Representative Name (if exists): _____ Clear Form

Participant Name: _____

UnitedHealthcare Community Plan

CONSUMER DIRECT CARE NETWORK

Note: This packet is set up for double sided paper printing.

Direct Service Worker (DSW) Data Form

Help with the hiring process. If you need help with this packet, please contact Consumer Direct at 877-270-9580 or UnitedHealthcare Toll-Free 800-791-9233; TTY/TTD 711. We are happy to help.

Direct Service Worker Info

Name: _____ _____ _____
First. Middle. Last.

Mailing Address: _____
Street.

_____
City. State. Zip Code.

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

Email: _____

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

Emergency Contact: _____ _____ _____
Name. Phone. Relationship.

Age and Training Requirements

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

An RN or LPN license is required for Attendant Care and Intermittent and Skilled Nursing Services. **Attach a copy of your license if you are providing these services.** This must be kept current.

Have you ever committed a felony? ☐ Yes ☐ No.

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

Please Read Carefully. This packet starts the hiring process. The Participant or Legal Guardian is the DSW's employer. Not Consumer Direct. Consumer Direct accepts paperwork on the Employer's behalf.

I authorize evaluation of all statements given to my employer. I understand I cannot falsify or omit any called for facts. This is cause for dismissal.

I understand my employment is conditional. This is until my background check has been approved. I understand that my background check results may be shared. They may be shared with my employer. They may be shared with my employer's Managed Care Plan.

Signature of Applicant: _____ Date: _____

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We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan member ID card, TTY 711, Monday through Friday, 8:00 a.m. to 7:00 p.m.

ATENCIÓN: Si no habla inglés, hay servicios de asistencia con el idioma disponibles sin costo para usted. Llame al **1-800-791-9233, TTY 711**.

ATENÇÃO: Se não fala inglês, estão disponíveis serviços de assistência linguística sem nenhum custo para si. Ligue para o **1-800-791-9233, TTY 711**.

Direct Service Worker (DSW) Enrollment Checklist

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

Complete each form in the list below. Keep a copy. Please send the **original forms to Consumer Direct.** The DSW may not begin work until all forms are reviewed and approved by Consumer Direct. DSWs must not work until they receive an "Okay to Work" form.

Forms required for all new DSWs:

1. ☐ DSW Data Form
2. ☐ DSW Enrollment Checklist (this form)
3. ☐ Employment Relationship Disclosure
4. ☐ I-9 - *Instructions are available on the CDCN Florida website under the Resources tab*
5. ☐ W-4
6. ☐ Pay Selection Form - *An attachment may be required, see form for instructions*
7. ☐ Participant/DSW Agreement Addendum
8. ☐ Participant/DSW Agreement
9. ☐ Care Provider Background Screening – Privacy Policy Acknowledgement
10. ☐ Attestation of Compliance with Background Screening Requirements
11. ☐ Information Needed for Fingerprinting
12. ☐ Job Description
13. ☐ Health Questionnaire (Optional)

Supplements:

1. ☐ Fingerprint Procedures – *Review only*
2. ☐ Health Care Marketplace

Please review all forms. Confirm that all forms are complete and legible. Please send all forms to Consumer Direct. Forms that are missing or cannot be read will result in a delayed start date.

Additional resources are available on the website: www.ConsumerDirectFL.com

Questions?
We're here to help. United Healthcare Community & State.
Toll-Free 800-791-9233
and TTY/TTD 711,
Monday through Friday, 8:00 a.m. to 8:00 p.m.

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UnitedHealthcare Community Plan

CONSUMER DIRECT CARE NETWORK

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. If you need help, please contact Consumer Direct at 877-270-9580 or UnitedHealthcare Toll-Free 800-791-9233; TTY/TTD 711. We are happy to help.

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

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UnitedHealthcare Community Plan

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.

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ATENCIÓN: Si no habla inglés, hay servicios de asistencia con el idioma disponibles sin costo para usted. Llame al **1-800-791-9233, TTY 711**.

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Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No.1615-0047
Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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 (if any)	Other Last Names Used (if any)

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

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number
/ /			

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

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

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears 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.

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)
Employer		

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

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 an individual temporarily authorized to work for a specific employer because of his or her status or parole: **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 individual's status or parole 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 For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		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				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	**OR**	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

Supplement A,
Preparer and/or Translator Certification for Section 1

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

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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

2024

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 surviving spouse**
☐ **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, and when to use the estimator at *www.irs.gov/W4App*.

