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: _____

03475

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

Divulgación de relación laboral

Nombre del empleado (trabajador de servicio directo)	Nombre del empleador (participante)

Instrucciones para el empleado: Coméntenos más abajo si tiene algún parentesco con su empleador. Llene cada sección. Firme la parte inferior del formulario e incluya la fecha.

1. **Receptor del servicio/situación de residencia:**
   - ☐ Sí ☐ No La persona que recibe los servicios es menor de edad (menor de 18 años)
   - ☐ Sí ☐ No Viviré en la misma dirección que mi empleador

2. **Divulgación de parentesco:**

   Mi parentesco con mi empleador es (marque uno):

   ☐ Cónyuge ☐ Padre ☐ Padre adoptivo o padrastro
   ☐ Hijo menor de 21 años ☐ Hijo mayor de 21 años ☐ Hermano
   ☐ Abuelo ☐ Nieto ☐ Pareja doméstica
   ☐ No hay parentesco ☐ Otra (por favor explique): _____

3. **Reconocimiento de la relación:**

   Podría estar exento de algunos impuestos. Esa exención depende de la información que haya proporcionado arriba. El reverso de este formulario explica qué impuestos debo pagar. Mi oficina local de desempleo puede darme más información sobre los impuestos FUTA y SUTA.

   Debo informar a Consumer Direct si esta relación o parentesco cambia. Tengo 5 días para hacerlo. En caso de que no lo haga, podría tener que devolver el dinero que debió haberse retenido de mi salario.

_____ _____
Firma del participante/representante *Fecha*

_____ _____
Firma del trabajador de servicio directo *Fecha*

Para uso interno únicamente - Oficina central		
Iniciales del evaluador: _____	SUTA (sujeto a impuestos) ☐ Sí ☐ No	FUTA (sujeto a impuestos) ☐ Sí ☐ No

Para uso interno únicamente - Oficina local		
Iniciales del evaluador: _____	Medicare (sujeto a impuestos) ☐ Sí ☐ No	Seguridad social (sujeto a impuestos) ☐ Sí ☐ No

10089

Divulgación de relación laboral

Explicación de exenciones para empleados

Estatuto de Florida 443.1216 (13) 2. (d)			
Parentesco con el titular del EIN (empleador)	**Ley de Contribución a la Renta Federal (Federal Income Contributions Act, FICA)**	**Ley Federal de Impuestos para el Desempleo (Federal Unemployment Tax Act, FUTA)**	**Ley Estatal de Impuestos para el Desempleo (State Unemployment Tax Act, SUTA)**
Cónyuge	Exento	Exento	Exento
Padre	*Exento **Sujeto a impuestos	Exento	Exento
Padre adoptivo o padrastro	*Exento **Sujeto a impuestos	Exento	Exento
Hermanos	Sujeto a impuestos	Sujeto a impuestos	Sujeto a impuestos
Hijos menores de 21 años	Exento	Exento	Exento
Hijos mayores de 21 años	Sujeto a impuestos	Sujeto a impuestos	Sujeto a impuestos
Abuelos	Sujeto a impuestos	Sujeto a impuestos	Sujeto a impuestos
Nietos	Sujeto a impuestos	Sujeto a impuestos	Sujeto a impuestos
Pareja doméstica	Sujeto a impuestos	Sujeto a impuestos	Sujeto a impuestos

*Exento si no cumple con los 4 siguientes criterios:

**Sujeto a impuestos si cumple con los 4 siguientes criterios:

a) Un padre que es empleado por sus hijos

b) El empleador (hijo o hija) tiene un hijo o hijastro que vive en casa.

c) El empleador es:
- viudo,
- divorciado o
- casado y vive con su cónyuge, pero el cónyuge no puede cuidar de su hijo o hijastro debido a un padecimiento físico o mental. El cónyuge no puede brindar cuidados por al menos 4 semanas consecutivas en 3 meses.

d) El hijo o hijastro del empleador es:
- menor de 18 años o
- necesita de cuidados personales de un adulto. Se requiere de atención por al menos 4 semanas consecutivas en 3 meses debido a un padecimiento físico o mental.

