from your bank with exact numbers to process direct deposits to your account. If the document is larger than a standard-sized check, please provide a separate document. Do not attach a deposit slip because it does not have all the necessary numbers.

I authorize Consumer Direct to process my selected method of pay as indicated above. In the event that funds are deposited mistakenly to my account, I authorize Consumer Direct to debit my account to correct the error. It is my responsibility to confirm that each deposit has occurred and to pay any fees caused by overdrafts on my account. Deposits will be made on each payday unless I notify my employer, in writing, of my request to stop direct deposits. I understand that Consumer Direct reserves the right to refuse any direct deposit request, that all direct deposits are made through an Automated Clearing House (ACH), and that the processing is subject to ACH terms and limitations, as well as those of my financial institution. **I understand that I may still receive a paper check while my selected method of pay is being set up.**

_____ _____

Signature Date



With the U.S. Bank Focus Card™...

life just got easy.

The U.S. Bank Focus Card

is a Visa® or Mastercard® prepaid debit card and a convenient alternative to receiving paper checks.

SAFE

- Your pay will be **deposited onto a prepaid Visa or Mastercard** each payday.
- **Funds are protected**[1] if lost or stolen.
- Keep track of purchases and loads with **text**[2] **and email alerts.**

CONVENIENT

- Your card can be **used anywhere Visa and Mastercard debit cards are accepted worldwide.**
- **Access to cash when you need it most** with over thousands of in-network ATMs nationwide.

PORTABLE

- **Your card can stay with you for life.**
- Add tax refunds, pay from a second employer, and even cash deposits!

Visit prepaidmaterials.com/usbankfocus

to learn more about the features and benefits of the U.S. Bank Focus Card.

[1] You are generally protected from all liability for unauthorized transactions with Zero Liability. You must call the number on the back of your Card immediately to report any unauthorized use. Certain conditions and limitations may apply. See your Cardholder Agreement for details.

[2] For text messages, standard messaging charges apply through your mobile carrier and message frequency depends on account settings.

usbank

Getting Started

For security, your card comes in a plain white windowed envelope.

Follow the activation instructions that accompany your card.

Features

Cash Back Rewards

For purchases at certain retail and restaurant locations.

Savings Account

Create an interest-bearing savings account without ever going to a bank.

Cash Reload Networks[5]

In addition to payroll deposits, there are a variety of ways to add cash to your Focus Card account.

Text and Email Alerts[4]

Instant notification when money is added or your card balance gets low.

Mobile Banking App[4]

Quickly see your account balance and transaction history.

Track Spending

Online | Phone | Email | Text[4] | Mobile App

Fee Schedule

Activity		Cost		
Monthly Account Maintenance		Free		
Purchases at Point-of-Sale (Domestic)		Free		
Cash Back with Purchases (Domestic)		Free		
ATM Transactions		Cash Withdrawal	Declined Withdrawal	Balance Inquiry
The owner of any Non-U.S. Bank or Non-MoneyPass ATM may assess an additional surcharge fee for any ATM transaction that you complete.	U.S. Bank ATM	Free	Free	Free
	MoneyPass® ATM	Free	Free	Free
	Allpoint® ATM	Free	Free	Free
	Other ATM	$2.00	$0.50	$1.00
	International ATM	$3.00	$0.50	$1.00
Teller Cash Withdrawal		Free		
Teller Cash Withdrawal Decline		$0.00		
Customer Service Automated Phone Service, Online, Live Phone Representative		Free		
Text or Email Alerts[4]		Free		
Inactivity After 90 consecutive days. Not assessed if balance is $0.00.		$2.00 Per Month		
Monthly Paper Statement		If requested – $2.00		
Card Replacement Non-Personalized Issued by employer (If applicable to your program) Personalized		$5.00 Standard $5.00; Expedited $15.00; Overnight $25.00		
ChekToday Convenience Checks (If applicable to your program)	Check Authorization	Free		
	Check Order	Free; Expedited $35.00		
	Check Return	$25.00		
	Stop Payment	$25.00		
	Lost/Stolen Check	$25.00		
	Void Check	Free		
	Check Reversal	$25.00		
	Check Copy	$10.00		
Foreign Transaction		Up to 3% of transaction amount		

