



My Voice, My Choice
EMPLOYEE DATA FORM

Name: _____
First Middle Last

Physical Address: _____
Street Apt/Unit # City State Zip Code

Mailing Address: _____
(if different than physical) Street Apt/Unit # City State Zip Code

Phone #: () _____ () _____
Home Cell

Email: _____

Gender: Male Female

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

Name of Participant: _____

I am currently employed by another Participant in the Idaho Self Direction Program

Please Read Carefully: If you complete an employment agreement you become an employee of the Participant receiving services. You will not be an employee of Consumer Direct Care Network.

Employee Signature Date





My Voice, My Choice
NEW EMPLOYEE (CSW) CHECKLIST

Table with 3 columns: Employee Name, Estimated Start Date, Participant Name

Welcome to Consumer Direct Care Network (CDCN)!

Please complete the forms as indicated in the lists below and submit to CDCN. The Employee is not approved to begin work until all forms have been reviewed by CDCN, and results of the Criminal Background check have been received (unless specifically waived). Upon approval, CDCN will notify the Employer and issue the Employee an ID number for use when submitting timesheets.

Instructions and additional information for completing these forms is available online at www.consumerdirectid.com.

The Participant should check each item in the lists below as they are completed.

Mandatory Forms - all new Employees

- 1. Employee Data Form
2. New Employee Checklist (this form)
3. Employment Relationship Disclosure
4. I-9 Form - Additional I-9 instructions are available on the CDCN Idaho website under the Resources tab
5. W-4 Form
6. Pay Selection Form - Attachment may be required, see form instructions
7. Participant-Community Support Worker Employment Agreement
8. Medicaid-Community Support Worker Agreement
9. Criminal History Check - Waiver of Liability - Assumption of Risk

Forms Required only if Employer waives certain Criminal History Check requirements

- 1. Criminal History Check - Waiver of Liability - Assumption of Risk - Failed Criminal History Check

I have reviewed these forms and agree that they are complete and readable.

Participant Signature Date Printed Name

Date submitted to CDCN: ___/___/___



Explanation of Employee Exemptions

| Idaho Statute 72-1316(2) & 72-1316A (1) & (2) | | | |
|--|-----------------------------|--------------------|--------------------|
| Relationship to EIN Holder (Employer) | FICA | FUTA | SUTA |
| Spouse | No wages permitted | No wages permitted | No wages permitted |
| 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:

- 1) The parent is employed by his or her son or daughter;
- 2) The son or daughter (the employer) has a child or stepchild living in the home;
- 3) The son or daughter (the employer) is a widow or widower, divorced, or living with a spouse who, because of a mental or physical condition, can't care for the child or stepchild for a least 4 continuous weeks in a calendar quarter; and
- 4) The child or stepchild is either under age 18 or requires the personal care of an adult for at least 4 continuous weeks in a calendar quarter due to a mental or physical condition.



Instructions for Completing Form I-9 Section 1




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

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

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

Employee (steps 1-9)

- ① Print your full legal name: Last, First and Middle Initial. Provide any other names used, such as maiden name. Enter "N/A" if you have never had another name.
- ② Print your physical address. Entering a PO Box is not allowed. Enter "N/A" if you have no apartment number.
- ③ Print your date of birth (mm/dd/yyyy).
- ④ Print your Social Security Number.
- ⑤ Print your email address or print "N/A" if you choose to not provide it.
- ⑥ Print your telephone number or print "N/A" if you choose to not provide it.
- ⑦ Check the one box that best describes your citizenship or immigration status in the United States.
- ⑧ Sign and print the date you completed the form. **No later than first day of work for pay.**
- ⑨ Check the box that indicates whether or not you were assisted by a preparer or translator.