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	ةظوحلم: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجانًا. اتصل برقم 1-866-472-4585 (رقم هاتف الصم والبكم: 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 નિ:શુલ્ક 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).

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

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No.1615-0047
Expires 05/31/2027

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'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.

11413

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 05/31/2027

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

2025

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.)

TIP: Consider using the estimator at *www.irs.gov/W4App* to determine the most accurate withholding for the rest of the year if: you are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

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 the 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)

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

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 2025 if you meet both of the following conditions: you had no federal income tax liability in 2024 **and** you expect to have no federal income tax liability in 2025. You had no federal income tax liability in 2024 if (1) your total tax on line 24 on your 2024 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 2025 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 17, 2026.

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. Are submitting this form after the beginning of the year;

2. Expect to work only part of the year;

3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;

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

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

TIP: Have your most recent pay stub(s) from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

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. Submit a separate Form W-4 for each job.

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 2025 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 2025 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:
- $30,000 if you're married filing jointly or a qualifying surviving spouse
- $22,500 if you're head of household
- $15,000 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	$700	$850	$910	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020
$10,000 - 19,999	0	700	1,700	1,910	2,110	2,220	2,220	2,220	2,220	2,220	2,220	3,220
$20,000 - 29,999	700	1,700	2,760	3,110	3,310	3,420	3,420	3,420	3,420	3,420	4,420	5,420
$30,000 - 39,999	850	1,910	3,110	3,460	3,660	3,770	3,770	3,770	3,770	4,770	5,770	6,770
$40,000 - 49,999	910	2,110	3,310	3,660	3,860	3,970	3,970	3,970	4,970	5,970	6,970	7,970
$50,000 - 59,999	1,020	2,220	3,420	3,770	3,970	4,080	4,080	5,080	6,080	7,080	8,080	9,080
$60,000 - 69,999	1,020	2,220	3,420	3,770	3,970	4,080	5,080	6,080	7,080	8,080	9,080	10,080
$70,000 - 79,999	1,020	2,220	3,420	3,770	3,970	5,080	6,080	7,080	8,080	9,080	10,080	11,080
$80,000 - 99,999	1,020	2,220	3,420	4,620	5,820	6,930	7,930	8,930	9,930	10,930	11,930	12,930
$100,000 - 149,999	1,870	4,070	6,270	7,620	8,820	9,930	10,930	11,930	12,930	14,010	15,210	16,410
$150,000 - 239,999	1,870	4,240	6,640	8,190	9,590	10,890	12,090	13,290	14,490	15,690	16,890	18,090
$240,000 - 259,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$260,000 - 279,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$280,000 - 299,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$300,000 - 319,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,170	19,170
$320,000 - 364,999	2,040	4,440	6,840	8,390	9,790	11,100	12,470	14,470	16,470	18,470	20,470	22,470
$365,000 - 524,999	2,790	6,290	9,790	12,440	14,940	17,350	19,650	21,950	24,250	26,550	28,850	31,150
$525,000 and over	3,140	6,840	10,540	13,390	16,090	18,700	21,200	23,700	26,200	28,700	31,200	33,700