Transaction Limits	Count	Amount
Maximum Card Balance	N/A	$40,000
Purchases (includes cash back)	20 per day	$4,000 per day
Cash Loads (If applicable to your program)	3 per day	$950 per day
Teller Cash Withdrawal	5 per day	$2,525 per day
ATM Withdrawal	5 per day	$1,525 per day; $1,025 max transaction
Loads or Deposits	10 per day	$20,000 per day
Signature-based POS returns	4 per day	N/A
Pending ACH Credits	5 per day	$5,000 per day
ACH Loads	5 per day	$20,000 per day

We reserve the right to change the above fee schedule upon written notification to you as required by applicable law.

[4]US Bank does not charge a fee for mobile banking. Standard messaging and data rates may apply through your mobile carrier.

[5]Businesses performing your reload may charge a fee. Cash reload services are provided by unaffiliated third parties.

CONSUMER DIRECT CARE NETWORK

ACUERDO ENTRE PARTICIPANTE/TRABAJADOR DE SERVICIO DIRECTO

Nombre de Trabajador Directo, Imprima _____ Nombre del Participante, Imprima _____

Relación de trabajador de servicio directo (DSW) al participante (s): _____

INSTRUCCIONES: Revisar cada tema, hacer preguntas como sea necesario y firmar a continuación para indicar su acuerdo.

1. El participante revisará el Manual de Empleo con el trabajador de servicio directo (DSW). El manual proporciona directrices sobre las políticas y procedimientos de la opción de dirección del participante. El manual también está disponible en el sitio web de Consumer Direct.
2. El participante revisará el Plan de cuidado con el DSW, trabajador de servicio directo. Ambas partes entienden que Consumer Direct no es financieramente responsable del pago de los servicios en situaciones donde:
   - El participante se convierte inelegible para Medicaid
   - El participante o representante permite al DSW, trabajador de servicio directo trabajar horas extras no autorizadas (horas superiores a 40 por semana)
   - El participante o representante permite al DSW trabajar más del tiempo aprobado, o hacer tareas no aprobadas el Plan de cuidado de los participantes.
3. El participante es responsable de entrenar al DSW, trabajador de servicio directo. El DSW trabajador de servicio directo completará los cursos siguientes, si procede:
   - Control de la infección (precauciones universales)
   - Levantar y mover los pacientes
   - HIPAA y confidencialidad
   - Abuso y negligencia
   - Fraude de Medicaid
4. El participante recordará al DSW, trabajador de servicio directo de completar un formulario de cambio de estado y lo transmitirá a Consumer Direct dentro de 5 días de cualquier cambio de nombre, dirección, teléfono y cualquier condena penal que ocurra después de la fecha de contratación.
5. Ambos partidos recibieron un cronograma de pago.
6. En el programa de PDO, es recomendado pero no obligatorio, que el DSW, trabajador de servicio directo reciba capacitación de primeros auxilios y resucitación cardiopulmonar. Esto es a discreción del participante.
7. Requerimientos de información:
   a. El DSW, trabajador de servicio directo debe reportar inmediatamente todos los incidentes, accidentes y lesiones de lugar de trabajo que implican al DSW, trabajador de servicio directo o al participante. Incidentes y accidentes deben ser reportados inmediatamente al participante o representante. Lesiones de lugar de trabajo deben notificarse a la línea de lesión directa al consumidor al 1-888-541-1701.
   b. El DSW, trabajador de servicio directo debe reportar la posible negligencia, abuso o explotación de un participante a la línea directa de su Condado de Abuso al Adulto o Anciano al 1-800-962-2873.
   c. Sospechas de fraude de Medicaid deben notificarse a la línea directa de fraude al 1-877-532-8530 de Consumer Direct. Consumer Direct le ayudará con otros procedimientos para reportar. El número de la línea directa de fraude de Medicaid AHCA es 1-866-966-7226.
8. Ambas partes acuerdan que el DSW, trabajador de servicio directo no puede comenzar a trabajar hasta que el participante recibe un formulario de "Acuerdo a trabajar".