|  Employment Eligibility Verification Department of Homeland Security U.S. Citizenship and Immigration Services | | USCIS Form I-9 OMB No. 1615-0047 Expires 08/31/2019 |
|--|---|--|
| <p>▶ START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.</p> <p>ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.</p> | | |
| <p>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.)</p> | | |
| Last Name (Family Name) ① <i>Doe</i> | | First Name (Given Name) <i>Jane</i> |
| Middle Initial <i>Q</i> | | Other Last Names Used (if any) <i>N/A</i> |
| Address (Street Number and Name) ② <i>123 Main St.</i> | | Apt. Number <i>N/A</i> |
| City or Town <i>Anytown</i> | | State <i>ID</i> |
| ZIP Code <i>12345</i> | | |
| Date of Birth (mm/dd/yyyy) ③ <i>03/13/1964</i> | U.S. Social Security Number ④ <i>123-45-6789</i> | Employee's E-mail Address ⑤ <i>employee@email.com</i> |
| Employee's Telephone Number ⑥ <i>555-123-4567</i> | | |
| <p>I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.</p> <p>I attest, under penalty of perjury, that I am (check one of the following boxes):</p> | | |
| <input checked="" type="checkbox"/> 1. A citizen of the United States. | | |
| <input type="checkbox"/> 2. A noncitizen national of the United States. (See instructions) | | |
| <input type="checkbox"/> 3. A lawful permanent resident. (Alien Registration Number/USCIS Number): | | |
| <input type="checkbox"/> 4. An alien authorized to work until (expiration date of approval) (mm/dd/yyyy). Some aliens may write "N/A" in the expiration date field. (See instructions) | | |
| <p>Alien authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</p> | | |
| 1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____ | | |
| Signature of Employee ⑧ <i>Jane Doe</i> | | Today's Date (mm/dd/yyyy) <i>02/05/2017</i> |
| <p>Preparer and/or Translator Certification (check one):</p> <input checked="" type="checkbox"/> I did not use a preparer or translator. <input type="checkbox"/> A preparer(s) and/or translator(s) assisted the employee in completing Section 1. (Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.) | | |
| <p>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.</p> | | |
| Signature of Preparer or Translator | | Today's Date (mm/dd/yyyy) |
| Last Name (Family Name) | | First Name (Given Name) |
| Address (Street Number and Name) | | City or Town |
| State | | ZIP Code |
|  Employer Completes Next Page  | | |
| Form I-9 11/14/2016 N | | Page 1 of 3 |

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

Instructions for Completing Form I-9 Section 2

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

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

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

Employer (steps 1-10)

- ① Print employee's name from Section 1: Last, First, and Middle Initial.
- ② Enter the number representing employee's citizenship status checked in Section 1.
- ③ Examine each document and note the details in the appropriate List column.
one document from List A

OR
one from List B and one from List C
Only accept unexpired, original documents (no photocopies).
- ④ Print the date of the employee's first day of work.
- ⑤ Sign the form.
- ⑥ Print the date you signed the form.
Must be completed and signed within 3 days of employee's first day of work.
- ⑦ If not pre-populated, print your title as "Employer."
- ⑧ Print your last then first name.
- ⑨ Print your first and last name.
- ⑩ Print physical address where services are provided: street, city, state and zip code.