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	$200	$850	$1,020	$1,020	$1,020	$1,370	$1,870	$1,870	$1,870	$1,870	$1,870	$2,040
$10,000 - 19,999	850	1,700	1,870	1,870	2,220	3,220	3,720	3,720	3,720	3,720	3,890	4,090
$20,000 - 29,999	1,020	1,870	2,040	2,390	3,390	4,390	4,890	4,890	4,890	5,060	5,260	5,460
$30,000 - 39,999	1,020	1,870	2,390	3,390	4,390	5,390	5,890	5,890	6,060	6,260	6,460	6,660
$40,000 - 59,999	1,220	3,070	4,240	5,240	6,240	7,240	7,880	8,080	8,280	8,480	8,680	8,880
$60,000 - 79,999	1,870	3,720	4,890	5,890	7,030	8,230	8,930	9,130	9,330	9,530	9,730	9,930
$80,000 - 99,999	1,870	3,720	5,030	6,230	7,430	8,630	9,330	9,530	9,730	9,930	10,130	10,580
$100,000 - 124,999	2,040	4,090	5,460	6,660	7,860	9,060	9,760	9,960	10,160	10,950	11,950	12,950
$125,000 - 149,999	2,040	4,090	5,460	6,660	7,860	9,060	9,950	10,950	11,950	12,950	13,950	14,950
$150,000 - 174,999	2,040	4,090	5,460	6,660	8,450	10,450	11,950	12,950	13,950	15,080	16,380	17,680
$175,000 - 199,999	2,040	4,290	6,450	8,450	10,450	12,450	13,950	15,230	16,530	17,830	19,130	20,430
$200,000 - 249,999	2,720	5,570	7,900	10,200	12,500	14,800	16,600	17,900	19,200	20,500	21,800	23,100
$250,000 - 399,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$400,000 - 449,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$450,000 and over	3,140	6,490	9,160	11,660	14,160	16,660	18,660	20,160	21,660	23,160	24,660	26,160

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	$450	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,870	$1,870	$1,870	$1,890
$10,000 - 19,999	450	1,450	2,000	2,200	2,220	2,220	2,220	3,180	4,070	4,070	4,090	4,290
$20,000 - 29,999	850	2,000	2,600	2,800	2,820	2,820	3,780	4,780	5,670	5,690	5,890	6,090
$30,000 - 39,999	1,000	2,200	2,800	3,000	3,020	3,980	4,980	5,980	6,890	7,090	7,290	7,490
$40,000 - 59,999	1,020	2,220	2,820	3,830	4,850	5,850	6,850	8,050	9,130	9,330	9,530	9,730
$60,000 - 79,999	1,020	3,030	4,630	5,830	6,850	8,050	9,250	10,450	11,530	11,730	11,930	12,130
$80,000 - 99,999	1,870	4,070	5,670	7,060	8,280	9,480	10,680	11,880	12,970	13,170	13,370	13,570
$100,000 - 124,999	1,950	4,350	6,150	7,550	8,770	9,970	11,170	12,370	13,450	13,650	14,650	15,650
$125,000 - 149,999	2,040	4,440	6,240	7,640	8,860	10,060	11,260	12,860	14,740	15,740	16,740	17,740
$150,000 - 174,999	2,040	4,440	6,240	7,640	8,860	10,860	12,860	14,860	16,740	17,740	18,940	20,240
$175,000 - 199,999	2,040	4,440	6,640	8,840	10,860	12,860	14,860	16,910	19,090	20,390	21,690	22,990
$200,000 - 249,999	2,720	5,920	8,520	10,960	13,280	15,580	17,880	20,180	22,360	23,660	24,960	26,260
$250,000 - 449,999	2,970	6,470	9,370	11,870	14,190	16,490	18,790	21,090	23,280	24,580	25,880	27,180
$450,000 and over	3,140	6,840	9,940	12,640	15,160	17,660	20,160	22,660	25,050	26,550	28,050	29,550

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

02593

wisely by ADP

Control financiero: ¡Ahora es posible!

Controle su dinero con una cuenta digital de Wisely®[1].

Reciba pagos con anticipación[2].

Ya sea que quiera pagar una factura u obtener dinero para planes de último momento, Wisely le permite obtener el dinero con hasta 2 días de anticipación[2].

Ahorre y organice su dinero como quiera.

Realice un seguimiento de su saldo y sus gastos las 24 horas del día, los 7 días de la semana, y obtenga importantes ahorros[3].