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). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **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 generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

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 Dependent and Other Credits

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 for qualifying children and other dependents. You may add to this the amount of any other credits. 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 2024 if you meet both of the following conditions: you had no federal income tax liability in 2023 **and** you expect to have no federal income tax liability in 2024. You had no federal income tax liability in 2023 if (1) your total tax on line 24 on your 2023 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), 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 2024 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, 2025.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

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. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

3. 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.

Instead, if you (and your spouse) have a total of only two jobs, you may 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 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 2024 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. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

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 2024 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:
- $29,200 if you're married filing jointly or a qualifying surviving spouse
- $21,900 if you're head of household
- $14,600 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 territories 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 Surviving Spouse

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	$0	$780	$850	$940	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,370
$10,000 - 19,999	0	780	1,780	1,940	2,140	2,220	2,220	2,220	2,220	2,220	2,570	3,570
$20,000 - 29,999	780	1,780	2,870	3,140	3,340	3,420	3,420	3,420	3,420	3,770	4,770	5,770
$30,000 - 39,999	850	1,940	3,140	3,410	3,610	3,690	3,690	3,690	4,040	5,040	6,040	7,040
$40,000 - 49,999	940	2,140	3,340	3,610	3,810	3,890	3,890	4,240	5,240	6,240	7,240	8,240
$50,000 - 59,999	1,020	2,220	3,420	3,690	3,890	3,970	4,320	5,320	6,320	7,320	8,320	9,320
$60,000 - 69,999	1,020	2,220	3,420	3,690	3,890	4,320	5,320	6,320	7,320	8,320	9,320	10,320
$70,000 - 79,999	1,020	2,220	3,420	3,690	4,240	5,320	6,320	7,320	8,320	9,320	10,320	11,320
$80,000 - 99,999	1,020	2,220	3,620	4,890	6,090	7,170	8,170	9,170	10,170	11,170	12,170	13,170
$100,000 - 149,999	1,870	4,070	6,270	7,540	8,740	9,820	10,820	11,820	12,830	14,030	15,230	16,430
$150,000 - 239,999	1,960	4,360	6,760	8,230	9,630	10,910	12,110	13,310	14,510	15,710	16,910	18,110
$240,000 - 259,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$260,000 - 279,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$280,000 - 299,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,380
$300,000 - 319,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,980	17,980	19,980
$320,000 - 364,999	2,040	4,440	6,840	8,310	9,710	11,280	13,280	15,280	17,280	19,280	21,280	23,280
$365,000 - 524,999	2,720	6,010	9,510	12,080	14,580	16,950	19,250	21,550	23,850	26,150	28,450	30,750
$525,000 and over	3,140	6,840	10,540	13,310	16,010	18,590	21,090	23,590	26,090	28,590	31,090	33,590

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	$240	$870	$1,020	$1,020	$1,020	$1,540	$1,870	$1,870	$1,870	$1,870	$1,910	$2,040
$10,000 - 19,999	870	1,680	1,830	1,830	2,350	3,350	3,680	3,680	3,680	3,720	3,920	4,050
$20,000 - 29,999	1,020	1,830	1,980	2,510	3,510	4,510	4,830	4,830	4,870	5,070	5,270	5,400
$30,000 - 39,999	1,020	1,830	2,510	3,510	4,510	5,510	5,830	5,870	6,070	6,270	6,470	6,600
$40,000 - 59,999	1,390	3,200	4,360	5,360	6,360	7,370	7,890	8,090	8,290	8,490	8,690	8,820
$60,000 - 79,999	1,870	3,680	4,830	5,840	7,040	8,240	8,770	8,970	9,170	9,370	9,570	9,700
$80,000 - 99,999	1,870	3,690	5,040	6,240	7,440	8,640	9,170	9,370	9,570	9,770	9,970	10,810
$100,000 - 124,999	2,040	4,050	5,400	6,600	7,800	9,000	9,530	9,730	10,180	11,180	12,180	13,120
$125,000 - 149,999	2,040	4,050	5,400	6,600	7,800	9,000	10,180	11,180	12,180	13,180	14,180	15,310
$150,000 - 174,999	2,040	4,050	5,400	6,860	8,860	10,860	12,180	13,180	14,230	15,530	16,830	18,060
$175,000 - 199,999	2,040	4,710	6,860	8,860	10,860	12,860	14,380	15,680	16,980	18,280	19,580	20,810
$200,000 - 249,999	2,720	5,610	8,060	10,360	12,660	14,960	16,590	17,890	19,190	20,490	21,790	23,020
$250,000 - 399,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$400,000 - 449,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$450,000 and over	3,140	6,450	9,110	11,610	14,110	16,610	18,430	19,930	21,430	22,930	24,430	25,870