| Section 2. Employer or Authorized Representative Review and Verification | | | | |
|--|--|---|--|--|
| (Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.") | | | | |
| Employee Info from Section 1 | Last Name (Family Name) <i>Dee</i> | First Name (Given Name) <i>Jane</i> | M.I. <i>R</i> | Citizenship/Immigration Status <i>1</i> |
| List A | OR | List B | AND | List C |
| Identity and Employment Authorization | | Identity | | Employment Authorization |
| Document Title <i>Driver's License</i> | Document Title <i>State of Residence</i> | Document Title <i>Social Security Card</i> | | |
| Issuing Authority <i>State of Residence</i> | Issuing Authority <i>SSA</i> | Issuing Authority <i>SSA</i> | | |
| Document Number <i>0123456789abode</i> | Document Number <i>08/17/2020</i> | Document Number <i>123-45-6789</i> | | |
| Expiration Date (if any)(mm/dd/yyyy) | Expiration Date (if any)(mm/dd/yyyy) | Expiration Date (if any)(mm/dd/yyyy) | | |
| Document Title | Additional Information | | QR Code - Sections 2 & 3 Do Not Write In This Space | |
| Issuing Authority | | | | |
| Document Number | | | | |
| Expiration Date (if any)(mm/dd/yyyy) | | | | |
| Document Title | | | | |
| Issuing Authority | | | | |
| Document Number | | | | |
| Expiration Date (if any)(mm/dd/yyyy) | | | | |
| Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States. The employee's first day of employment (mm/dd/yyyy): <i>02/05/2017</i> (See instructions for exemptions) | | | | |
| Signature of Employer or Authorized Representative <i>Ronald Smith</i> | Today's Date(mm/dd/yyyy) <i>02/05/2017</i> | Title of Employer or Authorized Representative <i>Employer</i> | | |
| Last Name of Employer or Authorized Representative <i>Smith</i> | First Name of Employer or Authorized Representative <i>Ronald</i> | Employer's Business or Organization Name <i>Ronald Smith</i> | | |
| Employer's Business or Organization Address (Street Number and Name) <i>500 Fictional St.</i> | | City or Town <i>Anytown</i> | State <i>1D</i> | ZIP Code <i>85018</i> |

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

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



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

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

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

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

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

| | | | | | | |
|----------------------------------|---|-------------------------|---------------------------|----------------|--------------------------------|-------------------|
| Last Name (Family Name) | | First Name (Given Name) | | Middle Initial | Other Last Names Used (if any) | |
| Address (Street Number and Name) | | | Apt. Number | City or Town | | State ZIP Code |
| Date of Birth (mm/dd/yyyy) | U.S. Social Security Number □□□□ - □□ - □□□□ | | Employee's E-mail Address | | Employee's Telephone Number | |

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

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

| | |
|--|--|
| <input type="checkbox"/> 1. A citizen of the United States | |
| <input type="checkbox"/> 2. A noncitizen national of the United States <i>(See instructions)</i> | |
| <input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____ | |
| <input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ Some aliens may write "N/A" in the expiration date field. <i>(See instructions)</i> | |
| <p><i>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</i></p> <p>1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____</p> | |
| <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> QR Code - Section 1 Do Not Write In This Space </div> | |

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

Preparer and/or Translator Certification (check one):
 I did not use a preparer or translator. A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

| | | | |
|-------------------------------------|--|---------------------------|-------------------|
| Signature of Preparer or Translator | | Today's Date (mm/dd/yyyy) | |
| Last Name (Family Name) | | First Name (Given Name) | |
| Address (Street Number and Name) | | City or Town | State ZIP Code |



Employer Completes Next Page



03149





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

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

Section 2. Employer or Authorized Representative Review and Verification

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

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

| List A Identity and Employment Authorization | OR | List B Identity | AND | List C Employment Authorization |
|---|----|--------------------------------------|-----|--|
| Document Title | | Document Title | | Document Title |
| Issuing Authority | | Issuing Authority | | Issuing Authority |
| Document Number | | Document Number | | Document Number |
| Expiration Date (if any)(mm/dd/yyyy) | | Expiration Date (if any)(mm/dd/yyyy) | | Expiration Date (if any)(mm/dd/yyyy) |
| Document Title | | Additional Information | | QR Code - Sections 2 & 3 Do Not Write In This Space |
| Issuing Authority | | | | |
| Document Number | | | | |
| Expiration Date (if any)(mm/dd/yyyy) | | | | |
| Document Title | | | | |
| Issuing Authority | | | | |
| Document Number | | | | |
| Expiration Date (if any)(mm/dd/yyyy) | | | | |

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

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

| | | | | |
|--|--|---|--|----------|
| Signature of Employer or Authorized Representative | | Today's Date (mm/dd/yyyy) | Title of Employer or Authorized Representative | |
| Last Name of Employer or Authorized Representative | | First Name of Employer or Authorized Representative | Employer's Business or Organization Name | |
| Employer's Business or Organization Address (Street Number and Name) | | City or Town | State | ZIP Code |

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

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

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

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

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

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



LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

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

| LIST A Documents that Establish Both Identity and Employment Authorization | OR | LIST B Documents that Establish Identity | AND | LIST C Documents that Establish Employment Authorization |
|--|-----------|---|------------|---|
| <ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 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 | OR | <ol style="list-style-type: none"> 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 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 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <li style="text-align: center;">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 | AND | <ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 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. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security |

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.