Realice compras con confianza.

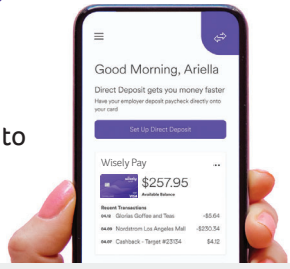
Pague en línea, en la tienda, en la aplicación o por teléfono dondequiera que se acepten tarjetas de débito Visa® o Mastercard®.

Evite los cargos del cajero automático.

Acceda a una red de 90 000 cajeros automáticos sin cargo a nivel nacional[4].

¡Aproveche todos los beneficios de Wisely hoy mismo!

Hable con su departamento de Nóminas.



Administre su dinero como quiera.

Afford yourself every advantage™.

[1] La tarjeta Wisely es una tarjeta prepagada. La cuenta digital se requiere para la administración y el mantenimiento de su tarjeta prepaga en línea de forma digital o mediante una aplicación móvil. La tarjeta Wisely no es una tarjeta de crédito, por cual no otorga crédito.

[2] Debe iniciar sesión en la aplicación myWisely o en su cuenta de mywisely.com para inscribirse en el depósito directo anticipado. No se garantiza el depósito directo anticipado de los fondos y queda sujeto a los plazos de la orden de pago del pagador. La referencia acerca del plazo de financiación más rápido se establece al comparar nuestra política de extender los fondos al recibir la orden de pago con la práctica bancaria habitual de otorgar los fondos al momento de la liquidación. Consulte las reglas completas en mywisely.com o en la aplicación myWisely. Si tiene una tarjeta Wisely Pay o Wisely Cash (vea el reverso), se requiere una actualización que es posible que no esté disponible para todos los tarjetahabientes. Permita que pase un plazo de hasta 3 semanas después de la configuración inicial del depósito directo para que su pago se cargue a su tarjeta.

[3] Los montos transferidos a su sobre de ahorros ya no aparecerán en su saldo disponible. Puede restituirlos a su saldo disponible en cualquier momento con la aplicación myWisely o desde su cuenta de mywisely.com.

[4] El número de transacciones en cajero automático sin cargo podría estar limitado. Inicie sesión en la aplicación myWisely o en mywisely.com para consultar el acuerdo del tarjetahabiente y la lista de todos los cargos a fin de obtener más información.

CONSUMER DIRECT CARE NETWORK

ACUERDO ENTRE PARTICIPANTE/TRABAJADOR DE SERVICIO DIRECTO

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

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

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

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

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

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

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

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

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

Domingo	Lunes	Martes	Miércoles	Jueves	Viernes	Sábado

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

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

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

13. Funciones y responsabilidades de Consumer Direct:

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

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

_____ _____ _____ _____

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

_____ _____

Firma de Manejador de Caso *Fecha*

PRIVACY POLICY ACKNOWLEDGEMENT FORM

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

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

_____

Employee/Contractor Name (Printed)

_____

Employee/Contractor Signature

_____

Date

DSW

ATTESTATION OF COMPLIANCE
with Background Screening Requirements

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

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

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

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

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

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

Criminal offenses found in section 435.04, F.S.

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

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

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

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

(e) Section 782.04, relating to murder.

(g) Section 782.071, relating to vehicular homicide

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

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

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

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

(l) Section 787.01, relating to kidnapping.

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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.