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	$510	$850	$1,020	$1,020	$1,020	$1,020	$1,220	$1,870	$1,870	$1,870	$1,960
$10,000 - 19,999	510	1,510	2,020	2,220	2,220	2,220	2,420	3,420	4,070	4,070	4,160	4,360
$20,000 - 29,999	850	2,020	2,560	2,760	2,760	2,960	3,960	4,960	5,610	5,700	5,900	6,100
$30,000 - 39,999	1,020	2,220	2,760	2,960	3,160	4,160	5,160	6,160	6,900	7,100	7,300	7,500
$40,000 - 59,999	1,020	2,220	2,810	4,010	5,010	6,010	7,070	8,270	9,120	9,320	9,520	9,720
$60,000 - 79,999	1,070	3,270	4,810	6,010	7,070	8,270	9,470	10,670	11,520	11,720	11,920	12,120
$80,000 - 99,999	1,870	4,070	5,670	7,070	8,270	9,470	10,670	11,870	12,720	12,920	13,120	13,450
$100,000 - 124,999	2,020	4,420	6,160	7,560	8,760	9,960	11,160	12,360	13,210	13,880	14,880	15,880
$125,000 - 149,999	2,040	4,440	6,180	7,580	8,780	9,980	11,250	13,250	14,900	15,900	16,900	17,900
$150,000 - 174,999	2,040	4,440	6,180	7,580	9,250	11,250	13,250	15,250	16,900	18,030	19,330	20,630
$175,000 - 199,999	2,040	4,510	7,050	9,250	11,250	13,250	15,250	17,530	19,480	20,780	22,080	23,380
$200,000 - 249,999	2,720	5,920	8,620	11,120	13,420	15,720	18,020	20,320	22,270	23,570	24,870	26,170
$250,000 - 449,999	2,970	6,470	9,310	11,810	14,110	16,410	18,710	21,010	22,960	24,260	25,560	26,860
$450,000 and over	3,140	6,840	9,880	12,580	15,080	17,580	20,080	22,580	24,730	26,230	27,730	29,230

UnitedHealthcare Community Plan

CONSUMER DIRECT CARE NETWORK

Pay Selection Form

Name: _____
(please print).

Consumer Direct suggests that you use direct deposit. This can be through a prepaid debit card or into an account that you choose.

Direct deposits avoid all likely delays linked with delivery of mail. This 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.

Below are the pay options to choose from. Please select one option.

☐ **Wisely Pay Card.** I authorize Consumer Direct to issue me a Wisely Pay Card. They will use my Social Security Number and other identification on file to set up the card. Pay will be put onto this card. I should receive my debit card in around two weeks. It will be sent to my address on file.

☐ **Direct Deposit to my account.** I authorize Consumer Direct to deposit my pay to (name of bank or financial institution): _____.

Account Type (check one): ☐ Checking. ☐ Savings.

For Checking Accounts:

Tape a voided check here.
Please do not attach a deposit slip.

For Savings Accounts: provide a document from your bank. This form must have the exact numbers to your account. It will be used to set up your direct deposit. Is the document larger than this box? Please send it in as a separate document. Do not attach a deposit slip. Deposit slips do not have all of the required numbers.

I authorize Consumer Direct to route my pay. This will be based on my answers above. Funds may be deposited into my account by mistake. If this happens, I authorize Consumer Direct to debit my account to correct the error. It is my duty to check that each deposit has occurred. I must pay any fees caused by overdrafts on my account. Deposits will be made on each applicable payday. I must let my employer know if I want to stop direct deposits. This must be in writing. Consumer Direct reserves the right to refuse any direct deposit request. All direct deposits are made through an Automated Clearing House (ACH); Processing is subject to ACH terms and limitations, as well as those of my financial institution. It may take some time to set up my selected method of pay. While this is being done, I will receive paper checks.

_____ _____
Signature Date

10308

UnitedHealthcare Community Plan

If you need help, please contact Consumer Direct at 877-270-9580 or UnitedHealthcare Toll-Free 800- 791-9233; TTY/TTD 711. We are happy to help.

UnitedHealthcare does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan member ID card, TTY 711, Monday through Friday, 8:00 a.m. to 7:00 p.m.

ATENCIÓN: Si no habla inglés, hay servicios de asistencia con el idioma disponibles sin costo para usted. Llame al **1-800-791-9233, TTY 711**.

ATENÇÃO: Se não fala inglês, estão disponíveis serviços de assistência linguística sem nenhum custo para si. Ligue para o **1-800-791-9233, TTY 711**.