Form W-4 (2018)

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

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. You may claim exemption from withholding for 2018 if **both** of the following apply.

- For 2017 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2018 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2018 expires February 15, 2019. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2018 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at www.irs.gov/W4App to determine your tax withholding more accurately. Consider

using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2018. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Filers with multiple jobs or working spouses. If you have more than one job at a time, or if you're married and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Other Income Worksheet on page 3 or the calculator at www.irs.gov/W4App to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at www.irs.gov/W4App to find out if you should adjust your withholding on Form W-4 or W-4P.

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

Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

Line C. Head of household please note: Generally, you can claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

Line E. Child tax credit. When you file your tax return, you might be eligible to claim a credit for each of your qualifying children. To qualify, the child must be under age 17 as of December 31 and must be your dependent who lives with you for more than half the year. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse, during the year.

Line F. Credit for other dependents. When you file your tax return, you might be eligible to claim a credit for each of your dependents that don't qualify for the child tax credit, such as any dependent children age 17 and older. To learn more about this credit, see Pub. 505. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total income includes all of

----- Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records. -----

| | | | | | |
|---|--|---|--|---|--|
| Form W-4 Department of the Treasury Internal Revenue Service | | Employee's Withholding Allowance Certificate ▶ Whether you're entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS. | | OMB No. 1545-0074 2018 | |
| 1 Your first name and middle initial | | Last name | | 2 Your social security number | |
| Home address (number and street or rural route) | | 3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note: If married filing separately, check "Married, but withhold at higher Single rate." | | | |
| City or town, state, and ZIP code | | 4 If your last name differs from that shown on your social security card, check here. You must call 800-772-1213 for a replacement card. ▶ <input type="checkbox"/> | | | |
| 5 Total number of allowances you're claiming (from the applicable worksheet on the following pages) | | | | 5 | |
| 6 Additional amount, if any, you want withheld from each paycheck | | | | 6 \$ | |
| 7 I claim exemption from withholding for 2018, and I certify that I meet both of the following conditions for exemption. • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here ▶ | | | | | |
| | | | | | |
| Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete. | | | | | |
| Employee's signature (This form is not valid unless you sign it.) ▶ | | Date ▶ | | | |
| 8 Employer's name and address (Employer: Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.) | | 9 First date of employment | | 10 Employer identification number (EIN) | |

your wages and other income, including income earned by a spouse, during the year.

Line G. Other credits. You might be able to reduce the tax withheld from your paycheck if you expect to claim other tax credits, such as the earned income tax credit and tax credits for education and child care expenses. If you do so, your paycheck will be larger but the amount of any refund that you receive when you file your tax return will be smaller. Follow the instructions for Worksheet 1-6 in Pub. 505 if you want to reduce your withholding to take these credits into account.

Deductions, Adjustments, and Additional Income Worksheet

Complete this worksheet to determine if you're able to reduce the tax withheld from your paycheck to account for your itemized deductions and other adjustments to income such as IRA contributions. If you do so, your refund at the end of the year will be smaller, but your paycheck will be larger. You're not required to complete this worksheet or reduce your withholding if you don't wish to do so.

You can also use this worksheet to figure out how much to increase the tax withheld from your paycheck if you have a large amount of nonwage income, such as interest or dividends.

Another option is to take these items into account and make your withholding more accurate by using the calculator at www.irs.gov/W4App. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Two-Earners/Multiple Jobs Worksheet

Complete this worksheet if you have more

than one job at a time or are married filing jointly and have a working spouse. If you don't complete this worksheet, you might have too little tax withheld. If so, you will owe tax when you file your tax return and might be subject to a penalty.

