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

Employment Relationship Disclosure

Employee (Direct Service Worker) Name	Employer (Participant) Name

Instructions to employee: Tell us below if you are related to your employer. Complete each section. Sign and date the bottom of the form.

1. **Service Recipient/Live-In Status:**
   - ☐ Yes ☐ No The person receiving services is a minor (less than age 18)
   - ☐ Yes ☐ No I will be residing at the same address as my employer

2. **Relationship Disclosure:**

   My relationship with my employer (check one):

   ☐ Spouse ☐ Parent ☐ Adoptive or Step Parent
   ☐ Child under age of 21 ☐ Child over age of 21 ☐ Sibling
   ☐ Grandparent ☐ Grandchild ☐ Domestic Partner
   ☐ No Relationship ☐ Other, please describe: _____

3. **Relationship Acknowledgment:**

   I may be exempt from some taxes. It depends on what I checked above. The back of this form explains what taxes I must pay. My local unemployment office can tell me more about FUTA and SUTA taxes.

   I must notify Consumer Direct if this relationship changes. I have 5 days to do so. If I do not, I may have to pay back money that should have been withheld from my pay.

_____ _____
Participant/Representative Signature *Date*

_____ _____
Direct Service Worker Signature *Date*

Internal Use Only – Home Office		
Evaluator's Initials: _____	SUTA (subject to tax) ☐ Yes ☐ No	FUTA (subject to tax) ☐ Yes ☐ No

Internal Use Only – Local Office		
Evaluator's Initials: _____	Medicare (subject to tax) ☐ Yes ☐ No	Social Security (subject to tax) ☐ Yes ☐ No

MOLINA HEALTHCARE

CONSUMER DIRECT CARE NETWORK

Employment Relationship Disclosure

Explanation of Employee Exemptions

Florida Statute 443.1216 (13) 2. (d)			
Relationship to EIN Holder (Employer)	**Federal Income Contributions Act (FICA)**	**Federal Unemployment Tax Act (FUTA)**	**State Unemployment Tax Act (SUTA)**
Spouse	Exempt	Exempt	Exempt
Parent	*Exempt **Subject to Tax	Exempt	Exempt
Adoptive or Step Parent	*Exempt **Subject to Tax	Exempt	Exempt
Sibling	Subject to Tax	Subject to Tax	Subject to Tax
Child under age 21	Exempt	Exempt	Exempt
Child over age 21	Subject to Tax	Subject to Tax	Subject to Tax
Grandparent	Subject to Tax	Subject to Tax	Subject to Tax
Grandchild	Subject to Tax	Subject to Tax	Subject to Tax
Domestic Partner	Subject to Tax	Subject to Tax	Subject to Tax

*Exempt if doesn't meet all 4 of the following criteria:

**Subject to Tax if meet all 4 of the following criteria:

a) A parent is employed by their son or daughter.

b) The employer (son or daughter) has a child or stepchild that lives in the home.

c) The employer is:
- a widow or widower,
- divorced, or
- married and lives with a spouse. But the spouse can't care for the child or stepchild due to a mental or physical condition. The spouse is unable to provide care for at least 4 straight weeks in 3 months.

d) The employer's child or stepchild is:
- less than 18 year old, or
- needs personal care from an adult. Care is needed for at least 4 straight weeks in 3 months due to a mental or physical condition.

Please note: If you have a disability and need more help, we can help you. If you need someone that speaks your language, we can also help. You may call our Member Services Department at 1-866-472-4585 for more help from 8:00 a.m to 7:00 p.m.. If you are blind or have trouble hearing or communicating, please call 711 for TTY/TTD services. We can help you get the information you need in large print, audio (sound), and braille. We provide you with these services for free.

Tenga en cuenta lo siguiente: Si tiene una discapacidad y necesita más ayuda, podemos ayudarlo. Si necesita una persona que hable su idioma, también podemos ayudarlo. Puede llamar a nuestro Departamento de Servicios para Miembros al 1-866-472-4585 para recibir más ayuda, de 8:00 a. m. a 7:00 p. m. Si es ciego o tiene problemas de audición o para comunicarse, llame al 711 para servicios de TTY/TTD. Podemos ayudarlo a obtener la información que necesita en letra grande, audio (sonido) y braille. Le brindamos estos servicios en forma gratuita.