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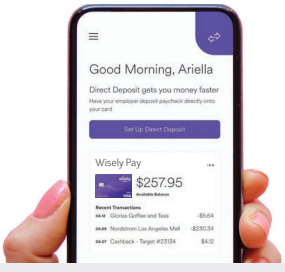

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[1] The Wisely card is a prepaid card. References to a digital account refer to the management and servicing of your prepaid card online digitally or through a mobile app. The Wisely card is not a credit card and does not build credit.

[2] You must log in to the myWisely app or mywisely.com to opt-in to early direct deposit. Early direct deposit of funds is not guaranteed and is subject to the timing of payor'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 the myWisely app. If you have a Wisely Pay or Wisely Cash card (see back of your card), this feature requires an upgrade which may not be available to all cardholders. Please allow up to 3 weeks after your initial setup of direct deposit for your pay to start loading to your card.

[3] Amounts transferred to your savings envelope will no longer appear in your available balance. You can transfer money from your savings envelope back to your available balance at any time using the myWisely app or at mywisely.com.

[4] The number of fee-free ATM transactions may be limited. Please log in to the myWisely app or mywisely.com and see your cardholder agreement and list of all fees for more information.

UnitedHealthcare Community Plan

CONSUMER DIRECT CARE NETWORK

Participant/Direct Service Worker (DSW) Agreement

Print DSW's Name _____ Print Participant's Name _____

INSTRUCTIONS

- Review each topic. Ask questions as needed. Sign below to show you agree.

TERMS

- In this agreement:
  a. "CDCN" refers to Consumer Direct for Florida, LLC. doing business as Consumer Direct Care Network Florida
  b. "AHCA" refers to the Florida Agency for Health Care Administration
  c. "MCP" refers to the Participant's Managed Care Plan
  d. "PDO" means Participant Direction Option
  e. "LG" means the Participant's Legal Guardian

The DSW is the employee of the Participant. **CDCN is not the DSW's employer.** CDCN is the Fiscal Employer Agent; we help the Participant with some employer tasks. This agreement is made between the DSW and the Participant. Please fill out all forms found in the DSW Enrollment Packet. Filling out these forms will set up your employment with the Participant/LG.

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

- Train the DSW.
- Supervise the DSW.
- Treat the DSW with respect; this includes their beliefs, culture, religion and privacy.
- Complete and submit correct time sheets; doing so will ensure that the DSW is paid as agreed.
- Ensure that the DSW does not work more hours than approved on this agreement.

2. The Participant/LG will:

A. Receive a copy of the Employer Handbook. They will go through the Handbook with the DSW. The Handbook maps out the guidelines within the PDO; it includes policies and procedures. The Handbook may be found on the CDCN website as well.

B. Receive a copy of the pay schedule.

C. Train the DSW.

i. CDCN supplies the following **optional** trainings to use at the Participant's discretion:

- Infection Control (Universal Precautions)
- Health Insurance Portability and Accountability Act (HIPAA) & Confidentiality
- Abuse, Neglect, and Exploitation (ANE)
- Medicaid Fraud
- Lifting & Moving Patients

ii. It is advised that the DSW be trained in First Aid/CPR. First Aid/CPR training is not required in the PDO program; the Participant must decide if they would like for their DSW to be trained.

D. Go through the Care Plan with the DSW. Both parties understand that CDCN is not financially responsible for payment of services in situations where:

i. The Participant is not eligible for Medicaid.

ii. The Participant/LG lets the DSW work overtime that has not been approved. Overtime is when a DSW works more than 40 hours in a week.

iii. The Participant/LG lets the DSW:

a. Work more time than what is approved on the Care Plan; or

b. Perform tasks that are not approved on the Care Plan.

E. Tell the DSW to keep CDCN up to date on changes. The DSW should let CDCN know within 5 days of changes. Changes to be reported to CDCN:

- Change in DSW name.
- Change in DSW address.
- Change in DSW phone number.
- Any criminal convictions that occur after hire date.

3. The DSW understands that:

a. The DSW must not misrepresent or omit facts. If the DSW does so, the DSW may be dismissed without notice.

b. Employment is conditional until the results of the criminal background check have been approved.

c. The results of the criminal background check or any future criminal background checks may be shared with:

i. The approving entity (MCP, county, etc.); and

ii. The Participant/LG with whom the DSW works for.

4. Participant and/or DSW Reporting Requirements

I. The DSW must report the following if it involves the DSW and/or the Participant:

a. All incidents, accidents and work place injuries. The DSW should tell the Participant/LG about all incidents and accidents right away. Work place injuries **must** be reported to the CDCN Injury Hotline.

i. **CDCN Injury Hotline:** 1-888-541-1701

b. All possible ANE to the County Adult or Elder Abuse hotline.

i. **Abuse Hotline:** 1-800-962-2873

II. The Participant and DSW must report:

a. All suspected Medicaid Fraud. Reports can be made to CDCN or AHCA. CDCN can help you through the process.