9. El DSW, trabajador de servicio directo está proporcionando los siguientes servicios según el Plan del participante de cuidado (favor de marcar)

   ☐ Servicios de cuidado y acompañante de adulto
   ☐ Servicios domésticos
   ☐ Servicios de cuidado personal
   ☐ Servicios de Servidor (acompañante)
   ☐ Servicios de enfermería intermitente y calificados (RN, LPN)

10. Información del salario (esto reemplaza cualquier información anterior con respecto a los salarios):

    - Salario primario: _____ **/ hora**
    - **Las horas de sobre tiempo no están permitidas** sin previa autorización por escrito (más de 40 horas en una semana)
    - Consumer Direct notificará al participante y DSW, trabajador de servicio directo al menos treinta días antes de un cambio en la tasa de pago. Esto puede ocurrir si el MCP cambia la tasa de pago.
    - Si cambia el salario, se firmará un nuevo acuerdo de trabajador de servicio con Consumer Direct.

11. Horario de trabajo del DSW, trabajador de servicio directo es:

Domingo	Lunes	Martes	Miércoles	Jueves	Viernes	Sábado

    En la opción de dirección de participante, el horario de trabajo de los trabajadores de servicio directo puede ser flexible. Horas de trabajo no pueden exceder las horas aprobadas en el Plan de cuidado del Participante.

12. Roles y responsabilidades del participante o representante incluyen, pero no se limitan a:

    - Horario del DSW, trabajador de servicio directo
    - Supervisar al DSW, trabajador de servicio directo
    - Tratar al DSW, trabajador de servicio directo con respeto, incluyendo las creencias, cultura, religión y privacidad
    - Completando y presentando las hojas de tiempo correctas para asegurarse de que el DSW, trabajador de servicio directo se le pague según lo convenido
    - Garantiza que el DSW, trabajador de servicio directo no trabaje más horas de lo aprobado en el presente acuerdo

13. Funciones y responsabilidades de Consumer Direct:

    - Envío de documentación requerida
    - Ayudar en la realización de trámites necesarios
    - Pagar a el DSW, trabajador de servicio directo
    - Asegurando que el DSW, trabajador de servicio directo no sea pagado para más horas que las aprobadas en este acuerdo
    - Presentar y pagar los impuestos estatales y federales para el DSW, trabajador de servicio directo
    - Proporcionar un número gratuito de servicio al cliente para llamar con cualquier pregunta acerca de la opción de Direccion de Participante.

La firma del DSW y el Participante indican acuerdo con los términos anteriores.

_____ _____ _____ _____

Participante/Representante, Firma *Fecha* *Trabajador de Servicio Directo, Firma* *Fecha*

_____ _____

Firma de Manejador de Caso *Fecha*

PRIVACY POLICY ACKNOWLEDGEMENT FORM

I acknowledge that I have received a copy of the privacy policies from the Florida Department of Law Enforcement and the Federal Bureau of Investigation, which describe the exchange of information where criminal record results will become part of the Care Provider Background Screening Clearinghouse.

I understand and agree that I will read and comply with the guidelines contained in the privacy policies.

_____

Employee/Contractor Name (Printed)

_____

Employee/Contractor Signature

_____

Date

DSW

ATTESTATION OF COMPLIANCE
with Background Screening Requirements

Authority: This form shall be used by **all employees** to comply with:

- the attestation requirements of **section 435.05(2), Florida Statutes**, which state that every employee required to undergo Level 2 background screening must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer; **AND**

- the proof of screening within the previous 5 years in **section 408.809(2), Florida Statutes,** which requires proof of compliance with level 2 screening standards that have been screened through the Care Provider Background Screening Clearinghouse created under Section 435.12, F.S., or screened within the previous 5 years by the Agency, Department of Health, Department of Elder Affairs, the Agency for Persons with Disabilities, Department of Children and Families, or the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S., and in accordance with the standards in Section 408.809(2), F.S., if that agency is not currently implemented in the Care Provider Background Screening Clearinghouse.