Veuillez noter: Si vous avez un handicap et vous avez besoin plus d'aide, nous pouvons vous aider. Si vous avez besoin de quelqu'un qui parle votre langue, nous pouvons vous aider aussi. Vous pouvez appeler le Service aux Membres au 1-866-472-4585 entre 8:00 a.m. et 7:00 p.m pour obtenir plus d'assistance. Si vous êtes aveugle ou si vous avez des problèmes auditifs, veuillez appeler 711 pour les services TTY/ATS. Nous pouvons vous aider à trouver l'information dont vous avez besoin en gros caractères, audio (son), et braille. Nous vous fournissons ces services gratuits.

Nota: siamo in grado di offrire ulteriore assistenza agli associati con disabilità. Ove necessario, è possibile richiedere l’intervento di un addetto che parli la lingua dell’associato. Per ulteriori informazioni è possibile chiamare il nostro Dipartimento dei servizi per gli associati (Member Services Department) al numero 1-866-472-4585 dalle ore

8:00 alle 19:00. Gli associati non vedenti, ipovedenti, non udenti o con difficoltà di comunicazione possono usufruire dei servizi TTY/TTD (trasmissione telefonica di testo/dispositivi di telecomunicazione per non udenti) resi disponibili tramite il numero 711. Siamo in grado di fornire le informazioni necessarie in formato di stampa a caratteri grandi, in formato audio (sonoro) e braille. Questi servizi sono fruibili gratuitamente.

Veuillez noter : si vous avez un handicap et besoin d'une aide supplémentaire, nous pouvons vous aider. Si vous avez besoin de quelqu'un qui parle votre langue, nous pouvons aussi vous aider. Vous pouvez appeler notre département de services aux membres au 1-866-472-4585 pour une aide supplémentaire de 8h00 à 19h00. Si vous êtes aveugle ou avez des troubles de l'audition ou de la communication, veuillez téléphoner au 711 pour les services de télécommunication à l'intention des malentendants. Nous pouvons vous aider à obtenir les informations dont vous avez besoin en grands caractères, sous forme audio (sonore) et en braille. Nous fournissons ces services gratuitement.

Обратите внимание: Мы помогаем лицам с ограниченными способностями или тем, кому требуется дополнительная помощь. Если вам требуется лицо, говорящее на вашем языке, мы также можем помочь. Для получения дополнительной информации вы можете связаться с отделом обслуживания участников программы по телефону 1-866-472-4585 с 08:00 до 19:00. Если у вас есть нарушения зрения, слуха или речи, позвоните по номеру 711 для связи по телетайпу/текстовому телефону. Мы можем предоставить вам необходимую информацию крупным шрифтом, в аудиоформате или шрифтом Брайля. Данные услуги предоставляются бесплатно.

MOLINA HEALTHCARE

Your Extended Family.

Non-Discrimination Notification
Molina Healthcare of Florida
Medicaid

Molina Healthcare of Florida (Molina) complies with all Federal civil rights laws that relate to healthcare services. Molina offers healthcare services to all members without regard to race, color, national origin, age, disability, or sex. Molina does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. This includes gender identity, pregnancy and sex stereotyping.

To help you talk with us, Molina provides services free of charge:

- Aids and services to people with disabilities
    - Skilled sign language interpreters
    - Written material in other formats (large print, audio, accessible electronic formats, Braille)
- Language services to people who speak another language or have limited English skills
    - Skilled interpreters
    - Written material translated in your language
    - Material that is simply written in plain language

If you need these services, contact Molina Member Services at (866) 472-4585.

If you think that Molina failed to provide these services or treated you differently based on your race, color, national origin, age, disability, or sex, you can file a complaint. You can file a complaint in person, by mail, fax, or email. If you need help writing your complaint, we will help you. Call our Civil Rights Coordinator at (866) 606-3889, or TTY, 711. Mail your complaint to:

Civil Rights Coordinator
200 Oceangate
Long Beach, CA 90802

You can also email your complaint to civil.rights@molinahealthcare.com. Or, fax your complaint to (877) 508-5738.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can mail it to:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

You can also send it to a website through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

If you need help, call 1-800-368-1019; TTY 800-537-7697.

MOLINA HEALTHCARE

Your Extended Family.

Non-Discrimination Tag Line– Section 1557
Molina Healthcare of Florida, Inc.