Participant/Direct Service Worker (DSW) Agreement

i. **CDCN's Fraud Hotline:** 1-877-532-8530

ii. **AHCA Medicaid Fraud Hotline:** 1-866-966-7226

5. Roles and Responsibilities of CDCN:

- Send required forms.
- Help in the completion of required forms.
- Pay the DSW.
- Ensure the DSW is not paid for working more hours than approved on this agreement.
- File and pay all state and federal taxes for the DSW.
- Provide a toll-free customer service number to call with any questions about PDO.

6. The DSW gives consent to look into all statements provided to the Participant/LG. This includes statements contained in the DSW paperwork.

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

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

Case Manager Signature	*Date*

UnitedHealthcare Community Plan

Questions?
We're here to help. United Healthcare Community & State.
Toll-Free 800-791-9233 and TTY/TTD 711,
Monday through Friday, 8:00 a.m. to 8:00 p.m.

UnitedHealthcare Community Plan does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free member phone number listed on your health plan member ID card, TTY 711, Monday through Friday, 8:00 a.m. to 7:00 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html

Phone:
Toll-free **1-800-368-1019**, **1-800-537-7697** (TDD)

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

If you need help with your complaint, please call the toll-free member phone number listed on your member ID card.

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan member ID card, TTY 711, Monday through Friday, 8:00 a.m. to 7:00 p.m.

UnitedHealthcare Community Plan no da un tratamiento diferente a sus miembros en base a su sexo, edad, raza, color, discapacidad o nacionalidad.

Si usted piensa que ha sido tratado injustamente por razones como su sexo, edad, raza, color, discapacidad o nacionalidad, puede enviar una queja a:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

Usted tiene que enviar la queja dentro de los 60 días de la fecha cuando se enteró de ella. Se le enviará la decisión en un plazo de 30 días. Si no está de acuerdo con la decisión, tiene 15 días para solicitar que la consideremos de nuevo.

Si usted necesita ayuda con su queja, por favor llame al número de teléfono gratuito para miembros que aparece en su tarjeta de identificación del plan de salud, TTY 711, de lunes a viernes, de 8:00 a.m. a 7:00 p.m.

Usted también puede presentar una queja con el Departamento de Salud y Servicios Humanos de los Estados Unidos.Usted también puede presentar una queja con el Departamento de Salud y Servicios Humanos de los Estados Unidos.

Internet:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Formas para las quejas se encuentran disponibles en:
http://www.hhs.gov/ocr/office/file/index.html

Teléfono:
Llamada gratuita, **1-800-368-1019**, **1-800-537-7697** (TDD)

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

Si necesita ayuda para presentar su queja, por favor llame al número gratuito para miembros anotado en su tarjeta de identificación como miembro.

Ofrecemos servicios gratuitos para ayudarle a comunicarse con nosotros. Tales como, cartas en otros idiomas o en letra grande. O bien, puede solicitar un intérprete. Para pedir ayuda, llame a Servicios para Miembros al **1-800-791-9233, TTY 711**, de lunes a viernes, de 8:00 a.m. a 7:00 p.m.

UnitedHealthcare®
Community Plan

ATTENTION: If you do not speak English, language assistance services, at no cost to you, are available. Call **1-800-791-9233, TTY 711**.

ATENCIÓN: Si no habla inglés, los servicios de asistencia de idiomas están disponibles sin costo para usted. Llame al **1-800-791-9233, TTY 711**.

ATANSYON: Si w pa pale Anglè, gen sèvis èd pou lang ki disponib san w pa peye anyen. Rele **1-800-791-9233, TTY 711**.

ВНИМАНИЕ: Если Вы не говорите по-русски, Вы можете воспользоваться бесплатной языковой помощью. Позвоните по телефону **1-800-791-9233, телетайп 711**.

ATENÇÃO: Se não fala inglês, estão disponíveis serviços de assistência linguística sem nenhum custo para si. Ligue para o **1-800-791-9233, TTY 711**.

注意：如果您不會說英文，您可獲得免費語言協助服務。
請致電 **1-800-791-9233，聽障專線 (TTY) 711**。

Participant/Direct Service Worker (DSW) Agreement Addendum

Print DSW's Name _____ Print Participant's Name _____

Relationship of DSW to Participant: _____

1. **The DSW will provide the following Service(s) according to the participant's Plan of Care. The DSW will be paid at the wages listed below. Please check and fill in the primary wage for all that apply.**

   ☐ Adult Companion Care Services – Primary Wage: _____/hour
   ☐ Homemaker Services – Primary Wage: _____/hour
   ☐ Personal Care Services – Primary Wage: _____/hour
   ☐ Attendant Nursing Care Services – Primary Wage: _____/hour
   ☐ Intermittent and Skilled Nursing Services (RN, LPN) – Primary Wage: _____/hour

   CDCN will notify the participant and DSW at least 30 days prior to a change in pay rate. This can occur if the Managed Care Plan changes the pay rate.