This form must be maintained in the employee's personnel file. If this form is used as proof of screening for an administrator or chief financial officer to satisfy the requirements of an **application for a health care provider license**, please attach a copy of the screening results and submit with the licensure application.

Employee/Contractor Name:
Health Care Provider/ Employer Name:
Address of Health Care Provider:

You must attest to meeting the requirements for employment and you may not have been arrested for and awaiting final disposition of, have been found guilty of, regardless of adjudication, or have entered a plea of nolo contendere (no contest) or guilty to, or have been adjudicated delinquent and the record has not been sealed or expunged for, any offense prohibited under *any* of the following provisions of state law or similar law of another jurisdiction:

Criminal offenses found in section 435.04, F.S.

(a) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.

(b) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.

(c) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.

(d) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(e) Section 782.04, relating to murder.

(g) Section 782.071, relating to vehicular homicide

(h) Section 782.09, relating to killing of an unborn child by injury to the mother.

(i) Chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.

(j) Section 784.011, relating to assault, if the victim of the offense was a minor.

(k) Section 784.03, relating to battery, if the victim of the offense was a minor.

(l) Section 787.01, relating to kidnapping.

(m) Section 787.02, relating to false imprisonment.

(n) Section 787.025, relating to luring or enticing a child.

(o) Section 787.04(2), relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings.

(p) Section 787.04(3), relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person.

(q) Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.

(r) Section 790.115(2)(b), relating to possessing an electric weapon or device, destructive device, or other weapon on school property.

(s) Section 794.011, relating to sexual battery.

(t) Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.

(u) Section 794.05, relating to unlawful sexual activity with certain minors.

(v) Chapter 796, relating to prostitution.

(w) Section 798.02, relating to lewd and lascivious behavior.

(x) Chapter 800, relating to lewdness and indecent exposure.

(y) Section 806.01, relating to arson.

(z) Section 810.02, relating to burglary.

(aa) Section 810.14, relating to voyeurism, if the offense is a felony.

(bb) Section 810.145, relating to video voyeurism, if the offense is a felony.

(cc) Chapter 812, relating to theft, robbery, and related crimes, if the offense is a felony.

(dd) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.

(ee) Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.

(ff) Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.

(gg) Section 825.103, relating to exploitation of an elderly person or disabled adult, if the offense was a felony.

(hh) Section 826.04, relating to incest.

(ii) Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child

(jj) Section 827.04, relating to contributing to the delinquency or dependency of a child.

(kk) Former s. 827.05, relating to negligent treatment of children.

(ll) Section 827.071, relating to sexual performance by a child.

(mm) Section 843.01, relating to resisting arrest with violence.

(nn) Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication.

(oo) Section 843.12, relating to aiding in an escape.

(pp) Section 843.13, relating to aiding in the escape of juvenile inmates in correctional institutions.

(qq) Chapter 847, relating to obscene literature.

(rr) Section 874.05(1), relating to encouraging or recruiting another to join a criminal gang.

(ss) Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.

(tt) Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.

(uu) Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.

(vv) Section 944.40, relating to escape.

(ww) Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.

(xx) Section 944.47, relating to introduction of contraband into a correctional facility.

(yy) Section 985.701, relating to sexual misconduct in juvenile justice programs.

(zz) Section 985.711, relating to contraband introduced into detention facilities.

(3) The security background investigations under this section must ensure that no person subject to this section has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense that constitutes domestic violence as defined in s. 741.28, whether such act was committed in this state or in another jurisdiction.

Criminal offenses found in section 408.809(4), F.S.

(a) Any authorizing statutes, if the offense was a felony.

(b) This chapter, if the offense was a felony.