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-866-472-4585 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-472-4585 (TTY: 711).
French Creole (Haitian Creole)	ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-472-4585 (TTY: 711).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-472-4585 (TTY: 711).
Portuguese	ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-866-472-4585 (TTY: 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-472-4585（TTY：711）。
French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-472-4585 (TTY : 711).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-472-4585 (TTY: 711).
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-472-4585 (телетайп: 711).
Arabic	مقرب لتصا .نجاملبا كل رفاوتت ةيوغللا ةدعاسملا تامدخ نفإ ،ةغللا ركذا ثدحتت تنك اذإ :ةظوحلم 4585-472-866-1 (مبكلاو ملصا فتاه مقر: 711).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-472-4585 (TTY: 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-472-4585 (TTY: 711).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-472-4585 (TTY: 711) 번으로 전화해 주십시오.
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-472-4585 (TTY: 711).
Gujarati	**ધ્યાન: જો તમ ગુજરાતી બોલતા હો, તો મફત ભાષા સહાય સવાઓ તમારા માટ ઉપલબ્ધ છ. ફોન કરો** 1-866-472-4585 (TTY: 711).
Thai	เรียน: ถาคณพดภาษาไทยคณสามารถใชบรการชวยเหลอทางภาษาไดฟร โทร 1-866-472-4585 (TTY: 711).

00540 - Delete

MHF – 1557 tag lines_v2
Created 10/14/16, rev 12/14/16

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.

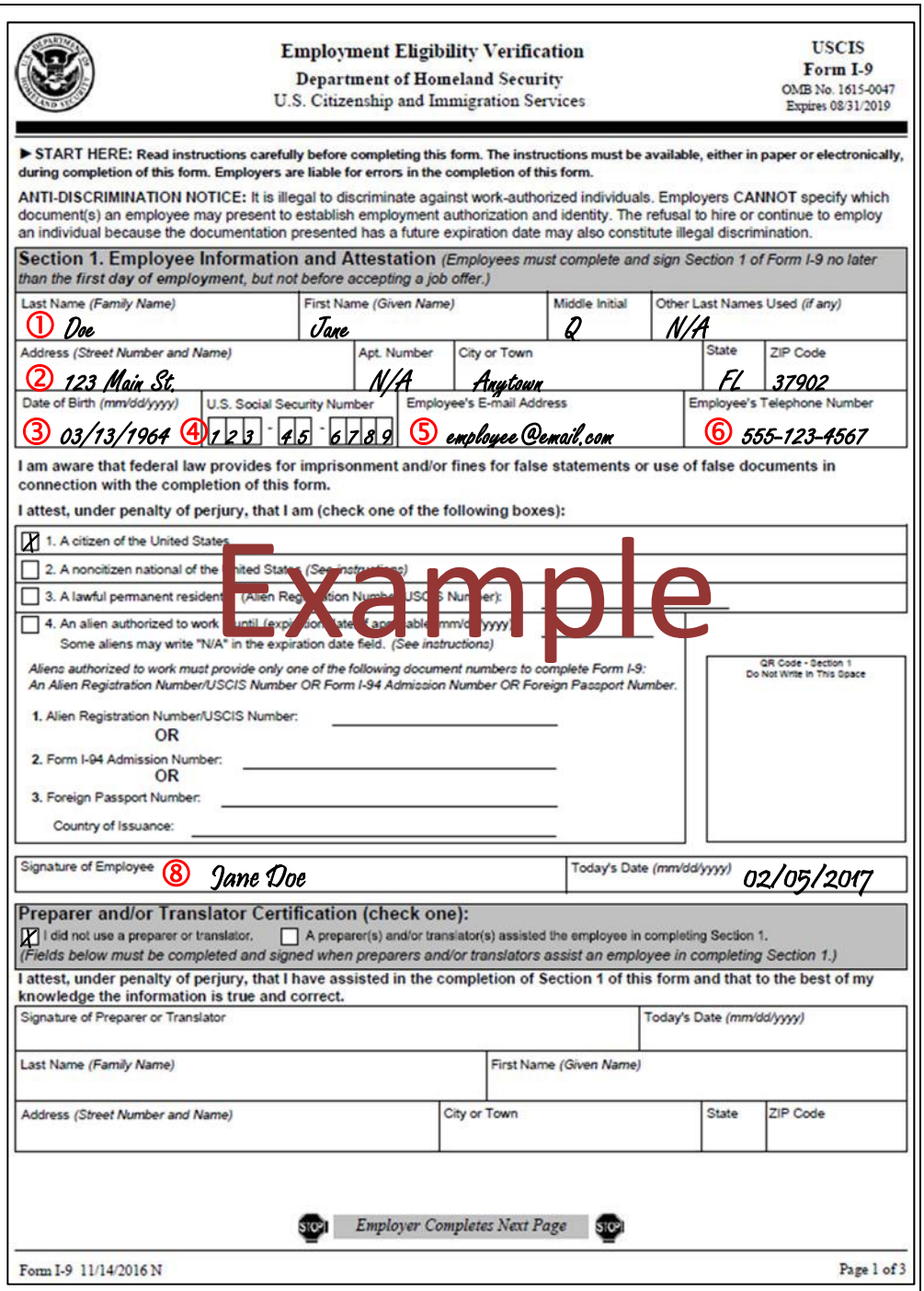
⑤ Print your email address or print "N/A" if you choose to not provide it.