2. **The DSW's work schedule is:**

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

   In the PDO, the DSW's shifts can change. Hours worked cannot be more than the approved hours on the Participant's Care Plan.

   The DSW has received a pay schedule.

As a reminder, an applicant cannot be scheduled for work until:

- All employment paperwork is approved;
- All background checks are complete; and
- The DSW is approved to begin work. CDCN will notify the participant/Legal Guardian when the DSW has been approved. The DSW must not start work prior to the date on the Okay to Work form.

Please sign below. Your signatures show agreement with the terms above.

_____ _____ _____ _____

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

UnitedHealthcare Community Plan

Questions?
We're here to help. United Healthcare Community & State.
Toll-Free 800-791-9233
and TTY/TTD 711,
Monday through Friday, 8:00 a.m. to 8:00 p.m.

UnitedHealthcare does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities

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ATENÇÃO: Se não fala inglês, estão disponíveis serviços de assistência linguística sem nenhum custo para si. Ligue para o **1-800-791-9233, TTY 711**.

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.

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(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.

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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

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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
_____	_____	_____

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UnitedHealthcare Community Plan

CONSUMER DIRECT CARE NETWORK

Direct Service Worker (DSW) Information Needed for Fingerprinting

Instructions: Complete every field below with your information. Print clearly. This is needed to register you for a fingerprint background check. If you need help, please contact Consumer Direct at 877-270-9580 or UnitedHealthcare Toll-Free 800-791-9233; TTY/TTD 711. We are happy to help.

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

Office use only.

CD Representative Name _____.

Participant Name _____.

Health Care Plan United.

Date of Enrollment Meeting _____.

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UnitedHealthcare does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan member ID card, TTY 711, Monday through Friday, 8:00 a.m. to 7:00 p.m.

ATENCIÓN: Si no habla inglés, hay servicios de asistencia con el idioma disponibles sin costo para usted. Llame al **1-800-791-9233, TTY 711**.

ATENÇÃO: Se não fala inglês, estão disponíveis serviços de assistência linguística sem nenhum custo para si. Ligue para o **1-800-791-9233, TTY 711**.

UnitedHealthcare Community Plan

CONSUMER DIRECT CARE NETWORK

Direct Service Worker (DSW) Job Description

DSW Name	Participant Name

Instructions: Use the lists below. Find and checkmark the services that will be provided and the tasks the DSW will perform. ***Complete each page. Check all that apply.***

Adult Companion Care Services (ACCS)

Will the DSW provide this service? ☐ **Yes** ☐ **No** (*Check yes or no. If yes complete below.*)

Job Summary. ACCS includes activities needed to aid the recipient. The DSW may help with household or personal tasks. ACCS also consists of providing social stimulation to relieve the adverse effects of loneliness and solitude.

☐ **Meal Preparation**
- ☐ Cooking clean up.
- ☐ Put food away.

☐ **Light House cleaning**
- ☐ Vacuum.
- ☐ Dust.
- ☐ Sweep.

☐ **Laundry**

☐ **Shopping**
- ☐ Prepare a shopping list.
- ☐ Pick up groceries and personal items.
- ☐ Pick up medications.

List other needs:

_____

_____

_____

_____

Homemaker Services

Will the DSW provide this service? ☐ **Yes** ☐ **No** (*Check yes or no. If yes complete below.*)

Job Summary. Assist with daily living activities. Help with household tasks that support clients in a home setting. Services may include maintenance of personal belongings and performance of light housekeeping.

☐ **House cleaning**
- ☐ Vacuum.
- ☐ Dust.
- ☐ Sweep.
- ☐ Make the bed.
- ☐ Clean the bathroom.

☐ **Meal Preparation**
- ☐ Cooking clean up.

List other needs: _____

_____

_____

UnitedHealthcare Community Plan

CONSUMER DIRECT CARE NETWORK

Direct Service Worker (DSW) Job Description

Personal Care Services (PCS)

Will the DSW provide this service? ☐ **Yes** ☐ **No** (*Check yes or no. If yes complete below.*)

Job Summary. Assist with, or supervise, activities of daily living. PCS offers a substitute to home health aide services when a client's condition no longer requires the attention of a nurse or aide acting under regular supervision. Tasks under PCS may include helping the recipient eat, bathe, get dressed, and use the bathroom. Other tasks may be to make the bed, dust, and vacuum.