(c) Section 409.920, relating to Medicaid provider fraud.

(d) Section 409.9201, relating to Medicaid fraud.

(e) Section 741.28, relating to domestic violence.

(f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(g) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.

(h) Section 817.234, relating to false and fraudulent insurance claims.

(i) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.

(j) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider.

(k) Section 817.505, relating to patient brokering.

(l) Section 817.568, relating to criminal use of personal identification information.

(m) Section 817.60, relating to obtaining a credit card through fraudulent means.

(n) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.

(o) Section 831.01, relating to forgery.

(p) Section 831.02, relating to uttering forged instruments.

(q) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.

(r) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.

(s) Section 831.30, relating to fraud in obtaining medicinal drugs.

(t) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony

(u) Section 895.03, relating to racketeering and collection of unlawful debts.

(v) Section 896.101, relating to the Florida Money Laundering Act.

☐ **I have been granted an Exemption from Disqualification through the Agency for Healthcare Administration (AHCA).**

Date of Decision: _____

☐ **I have been granted an Exemption from Disqualification through the Florida Department of Health.**

Date of Decision: _____

*****A copy of the Exemption from Disqualification decision letter must be attached*****

If you are also using this form to provide evidence of prior Level 2 screening (fingerprinting) in the last 5 years and have not been unemployed for more than 90 days, please provide the following information. **A copy of the prior screening results must be attached**.

Purpose of Prior Screening:_____

Screening conducted by: Date of Prior Screening: _____

- ☐ Agency for Healthcare Administration
- ☐ Department of Health
- ☐ Agency for Persons with Disabilities
- ☐ Department of Elder Affairs
- ☐ Department of Financial Services
- ☐ Department of Children and Families

04041

Attestation

Under penalty of perjury, I, _____, hereby swear or affirm that I meet the requirements for qualifying for employment in regards to the background screening standards set forth in Chapter 435 and section 408.809, F.S. In addition, I agree to immediately inform my employer if arrested or convicted of any of the disqualifying offenses while employed by any health care provider licensed pursuant to Chapter 408, Part II F.S.

_____	_____	_____
Employee/Contractor Signature	Title	Date

CONSUMER DIRECT CARE NETWORK

INFORMATION NEEDED FOR FINGERPRINTING

Instructions: *Complete each and every field below with your demographic information. Please print clearly. This information is required to register you for a fingerprint background check.*

* Last Name _____
* First Name _____
* Middle Name _____
* Date of birth ____/____/____
* State/Country of birth _____
* City of birth _____
* Social security number _____
* Sex _____
* Race _____
* Eye color _____
* Hair color _____
* Height (feet/inches) _____
* Weight _____
* Country of citizenship _____
* Address - Street _____
* Address - City, State, Zip Code _____
* Phone number _____
* Email address _____

To be completed by Consumer Direct

CD Representative Name: _____

Participant Name: _____

Health Care Plan: _____

Date of Enrollment Meeting: _____

Relationship to Participant (check one): ☑ Direct Service Worker ☐ Representative

TRABAJADOR DE SERVICIO DIRECTO
DESCRIPCION DE TRABAJO

Nombre de Trabajador de Servicio Directo	Nombre del Participante

Instrucciones: Utilizando las siguientes listas identifique cuales servicios PDO serán proporcionados. Para los servicios que van a ser entregados, identifique cuáles serán las responsabilidades de trabajo que el trabajador de servicio directo (DSW) estará obligado a realizar. ***Por favor complete cada página y marque todas las que apliquen.***

Cuidado de Acompañante Adulto

¿Este servicio será proporcionado? ☐ Si ☐ No (marque por favor si la respuesta es sí complete debajo)

Resumen de trabajo: Cuidado no médico, supervisión y socialización proporcionada a un adulto funcionalmente deteriorado. Acompañantes asistirán o supervisaran al afiliado con las tareas, como preparación de la comida o ropa y compras, pero no realizaran estas actividades como servicios discretos. La prestación de servicios de acompañante no implica la atención de enfermería. Este servicio incluye las tareas de limpieza ligera incidental al cuidado y supervisión del afiliado.