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

03149

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

2022

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 estimator at *www.irs.gov/W4App*, 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 2022 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 total 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)

02227

General Instructions

Section references are to the Internal Revenue Code.

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, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2022 if you meet both of the following conditions: you had no federal income tax liability in 2021 **and** you expect to have no federal income tax liability in 2022. You had no federal income tax liability in 2021 if (1) your total tax on line 24 on your 2021 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), 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 2022 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 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2023.

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 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. This step 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. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. 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 2022 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 2022 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $

2 Enter:
- $25,900 if you're married filing jointly or qualifying widow(er)
- $19,400 if you're head of household
- $12,950 if you're single or married filing separately

. . . . . **2** $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. 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 Part II of Schedule 1 (Form 1040)). 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	$110	$850	$860	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,770	$1,870
$10,000 - 19,999	110	1,110	1,860	2,060	2,220	2,220	2,220	2,220	2,220	2,970	3,970	4,070
$20,000 - 29,999	850	1,860	2,800	3,000	3,160	3,160	3,160	3,160	3,910	4,910	5,910	6,010
$30,000 - 39,999	860	2,060	3,000	3,200	3,360	3,360	3,360	4,110	5,110	6,110	7,110	7,210
$40,000 - 49,999	1,020	2,220	3,160	3,360	3,520	3,520	4,270	5,270	6,270	7,270	8,270	8,370
$50,000 - 59,999	1,020	2,220	3,160	3,360	3,520	4,270	5,270	6,270	7,270	8,270	9,270	9,370
$60,000 - 69,999	1,020	2,220	3,160	3,360	4,270	5,270	6,270	7,270	8,270	9,270	10,270	10,370
$70,000 - 79,999	1,020	2,220	3,160	4,110	5,270	6,270	7,270	8,270	9,270	10,270	11,270	11,370
$80,000 - 99,999	1,020	2,820	4,760	5,960	7,120	8,120	9,120	10,120	11,120	12,120	13,150	13,450
$100,000 - 149,999	1,870	4,070	6,010	7,210	8,370	9,370	10,510	11,710	12,910	14,110	15,310	15,600
$150,000 - 239,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	15,340	16,540	16,830
$240,000 - 259,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	15,340	16,540	17,590
$260,000 - 279,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	16,100	18,100	19,190
$280,000 - 299,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	13,700	15,700	17,700	19,700	20,790
$300,000 - 319,999	2,040	4,440	6,580	7,980	9,340	11,300	13,300	15,300	17,300	19,300	21,300	22,390
$320,000 - 364,999	2,100	5,300	8,240	10,440	12,600	14,600	16,600	18,600	20,600	22,600	24,870	26,260
$365,000 - 524,999	2,970	6,470	9,710	12,210	14,670	16,970	19,270	21,570	23,870	26,170	28,470	29,870
$525,000 and over	3,140	6,840	10,280	12,980	15,640	18,140	20,640	23,140	25,640	28,140	30,640	32,240

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	$400	$930	$1,020	$1,020	$1,250	$1,870	$1,870	$1,870	$1,870	$1,970	$2,040	$2,040
$10,000 - 19,999	930	1,570	1,660	1,890	2,890	3,510	3,510	3,510	3,610	3,810	3,880	3,880
$20,000 - 29,999	1,020	1,660	1,990	2,990	3,990	4,610	4,610	4,710	4,910	5,110	5,180	5,180
$30,000 - 39,999	1,020	1,890	2,990	3,990	4,990	5,610	5,710	5,910	6,110	6,310	6,380	6,380
$40,000 - 59,999	1,870	3,510	4,610	5,610	6,680	7,500	7,700	7,900	8,100	8,300	8,370	8,370
$60,000 - 79,999	1,870	3,510	4,680	5,880	7,080	7,900	8,100	8,300	8,500	8,700	8,970	9,770
$80,000 - 99,999	1,940	3,780	5,080	6,280	7,480	8,300	8,500	8,700	9,100	10,100	10,970	11,770
$100,000 - 124,999	2,040	3,880	5,180	6,380	7,580	8,400	9,140	10,140	11,140	12,140	13,040	14,140
$125,000 - 149,999	2,040	3,880	5,180	6,520	8,520	10,140	11,140	12,140	13,320	14,620	15,790	16,890
$150,000 - 174,999	2,040	4,420	6,520	8,520	10,520	12,170	13,470	14,770	16,070	17,370	18,540	19,640
$175,000 - 199,999	2,720	5,360	7,460	9,630	11,930	13,860	15,160	16,460	17,760	19,060	20,230	21,330
$200,000 - 249,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,310
$250,000 - 399,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,310
$400,000 - 449,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,470
$450,000 and over	3,140	6,290	8,880	11,380	13,880	16,010	17,510	19,010	20,510	22,010	23,380	24,680