Dressing and Undressing
- ☐ Get dressed.

Hygiene and Grooming
- ☐ Teeth care. (Brush, floss, mouth wash).
- ☐ Shaving.
- ☐ Put on facial and body products. (Lotion, make-up).
- ☐ Nail care. (If diabetic, give directions).
- ☐ Hair care. (Brush, braid).

Range of Motion and Body Mobility
- ☐ Exercising.
- ☐ Getting me out of bed. Positioning me in bed or in a chair.

Medication Assistance
- ☐ Open a medicine bottle or pill box.
- ☐ Get me a drink to take my medications.
- ☐ Read medication labels.
- ☐ Help me remember what medications I take.
- ☐ Help me refill prescriptions.
- ☐ Help with placement of oxygen tubes.
- ☐ Remind me and/or place within my reach eye drops and skin ointments.

Bathing and Showering
- ☐ Sponge bath.
- ☐ Bed bath.
- ☐ Get into the bath or shower. (Wash body or hair).
- ☐ Get out of the bath or shower. (Drying).
- ☐ Get dressed.

Locomotion and Walking
- ☐ Assist walking outside the home.
- ☐ Assist moving to rooms. Help move to different levels in a home.

Toileting and Continence
- ☐ Assist with toileting.
- ☐ Continence care.

House keeping
- ☐ Light house cleaning.
  - ☐ Vacuum.
  - ☐ Dust.
  - ☐ Sweep.
  - ☐ Make the bed.

Meal Preparation and Feeding Assistance
- ☐ Meal prep and cleanup.
- ☐ Eating assistance. (Cutting food).

List other needs: _____

_____

_____

_____

_____

UnitedHealthcare Community Plan

CONSUMER DIRECT CARE NETWORK

Direct Service Worker (DSW) Job Description

Attendant Nursing Care Services

Will the DSW provide this service? ☐ **Yes** ☐ **No** (*Check yes or no. If yes complete below.*)

Job Summary. Care provided by a licensed nurse. Care is usually for longer periods during the day. Periods tend to be more than two hours. The nurse helps with medical needs.

List specific medical needs:

_____

_____

_____

_____

Intermittent and Skilled Nursing

Will the DSW provide this service? ☐ **Yes** ☐ **No** (*Check yes or no. If yes complete below.*)

Job Summary. Skilled nursing services provided to assure the client's safety and achieve the objectives of the physician authorized treatment plan. These skilled services may be done in the client's home by a LPN or RN. Care tends to be during brief times of the day; usually in less than two hours. The nurse helps with medical needs. Needs may be injections. Needs may also include wound care.

List specific medical needs:

_____

_____

_____

The DSW's responsibilities to the participant:

- Treat the participant with dignity and respect. Respect their personal beliefs, culture, and religion. Also respect their privacy and personal property.
- Report suspected abuse and neglect.
- Call 911 if there is an emergency.
- Respect and use the participant's preferred communication methods.
- Keep the participant's personal information private.
- Report a change in health condition to the managed care plan.
- Provide at least a two-weeks notice if quitting.
- Provide safe care.
- Provide notice if running late or unable to work.

_____ _____ _____ _____

Participant/Rep Signature *Date* *DSW Signature* *Date*

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UnitedHealthcare Community Plan

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ATENÇÃO: Se não fala inglês, estão disponíveis serviços de assistência linguística sem nenhum custo para si. Ligue para o **1-800-791-9233, TTY 711**.

UnitedHealthcare Community Plan

CONSUMER DIRECT CARE NETWORK

Direct Service Worker (DSW) Health Questionnaire

_____

DSW Printed Name

Background. Welcome! You are in the employment process. You have been conditionally hired by a Participant. They are your Employer. Your job title is a DSW. Your title requires you to provide services for the Employer. Duties will vary. They are fit to the needs of the Employer. These services must be authorized. Your duties will require you to perform tasks of a physical nature; these tasks have physical demands. The purpose of this form is to get information about your ability to safely do these tasks. This will be used to help manage your employment in a safe manner.

Instructions. Please respond to each item. Your responses are *Confidential*. Check yes if you have a medical or physical activity restriction/limitation. **Please explain each "Yes" answer on the next page. Attach more pages if needed.** Check "No" if you do not have a restriction or limitation. Answers marked "No" do not need to be explained.

Return this form to Consumer Direct. If you have questions, please contact Consumer Direct at 877-270-9580 or UnitedHealthcare Toll-Free 800-791-9233; TTY/TTD 711. We are happy to help. Thank you.