- ☐ **Preparación de las comidas**
  - ☐ Limpieza de cocina
  - ☐ Guardar alimentos
- ☐ **Limpieza ligera**
  - ☐ Pasar la aspiradora
  - ☐ El polvo, despolvar
  - ☐ Barrer
- ☐ **Servicio de Lavandería**
- ☐ **Ir de compras**
  - ☐ Preparar lista de compras
  - ☐ Recoger mi comida del mercado y artículos personales
  - ☐ Recoger mis medicamentos

Lista de otra asistencia necesaria o peticiones especiales: _____

_____

_____

_____

Servicios Domésticos

¿Este servicio será proporcionado? ☐ Si ☐ No (marque por favor, si la respuesta es sí complete debajo)

Resumen del puesto – Actividades generales domésticas, tales como preparación de comida y rutina de cuidado del hogar proporcionados por un empleado domestico(a) entrenado(a) cuando el individuo regularmente responsable de estas actividades es temporalmente ausente o incapaz de ejercer estas actividades. Servicios de tarea, incluyendo servicios pesados y control de plagas pueden estar incluidos en este servicio.

- ☐ **Limpieza de la casa**
  - ☐ Pasar la aspiradora
  - ☐ Despolvar
  - ☐ Barrer
  - ☐ Arreglar la cama
  - ☐ Limpieza del baño
- ☐ **Preparación de las comidas**
  - ☐ Limpieza de cocina
- ☐ **Cuidado del césped**
- ☐ **Control de plagas**
- ☐ **Reparaciones menores al hogar**

Lista de otra asistencia necesaria o peticiones especiales: _____

_____

_____

_____

Nombre de Trabajador de Servicio Directo	Nombre del Participante

Cuidado personal

¿Este servicio será proporcionado? ☐ Si ☐ No (marque por favor, si la respuesta es si complete debajo)

Resumen del puesto – un servicio que proporciona asistencia a comer, bañarse, vestirse, higiene personal y otras actividades de la vida diaria. Este servicio incluye la asistencia con la preparación de las comidas, pero no incluye el costo de las comidas. Este servicio puede incluir también las tareas de limpieza, tales como hacer la cama, quitar el polvo y limpiar con la aspiradora, que son incidentales al cuidado proporcionado o son esenciales para la salud y el bienestar de la persona inscrita, y no para la familia de la persona inscrita.

Vestirse/desvestirse
- Vistiendo (AM, PM)

Higiene/Aseo
- Cuidado Dental (cepillo, hilo dental, enjuague bucal)
- Afeitar
- Poniendo productos faciales/cuerpo (loción, maquillaje)
- Cuidado de las uñas (si es diabético, dar direcciones)
- Cuidado del cabello (cepillo, trenza)

Movilidad de rango de movimiento/cuerpo
- Ejercicio
- Levantar de la cama o posicionamiento en la cama o silla

Asistencia de medicamentos
- Abriendo mis botellas de medicina o caja de las píldoras
- Buscándome un vaso de agua para tomar mis medicamentos
- Leer las etiquetas de medicamentos
- Me ayuda a recordar qué medicamentos tomar durante todo el día
- Ayudarme a rellenar las recetas cuando sea necesario
- Ayuda con la colocación de tubos de oxígeno
- Recordarme o poner a mi alcance, gotas para los ojos y ungüentos de la piel

Baño/ducha
- Baño de Esponja
- Baño en la cama
- Entrar a la bañera/ducha (lavar cuerpo/pelo)
- Salir de la bañera/ducha (secarse)
- Ayudando a vestir

Locomoción, caminar
- Asistencia con caminar fuera del hogar
- Asistencia con moverse a cuartos diferentes o diferentes niveles en una casa

Inodoro/Continencia
- Asistencia con control de esfínteres
- Cuidado de la continencia