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	$760	$910	$1,020	$1,020	$1,020	$1,190	$1,870	$1,870	$1,870	$2,040	$2,040
$10,000 - 19,999	760	1,820	2,110	2,220	2,220	2,390	3,390	4,070	4,070	4,240	4,440	4,440
$20,000 - 29,999	910	2,110	2,400	2,510	2,680	3,680	4,680	5,360	5,530	5,730	5,930	5,930
$30,000 - 39,999	1,020	2,220	2,510	2,790	3,790	4,790	5,790	6,640	6,840	7,040	7,240	7,240
$40,000 - 59,999	1,020	2,240	3,530	4,640	5,640	6,780	7,980	8,860	9,060	9,260	9,460	9,460
$60,000 - 79,999	1,870	4,070	5,360	6,610	7,810	9,010	10,210	11,090	11,290	11,490	11,690	12,170
$80,000 - 99,999	1,870	4,210	5,700	7,010	8,210	9,410	10,610	11,490	11,690	12,380	13,370	14,170
$100,000 - 124,999	2,040	4,440	5,930	7,240	8,440	9,640	10,860	12,540	13,540	14,540	15,540	16,480
$125,000 - 149,999	2,040	4,440	5,930	7,240	8,860	10,860	12,860	14,540	15,540	16,830	18,130	19,230
$150,000 - 174,999	2,040	4,460	6,750	8,860	10,860	12,860	15,000	16,980	18,280	19,580	20,880	21,980
$175,000 - 199,999	2,720	5,920	8,210	10,320	12,600	14,900	17,200	19,180	20,480	21,780	23,080	24,180
$200,000 - 449,999	2,970	6,470	9,060	11,480	13,780	16,080	18,380	20,360	21,660	22,960	24,250	25,360
$450,000 and over	3,140	6,840	9,630	12,250	14,750	17,250	19,750	21,930	23,430	24,930	26,420	27,730

CONSUMER DIRECT CARE NETWORK

PAY SELECTION FORM

Name: _____
(please print)

Consumer Direct recommends every employee select direct deposit, either to a prepaid debit card 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. Pay stubs (summary of your pay) are available online through our secure web portal: www.DirectMyCare.com.

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

☐ **Wisely Pay Card Direct Deposit** – I authorize Consumer Direct to issue me a Wisely Pay 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

Sign up for the Wisely® Pay card today!

It's a reloadable prepaid pay card that's **yours to keep no matter where you work**.[1] There's no fee to sign up, and there's **no credit check** to get the Wisely Pay card because it's not a credit card.[2]

Enjoy these great benefits when you activate your Wisely Pay card account.

Shop and Pay Bills — In stores, by phone, or online, everywhere Visa debit cards are accepted and where Debit Mastercard is accepted.[3] Pay with a single touch anywhere Apple Pay®, Samsung Pay®, or Google Pay™ is accepted.

No Charge for Direct Deposit — Get paid up to 2 days early[4] for your pay and other sources of income.[5] A no-fee[6] upgrade is required.[7]

Safe and Secure — Balance is protected from fraud if the card is lost or stolen, and is FDIC insured.[8]

Manage your Money — Save for a rainy day, plan your budget, and track your spending to boost your financial wellness with myWisely® app.[9]

[1] Adding funds from other sources requires additional cardholder identification verification.
[2] Wisely Pay is not a credit card and does not build credit.
[3] Additional terms and third-party fees may apply.
[4] You must opt into early direct deposit on myWisely.com/pay or myWisely mobile app. Early direct deposit of funds is not guaranteed and is subject to payer's support and the timing of payer's payment instruction. Faster-funding claim is based on a comparison of our policy of making funds available upon our receipt of payment instruction with the typical banking practice of posting funds at settlement. Please see full disclosures on myWisely.com or myWisely app. Please allow up to 3 weeks for funds to be loaded to the card after initial setup of direct deposit to your card.
[5] Please allow up to 3 weeks for your pay to be loaded to the card after initial setup of direct deposit to your card.
[6] While this feature is available at no additional charge, certain other transaction fees and costs, terms, and conditions are associated with the use of this Card. See the cardholder agreement for more details.
[7] Additional verification required and may not be available to all cardholders.
[8] You must notify us immediately and assist us in our investigation if your card is lost or stolen or you believe someone is using your card without your permission.
[9] Standard text message fees and data rates may apply.