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
_____	_____	_____

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

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CONSUMER DIRECT CARE NETWORK

TRABAJADOR DE SERVICIO DIRECTO
DESCRIPCION DE TRABAJO

Nombre de Trabajador de Servicio Directo	Nombre del Participante

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

Cuidado de Acompañante Adulto

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

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

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

Lista de otra asistencia necesaria o peticiones especiales: _____

_____

_____

_____

Servicios Domésticos

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

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

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

Lista de otra asistencia necesaria o peticiones especiales: _____

_____

_____

_____

Nombre de Trabajador de Servicio Directo	Nombre del Participante

Cuidado personal

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

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

Vestirse/desvestirse
- Vistiendo (AM, PM)

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

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

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

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

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

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

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

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

Lista de otra asistencia necesaria o peticiones especiales: _____

_____

_____

_____

_____

_____

Nombre de Trabajador de Servicio Directo	Nombre del Participante

Atencion Auxiliar

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

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

Lista de necesidades médicas específicas aquí:

_____

_____

_____

_____

_____

_____

Enfermería Intermitente y Cualificado

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

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

Lista de necesidades médicas específicas aquí:

_____

_____

_____

_____

_____

_____

Nombre de Trabajador de Servicio Directo	Nombre del Participante

Además, el empleado es responsable de:

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

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

CONSUMER DIRECT CARE NETWORK

CUESTIONARIO DE SALUD DEL EMPLEADO

Nombre Impreso de Empleado

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

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

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

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

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

CONSUMER DIRECT CARE NETWORK

CUESTIONARIO DE SALUD DEL EMPLEADO

Nombre Impreso de Empleado

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

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

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

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

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

Office Use Only

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

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

05095

Calendario de Nómina 2025

Clave de símbolos: ◯ Día de paga △ Asuetos bancarios y postales

ENERO

Dom	Lun	Mar	Mié	Jue	Vie	Sáb
			△1	2	3	4
5	6	7	8	9	◯10	11
12	13	14	15	16	17	18
19	△20	21	22	23	◯24	25
26	27	28	29	30	31	

FEBRERO

Dom	Lun	Mar	Mié	Jue	Vie	Sáb
						1
2	3	4	5	6	◯7	8
9	10	11	12	13	14	15
16	△17	18	19	20	◯21	22
23	24	25	26	27	28	

MARZO

Dom	Lun	Mar	Mié	Jue	Vie	Sáb
						1
2	3	4	5	6	◯7	8
9	10	11	12	13	14	15
16	17	18	19	20	◯21	22
23	24	25	26	27	28	29
30	31					

ABRIL

Dom	Lun	Mar	Mié	Jue	Vie	Sáb
		1	2	3	◯4	5
6	7	8	9	10	11	12
13	14	15	16	17	◯18	19
20	21	22	23	24	25	26
27	28	29	30			

MAYO

Dom	Lun	Mar	Mié	Jue	Vie	Sáb
				1	◯2	3
4	5	6	7	8	9	10
11	12	13	14	15	◯16	17
18	19	20	21	22	23	24
25	△26	27	28	29	◯30	31

JUNIO

Dom	Lun	Mar	Mié	Jue	Vie	Sáb
1	2	3	4	5	6	7
8	9	10	11	12	◯13	14
15	16	17	18	△19	20	21
22	23	24	25	26	◯27	28
29	30					

JULIO

Dom	Lun	Mar	Mié	Jue	Vie	Sáb
		1	2	3	△4	5
6	7	8	9	10	◯11	12
13	14	15	16	17	18	19
20	21	22	23	24	◯25	26
27	28	29	30	31		

AGOSTO

Dom	Lun	Mar	Mié	Jue	Vie	Sáb
					1	2
3	4	5	6	7	◯8	9
10	11	12	13	14	15	16
17	18	19	20	21	◯22	23
24	25	26	27	28	29	30
31						

SEPTIEMBRE

Dom	Lun	Mar	Mié	Jue	Vie	Sáb
	△1	2	3	4	◯5	6
7	8	9	10	11	12	13
14	15	16	17	18	◯19	20
21	22	23	24	25	26	27
28	29	30				

OCTUBRE

Dom	Lun	Mar	Mié	Jue	Vie	Sáb
			1	2	◯3	4
5	6	7	8	9	10	11
12	△13	14	15	16	◯17	18
19	20	21	22	23	24	25
26	27	28	29	30	◯31	