Servicio de limpieza
- Limpieza ligera
  - Pasar la aspiradora
  - Despolvar
  - Barrer
  - Hacer la cama

Ayuda de preparación de alimentación comida
- Preparación de comida/limpieza
- Asistencia Comiendo (cortando)

Lista de otra asistencia necesaria o peticiones especiales: _____

_____

_____

_____

_____

_____

Nombre de Trabajador de Servicio Directo	Nombre del Participante

Atencion Auxiliar

¿Este servicio será proporcionado? ☐ Si ☐ No (marque por favor, si la respuesta es si complete debajo)

Resumen del puesto – Cuidado práctico, de apoyo y también relacionados con la salud, específicamente a la persona que esta medicamente estable pero físicamente discapacitados. Servicios de apoyo son los que sustituyen la ausencia, pérdida, disminución o deterioro de una función física o cognitiva. Este servicio puede incluir atención especializada o de enfermería en la medida permitida por la ley estatal. Las actividades de limpieza que son incidentales al funcionamiento de la atención también pueden ser equipadas como parte de esta actividad. Atención de un auxiliar que no califica debe tener supervisión proporcionado por una enfermera registrada, con licencia para practicar en el estado.

Lista de necesidades médicas específicas aquí:

_____
_____
_____
_____
_____
_____

Enfermería Intermitente y Cualificado

¿Este servicio será proporcionado? ☐ Si ☐ No (marque por favor, si la respuesta es si complete debajo)

Resumen del puesto – Este servicio incluye el beneficio de la salud en el hogar disponible bajo el plan estatal de Medicaid, así como cobertura amplia servicios de enfermería bajo esta dispensa. Servicios enumerados en el plan de cuidado que están dentro del alcance del Acto de la practica de enfermeria y que sean proporcionados por una enfermera registrada profesional o licencia de enfermera profesional o práctica bajo la supervisión de una enfermera registrada, con licencia para practicar en el estado. Servicios de enfermería especializada deben estar en el plan de cuidado del participante y son proporcionados de forma intermitente a los participantes que no requieren supervisión de enfermería continua o cuya necesidad es predecible.

Lista de necesidades médicas específicas aquí:

_____
_____
_____
_____
_____
_____

Nombre de Trabajador de Servicio Directo	Nombre del Participante

Además, el empleado es responsable de:

- El tratamiento del participante con dignidad y respeto. Esto incluye el respeto a las creencias personales, la cultura, región, y de la intimidad, así como el respeto de los bienes personales del participante.
- Mantener la información personal sobre el participante confidencial.
- La comunicación eficaz con el participante. Respetar y utilizar métodos preferidos de los participantes.
- Proporcionar una atención segura. La utilización de las precauciones universales.
- Informar de inmediato una situación de emergencia llamando al 911.
- Reportar cualquier sospecha de abuso y negligencia en el plan de cuidado al manejador del plan de cuidado y autoridades competentes.
- Notificar cambios en la condición de salud al manejador del plan de cuidado.
- Proporcionar suficiente antelación a los participantes si no puede trabajar un turno regular o si va a llegar tarde al trabajo.
- Proporcionar un aviso de dos semanas a la participante si el empleado está terminando voluntariamente el empleo.

Participante/Representante, Firma	*Fecha*	*Trabajador de Servicio Directo, Firma*	*Fecha*

CONSUMER DIRECT CARE NETWORK

CUESTIONARIO DE SALUD DEL EMPLEADO

Nombre Impreso de Empleado

Antecedentes: A este punto del proceso de empleo, has sido seleccionado por un Consumidor/Representante/ Miembro / Individuo ("Empleador") como un empleado. Su posición consiste en dar cuidados prácticos a tu Empleador. Tus deberes varían de acuerdo a las necesidades y servicios autorizados del Empleador, pero necesitarás que hagas trabajos de naturaleza física, lo cual requiere de mucha demanda física. El propósito de este Cuestionario de Salud es obtener información sobre tus habilidades para realizar los deberes autorizados. La información proveída en este formulario será usado para ayudarte a manejar tu empleo en una manera segura. Tus respuestas son consideradas Confidenciales.