WiselyCard_Poster_V4 Rev. Aug 2020

CONSUMER DIRECT CARE NETWORK

PARTICIPANT/DIRECT SERVICE WORKER AGREEMENT

Print Direct Service Worker's Name _____ Print Participant's Name _____

Relationship of direct service worker (DSW) to participant: _____

INSTRUCTIONS: Review each topic, ask questions as necessary, and sign below to signify your agreement.

1. The participant will review the Employment Handbook with the direct service worker (DSW). The Handbook provides guidelines on the policies and procedures of the Participant Direction Option. The Handbook is also available on the Consumer Direct website.
2. The participant will review the Care Plan with the DSW. Both parties understand that Consumer Direct is not financially responsible for payment of services in situations where:
    - The participant becomes ineligible for Medicaid
    - The participant/representative allows DSWs to work unauthorized overtime (hours in excess of 40 per week)
    - The participant/representative allows DSWs to work in excess of time approved, or for tasks not approved on the participant's Care Plan.
3. The participant is responsible for training the DSW. The DSW will complete the following trainings, if applicable:
    - Infection Control (Universal Precautions)
    - Lifting & Moving Patients
    - HIPAA & Confidentiality
    - Abuse & Neglect
    - Medicaid Fraud
4. The participant will remind the DSW to complete a Status Change Form and submit it to Consumer Direct within 5 days of any change in name, address, telephone and any criminal convictions occurring after hire date.
5. Both parties received a Pay Schedule.
6. In the PDO program, it is recommended, but not mandatory, that the DSW receive First Aid/CPR training. This is at the Participant's discretion.
7. Reporting Requirements:
    a. The DSW must immediately report all incidents, accidents and work place injuries involving the DSW or the participant. Incidents and accidents should be reported immediately to the participant/representative. Work place injuries must be reported to the Consumer Direct Injury Hotline at 1-888-541-1701.
    b. The DSW must report possible neglect, abuse or exploitation of a participant to their County Adult or Elder Abuse reporting line at 1-800-962-2873.
    c. Suspected Medicaid Fraud must be reported to Consumer Direct's Fraud Hotline 1-877-532-8530. Consumer Direct will assist you with other reporting procedures. The AHCA Medicaid Fraud Hotline number is 1-866-966-7226.
8. Both parties agree that the DSW cannot begin work until the participant receives an "Okay to Work" form.

9. The DSW is providing the following Service(s) according to the participant's Care Plan (please check)

   ☐ Adult Companion Care Services
   ☐ Homemaker Services
   ☐ Personal Care Services
   ☐ Attendant Care Services
   ☐ Intermittent and Skilled Nursing Services (RN, LPN)

10. Wage Information (this supersedes any previous information regarding wages):

    - Primary Wage: **_____ / hour**
    - **Overtime is not allowed** without prior written approval (more than 40 hours in a week)
    - Consumer Direct will notify the participant and DSW at least thirty days prior to a change in pay rate. This can occur if the MCP changes the pay rate.
    - A new Participant/Direct Service Worker Agreement will be signed if the wage changes.

11. The DSW's work schedule is:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

    In the Participant Direction Option, the direct service worker's work schedule can be flexible. Hours worked cannot exceed approved hours on the participants Care Plan.

12. Roles and Responsibilities of the participant/representative include, but are not limited to:

    - Training the DSW
    - Supervising the DSW
    - Treating the DSW with respect, including beliefs, culture, religion and privacy
    - Completing and submitting correct time sheets to make sure the DSW is paid as agreed
    - Ensuring that the DSW does not work more hours than approved on this agreement

13. Roles and Responsibilities of Consumer Direct:

    - Sending required paperwork
    - Helping in the completion of required paperwork
    - Paying the DSW
    - Ensuring the DSW is not paid for providing more hours than approved on this agreement
    - Filing and paying all state and federal taxes for the DSW
    - Providing a toll-free customer service number to call with any questions about Participant Direction Option

The DSW's and participant's signature indicate agreement with the terms above.