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

UnitedHealthcare Community Plan

CONSUMER DIRECT CARE NETWORK

Direct Service Worker (DSW) Health Questionnaire

_____

DSW Printed Name

	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 Disc?		
26	Joint Injury? Joint Pain?		
27	Fractures?		
28	Tuberculosis? Had a Positive TB Test?		
29	Lung Problems? Lung Disease?		
30	Head Injury?		
31	Allergies?		
32	Other Current Problems, Diseases, or Conditions?		
33	Have you ever been hospitalized or had surgery? **Child birth is excluded.**		
34	Have you ever refused a recommended surgical procedure?		
35	Are you taking medication or drugs that could impair your judgment?		

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.

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UnitedHealthcare Community Plan

CONSUMER DIRECT CARE NETWORK

Direct Service Worker (DSW) Health Questionnaire

_____

DSW Printed Name

Did you answer "Yes" on page 1 or 2? Please explain each below. Note the associated number or letter. Include the dates of injuries & surgeries. Use more pages if needed.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I hereby certify that I answered all questions to the best of my knowledge. My answers are true. They are complete. I understand if I falsify or omit any requested fact(s), it is cause for dismissal and may result in denial of workers' compensation benefits.

DSW Signature: _____ Date: _____

Office Use Only

Reviewed by: _____. Date: _____. Date sent to Risk Mgr: _____.

State Office/Location: _____. Risk Mgr Review: ____. OK: ____. See Attached: _____.

Date: _____.

UnitedHealthcare Community Plan does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free member phone number listed on your health plan member ID card, TTY 711, Monday through Friday, 8:00 a.m. to 7:00 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html

Phone:
Toll-free **1-800-368-1019**, **1-800-537-7697** (TDD)

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

If you need help with your complaint, please call the toll-free member phone number listed on your member ID card.

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan member ID card, TTY 711, Monday through Friday, 8:00 a.m. to 7:00 p.m.

UnitedHealthcare Community Plan no da un tratamiento diferente a sus miembros en base a su sexo, edad, raza, color, discapacidad o nacionalidad.

Si usted piensa que ha sido tratado injustamente por razones como su sexo, edad, raza, color, discapacidad o nacionalidad, puede enviar una queja a:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

Usted tiene que enviar la queja dentro de los 60 días de la fecha cuando se enteró de ella. Se le enviará la decisión en un plazo de 30 días. Si no está de acuerdo con la decisión, tiene 15 días para solicitar que la consideremos de nuevo.

Si usted necesita ayuda con su queja, por favor llame al número de teléfono gratuito para miembros que aparece en su tarjeta de identificación del plan de salud, TTY 711, de lunes a viernes, de 8:00 a.m. a 7:00 p.m.

Usted también puede presentar una queja con el Departamento de Salud y Servicios Humanos de los Estados Unidos.Usted también puede presentar una queja con el Departamento de Salud y Servicios Humanos de los Estados Unidos.

Internet:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Formas para las quejas se encuentran disponibles en:
http://www.hhs.gov/ocr/office/file/index.html

Teléfono:
Llamada gratuita, **1-800-368-1019**, **1-800-537-7697** (TDD)

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

Si necesita ayuda para presentar su queja, por favor llame al número gratuito para miembros anotado en su tarjeta de identificación como miembro.

Ofrecemos servicios gratuitos para ayudarle a comunicarse con nosotros. Tales como, cartas en otros idiomas o en letra grande. O bien, puede solicitar un intérprete. Para pedir ayuda, llame a Servicios para Miembros al **1-800-791-9233, TTY 711**, de lunes a viernes, de 8:00 a.m. a 7:00 p.m.

UnitedHealthcare®
Community Plan

ATTENTION: If you do not speak English, language assistance services, at no cost to you, are available. Call **1-800-791-9233, TTY 711**.

ATENCIÓN: Si no habla inglés, los servicios de asistencia de idiomas están disponibles sin costo para usted. Llame al **1-800-791-9233, TTY 711**.

ATANSYON: Si w pa pale Anglè, gen sèvis èd pou lang ki disponib san w pa peye anyen. Rele **1-800-791-9233, TTY 711**.

ВНИМАНИЕ: Если Вы не говорите по-русски, Вы можете воспользоваться бесплатной языковой помощью. Позвоните по телефону **1-800-791-9233, телетайп 711**.

ATENÇÃO: Se não fala inglês, estão disponíveis serviços de assistência linguística sem nenhum custo para si. Ligue para o **1-800-791-9233, TTY 711**.

注意：如果您不會說英文，您可獲得免費語言協助服務。請致電 **1-800-791-9233，聽障專線 (TTY) 711**。