Instrucciones: Por favor responda a cada artículo en cuanto a si tienes alguna restricción médica o física o alguna limitación a actividades físicas. Solo responda a restricciones permanentes o restricciones que hayan ocurrido en los últimos cinco (5) años. **Por favor explica cada respuesta afirmativa en el reverso de este formulario, e incluya cualquier otra información adicional que crea necesaria.**

Devuelva el formulario lleno, con los otros formularios de empleo, a la oficina de Consumer Direct.

	Tiene usted alguna restricción física para:	**NO**	**SI**
1	Sentarse		
2	Parándose fijamente		
3	Caminando		
4	Habilidad en Movilizarse		
5	Agacharse (doblado en la rodilla)		
6	Arrodillarse/Gatear		
7	Encorvarse (doblarse en la cintura)		
8	Torcer (rodillas/cintura/cuello)		
9	Girarse/Pivotarse		
10	Treparse		
11	Balancearse		
12	Alcanzar arriba		
13	Alcanzar extensión		
14	Agarrando		
15	Empujando/Jalando		
16	Levantando/Cargando		
17	Total/Parcial Pérdida de Audición		
18	Ceguera (parcial o completa) o Problemas con los Ojos		
19	¿Has sido aconsejado alguna vez por un profesional de la salud de restringirte de alguna actividad física?		

	Historial Médico Personal. Ha tenido o ha sido tratado por:	**NO**	**SI**
20	Epilepsia		
21	Desmayos/Mareos		
22	Hernia		
23	Tensión Muscular		
24	Tensión o Lesión Cuello o Espalda		
25	Ruptura de Disco Invertebral		
26	Lesiones o Dolor en Coyunturas		
27	Fracturas		
28	Tuberculosis o Examen TB no negativa		
29	Problemas o Enfermedades del Pulmón		
30	Lesiones en la Cabeza		
31	Alergias		
32	Otro problemas actuales, enfermedad, condición		
33	¿Has estado hospitalizado o has tenido cirugías sin incluir hospitalizaciones para tener niños?		
34	¿Has rechazado la recomendación de algún procedimiento de cirugía?		
35	¿Estas tomando actualmente algún medicamento o drogas, ya sea prescripción médica o no, que pueda impedir tu buen juicio?		

CONSUMER DIRECT CARE NETWORK

CUESTIONARIO DE SALUD DEL EMPLEADO

_____

Nombre Impreso de Empleado

¿Tienes actualmente, o te han dicho alguna vez algún profesional de la salud que tienes alguna limitación física en referencia a los del listado a continuación?							
		NO	**SI**			**NO**	**SI**
A	Espalda			H	Brazo		
B	Hombros			I	Cadera		
C	Cuello			J	Rodilla		
D	Codo			K	Tobillo		
E	Muñeca			L	Pies		
F	Mano			M	Pierna		
G	Dedo			N	Otros		

Consumer Direct no discrimina en contratar, promover, o políticas y prácticas de retención contra personas que han, de buena fe, presentado una reclamación para o ha recibido beneficios en conformidad a la Ley de Compensación de Trabajadores del Estado.

Por favor explique cualquier contesta marcada "SI" en la página 1 y marque a que número corresponde. También incluya días de lesiones o cirugías. Use páginas adicionales si es necesario:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Por la presente certifico que he contestado las preguntas anteriores a la mejor de mi conocimiento, y que mis respuestas son verdaderas y completas. Entiendo que la tergiversación u omisión de hechos es causa de despido y puede resultar en la negación de los beneficios de compensación laboral.

Firma de Empleado: _____ *Fecha*: _____/_____/_____

Office Use Only

Reviewed by: [_____] Date _____/_____/_____ Date sent to Risk Mgr: _____/_____/_____

State Office/Location: _____ Risk Mgr: [_____] Date _____/_____/_____

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