_____ _____ _____ _____

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

_____ _____

Case Manager Signature *Date*

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

CONSUMER DIRECT CARE NETWORK

DIRECT SERVICE WORKER JOB DESCRIPTION

Direct Service Worker Name	Participant Name

Instructions: Using the following lists identify which PDO services will be provided. For those services that will be provided, identify the job responsibilities the direct service worker (DSW) will be required to perform. ***Please complete each page and check all that apply.***

Adult Companion Care

Will this service be provided? ☐ Yes ☐ No (Please check, if yes complete below)

Job Summary: Non-medical care, supervision and socialization provided to a functionally impaired adult. Companions assist or supervise the enrollee with tasks, such as meal preparation or laundry and shopping, but do not perform these activities as discreet services. The provision of companion services does not entail hands-on nursing care. This service includes light housekeeping tasks incidental to the care and supervision of the enrollee.

- ☐ **Meal Preparation**
  - ☐ Cooking clean up
  - ☐ Putting food away
- ☐ **Light Housecleaning**
  - ☐ Vacuuming
  - ☐ Dusting
  - ☐ Sweeping
- ☐ **Laundry**
- ☐ **Shopping**
  - ☐ Preparing shopping list
  - ☐ Picking up my groceries and personal items
  - ☐ Picking up my medications

List other assistance needed or special requests: _____

Homemaker Services

Will this service be provided? ☐ Yes ☐ No (Please check, if yes complete below)

Job Summary – General household activities, such as meal preparation and routine household care provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities. Chore services, including heavy chore services and pest control may be included in this service.

- ☐ **Housecleaning**
  - ☐ Vacuuming
  - ☐ Dusting
  - ☐ Sweeping
  - ☐ Making the bed
  - ☐ Cleaning the bathroom
- ☐ **Meal Preparation**
  - ☐ Cooking clean up
- ☐ **Lawn Care**
- ☐ **Pest Control**
- ☐ **Minor Repairs to Home**

List other assistance needed or special requests: _____

CONSUMER DIRECT CARE NETWORK

DIRECT SERVICE WORKER JOB DESCRIPTION

Direct Service Worker Name	Participant Name

Personal Care

Will this service be provided? ☐ Yes ☐ No (Please check, if yes complete below)

Job Summary – A service that provides assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service includes assistance with preparation of meals, but does not include the cost of the meals. This service may also include housekeeping chores, such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the enrollee, rather than the enrollee's family.

Dressing/Undressing
- ☐ Getting dressed (AM, PM)

Hygiene/Grooming
- ☐ Teeth care (brush, floss, mouth wash)
- ☐ Shaving
- ☐ Putting on facial/body products (lotion, make-up)
- ☐ Nail care (if diabetic, give directions)
- ☐ Hair care (brush, braid)

Range of Motion/Body Mobility
- ☐ Exercising
- ☐ Getting me out of bed or positioning me in the bed or chair

Medication Assistance
- ☐ Opening my medicine bottles or pill box
- ☐ Getting me a drink to take my medications
- ☐ Reading medication labels
- ☐ Helping me remember what medications I take throughout the day
- ☐ Helping me refill prescriptions when needed
- ☐ Helping with the placement of oxygen tubes
- ☐ Reminding me and/or placing within my reach, eye drops, and skin ointments

Bathing/Showering
- ☐ Sponge bathing
- ☐ Bed bathing
- ☐ Getting into the bath/shower (washing body/hair)
- ☐ Getting out of the bath/shower (drying)
- ☐ Getting dressed

Locomotion/Walking
- ☐ Assistance with walking outside the home
- ☐ Assistance moving to rooms or to different levels in a home

Toileting/Continence
- ☐ Assistance with toileting
- ☐ Continence care

Housekeeping
- ☐ Light Housecleaning
  - ☐ Vacuuming
  - ☐ Dusting
  - ☐ Sweeping
  - ☐ Make the bed

Meal Preparation/Feeding Assistance
- ☐ Meal Preparation/Cleanup
- ☐ Eating Assistance (cutting)

List other assistance needed or special requests: _____

Direct Service Worker Name	Participant Name

Attendant Care

Will this service be provided? ☐ Yes ☐ No (Please check, if yes complete below)

Job Summary – Hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those which substitute for the absence, loss, diminution or impairment of a physical or cognitive function. This service may include skilled or nursing care to the extent permitted by state law. Housekeeping activities which are incidental to the performance of care may also be furnished as part of this activity. Unskilled attendant care must have supervision provided by a registered nurse, licensed to practice in the state.