NOVIEMBRE

Dom	Lun	Mar	Mié	Jue	Vie	Sáb
						1
2	3	4	5	6	7	8
9	10	△11	12	13	◯14	15
16	17	18	19	20	21	22
23	24	25	◯26	△27	28	29
30						

DICIEMBRE

Dom	Lun	Mar	Mié	Jue	Vie	Sáb
	1	2	3	4	5	6
7	8	9	10	11	◯12	13
14	15	16	17	18	19	20
21	22	23	◯24	△25	26	27
28	29	30	31			

Asuetos bancarios y de las oficinas postales en 2025

*Cierre de oficinas de Consumer Direct Care Network

- ***Día de Año Nuevo** - Miércoles 1 de Enero
- ***Día de Martin Luther King, Jr.** - Lunes 20 de Enero
- **Día de los Presidentes** - Lunes 17 de Febrero
- ***Día de los Caídos** - Lunes 26 de Mayo
- ***Juneteenth** - Jueves 19 de Junio
- ***Día de la Independencia** - Viernes 4 de Julio
- ***Día del Trabajo** - Lunes 1 de Septiembre
- **Día de Colón** - Lunes 13 de Octubre
- ***Día de los Veteranos** - Martes 11 de Noviembre
- ***Día de Acción de Gracias** - Jueves 28 de Noviembre
- ***Día de Navidad** - Jueves 25 de Diciembre

Las semanas laborales van de domingo a sábado. Debes enviar tiempo diariamente. Las correcciones deben ser entregadas antes de la fecha límite. El retraso en el tiempo o el tiempo con errores puede resultar en un pago atrasado. Comuníquese con CDFL si tiene problemas para ingresar o aprovar el tiempo trabajado.

Periodo de paga de dos semanas		Fecha limite de correcciones a tiempo EVV	Fecha de pago
Fecha de inicio	Fecha de finalización		
Domingo	**Sábado**	**Lunes**	**Viernes**
12/15/2024	12/28/2024	12/30/2024	1/10/2025
12/29/2024	1/11/2025	1/13/2025	1/24/2025
1/12/2025	1/25/2025	1/27/2025	2/7/2025
1/26/2025	2/8/2025	2/10/2025	2/21/2025
2/9/2025	2/22/2025	2/24/2025	3/7/2025
2/23/2025	3/8/2025	3/10/2025	3/21/2025
3/9/2025	3/22/2025	3/24/2025	4/4/2025
3/23/2025	4/5/2025	4/7/2025	4/18/2025
4/6/2025	4/19/2025	4/21/2025	5/2/2025
4/20/2025	5/3/2025	5/5/2025	5/16/2025
5/4/2025	5/17/2025	5/19/2025	5/30/2025
5/18/2025	5/31/2025	6/2/2025	6/13/2025
6/1/2025	6/14/2025	6/16/2025	6/27/2025
6/15/2025	6/28/2025	6/30/2025	7/11/2025
6/29/2025	7/12/2025	7/14/2025	7/25/2025
7/13/2025	7/26/2025	7/28/2025	8/8/2025
7/27/2025	8/9/2025	8/11/2025	8/22/2025
8/10/2025	8/23/2025	8/25/2025	9/5/2025
8/24/2025	9/6/2025	9/8/2025	9/19/2025
9/7/2025	9/20/2025	9/22/2025	10/3/2025
9/21/2025	10/4/2025	10/6/2025	10/17/2025
10/5/2025	10/18/2025	10/20/2025	10/31/2025
10/19/2025	11/1/2025	11/3/2025	11/14/2025
11/2/2025	11/15/2025	11/17/2025	11/26/2025*
11/16/2025	11/29/2025	12/1/2025	12/12/2025
11/30/2025	12/13/2025	12/15/2025	12/24/2025*
12/14/2025	12/27/2025	12/29/2025	1/9/2026
12/28/2025	1/10/2026	1/12/2026	1/23/2026

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