List your specific medical needs here:

Intermittent and Skilled Nursing

Will this service be provided? ☐ Yes ☐ No (Please check, if yes complete below)

Job Summary – This service includes the home health benefit available under the Medicaid state plan as well as expanded nursing services coverage under this waiver. Services listed in the care plan that are within the scope of Florida's Nurse Practice act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the state. Skilled nursing services must be listed in the enrollee's plan of care and are provided on an intermittent basis to enrollees who either do not require continuous nursing supervision or whose need is predictable.

List your specific medical needs here:

Direct Service Worker Name	Participant Name

Additionally the employee is responsible for:

- Treating the participant with dignity and respect. This includes respecting personal beliefs, culture, region, and privacy as well as respect for the participant's personal property.
- Keeping personal information about the participant confidential.
- Communicating effectively with the participant. Respect and utilize the participant's preferred methods.
- Providing safe care. Utilizing Universal Precautions.
- Immediately reporting an emergency situation by calling 911.
- Reporting suspected abuse and neglect to the managed care plan and proper authorities.
- Reporting a change in health condition to the managed care plan.
- Provide enough notice to the participant if unable to work a regularly scheduled shift including being late for work.
- Providing a two week notice to the participant if the employee is voluntarily terminating employment.

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

CONSUMER DIRECT CARE NETWORK

EMPLOYEE HEALTH QUESTIONNAIRE

Employee Printed Name

Background: At this point in the employment process, you have been conditionally hired by a Consumer/Member/ Representative/Individual ("Employer") as an Employee. Your position involves delivering services for the Employer. Your duties will vary according to the needs and authorized services of the Employer, but will require you to perform tasks of a physical nature, which have physical demand requirements. The purpose of this Health Questionnaire is to obtain information about your ability to safely perform the authorized tasks. The information provided on this Questionnaire will be used to help manage your employment in a safe manner. Your responses are considered *Confidential*.

Instructions: Please respond to each item as to whether you have a medical or physical activity restriction or limitation to physical activity. **Please explain each "Yes" answer on the reverse of this form, and attach additional information as necessary.**

Return this completed form, with the other employment forms, to the Consumer Direct office.

	Do you currently have a Physical Activity Restriction for:	**NO**	**YES**
1	Sitting		
2	Stationary Standing		
3	Walking		
4	Ability to be Mobile		
5	Crouching (bending at knee)		
6	Kneeling/Crawling		
7	Stooping (bending at waist)		
8	Twisting (knees/waist/neck)		
9	Turning/Pivoting		
10	Climbing		
11	Balancing		
12	Reaching overhead		
13	Reaching extension		
14	Grasping		
15	Pushing/Pulling		
16	Lifting/Carrying		
17	Whole/Partial Loss of Hearing		
18	Blindness (partial or complete) or Eye Problems		
19	Have you ever been advised by a health care professional to restrict your physical activities in any way?		

	Personal Medical History **In the past 5 years, have you had or been treated for:**	**NO**	**YES**
20	Epilepsy		
21	Fainting/Dizzy Spells		
22	Hernia		
23	Muscular Strain		
24	Neck or Back Strain or Injury		
25	Ruptured Intervertebral Disc		
26	Joint Injury or Pain		
27	Fractures		
28	Tuberculosis or Non-Negative TB Test		
29	Lung Problems/Disease		
30	Head Injury		
31	Allergies		
32	Other Current Problems, Diseases, Conditions		
33	Have you ever been hospitalized or undergone surgery, other than for childbirth?		
34	Have you ever refused a recommended surgical procedure?		
35	Are you currently taking any medication or drugs, whether by prescription or not, that could impair your judgment?		

CONSUMER DIRECT CARE NETWORK

EMPLOYEE HEALTH QUESTIONNAIRE

_____

Employee Printed Name

Do you currently have, or have you ever been told by a health care professional that you have, any physical limitations in reference to the list below?							
		NO	**YES**			**NO**	**YES**
A	Back			H	Arm		
B	Shoulder			I	Hip		
C	Neck			J	Knee		
D	Elbow			K	Ankle		
E	Wrist			L	Foot		
F	Hand			M	Leg		
G	Finger			N	Other		

Consumer Direct does not discriminate in hiring, promotion, or retention policies or practices against persons who have, in good faith, filed a claim for or received benefits pursuant to State Workers' Compensation Laws.

Please explain any "Yes" answers from page 1 and 2 in detail below and note the associated number or letter. Also, include the dates of injuries & surgeries. Use additional pages if necessary:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I hereby certify that I have answered the above questions to the best of my knowledge, and that my answers are true and complete. I understand that misrepresentation or omission of facts is cause for dismissal and may result in denial of workers' compensation benefits.

Employee Signature: _____ Date: _____/_____/_____

Office Use Only

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

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

05095