Figure the total number of allowances you're entitled to claim and any additional amount of tax to withhold on all jobs using worksheets from only one Form W-4. Claim all allowances on the W-4 that you or your spouse file for the highest paying job in your family and claim zero allowances on Forms W-4 filed for all other jobs. For example, if you earn \$60,000 per year and your spouse earns \$20,000, you should complete the worksheets to determine what to enter on lines 5 and 6 of your Form W-4, and your spouse should enter zero ("-0-") on lines 5 and 6 of his or her Form W-4. See Pub. 505 for details.

Another option is to use the calculator at www.irs.gov/W4App to make your withholding more accurate.

Tip: If you have a working spouse and your incomes are similar, you can check the "Married, but withhold at higher Single rate" box instead of using this worksheet. If you choose this option, then each spouse should fill out the Personal Allowances Worksheet and check the "Married, but withhold at higher Single rate" box on Form W-4, but only one spouse should claim any allowances for credits or fill out the Deductions, Adjustments, and Additional Income Worksheet.

Instructions for Employer

Employees, do not complete box 8, 9, or 10. Your employer will complete these boxes if necessary.

New hire reporting. Employers are

required by law to report new employees to a designated State Directory of New Hires. Employers may use Form W-4, boxes 8, 9, and 10 to comply with the new hire reporting requirement for a newly hired employee. A newly hired employee is an employee who hasn't previously been employed by the employer, or who was previously employed by the employer but has been separated from such prior employment for at least 60 consecutive days. Employers should contact the appropriate State Directory of New Hires to find out how to submit a copy of the completed Form W-4. For information and links to each designated State Directory of New Hires (including for U.S. territories), go to www.acf.hhs.gov/programs/css/employers.

If an employer is sending a copy of Form W-4 to a designated State Directory of New Hires to comply with the new hire reporting requirement for a newly hired employee, complete boxes 8, 9, and 10 as follows.

Box 8. Enter the employer's name and address. If the employer is sending a copy of this form to a State Directory of New Hires, enter the address where child support agencies should send income withholding orders.

Box 9. If the employer is sending a copy of this form to a State Directory of New Hires, enter the employee's first date of employment, which is the date services for payment were first performed by the employee. If the employer rehired the employee after the employee had been separated from the employer's service for at least 60 days, enter the rehire date.

Box 10. Enter the employer's employer identification number (EIN).



Personal Allowances Worksheet (Keep for your records.)

- A** Enter "1" for yourself **A** _____
- B** Enter "1" if you will file as married filing jointly **B** _____
- C** Enter "1" if you will file as head of household **C** _____
- D** Enter "1" if: {
 - You're single, or married filing separately, and have only one job; or
 - You're married filing jointly, have only one job, and your spouse doesn't work; or
 - Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.} **D** _____
- E** **Child tax credit.** See Pub. 972, Child Tax Credit, for more information.
 - If your total income will be less than \$69,801 (\$101,401 if married filing jointly), enter "4" for each eligible child.
 - If your total income will be from \$69,801 to \$175,550 (\$101,401 to \$339,000 if married filing jointly), enter "2" for each eligible child.
 - If your total income will be from \$175,551 to \$200,000 (\$339,001 to \$400,000 if married filing jointly), enter "1" for each eligible child.
 - If your total income will be higher than \$200,000 (\$400,000 if married filing jointly), enter "-0-" **E** _____
- F** **Credit for other dependents.**
 - If your total income will be less than \$69,801 (\$101,401 if married filing jointly), enter "1" for each eligible dependent.
 - If your total income will be from \$69,801 to \$175,550 (\$101,401 to \$339,000 if married filing jointly), enter "1" for every two dependents (for example, "-0-" for one dependent, "1" if you have two or three dependents, and "2" if you have four dependents).
 - If your total income will be higher than \$175,550 (\$339,000 if married filing jointly), enter "-0-" **F** _____
- G** **Other credits.** If you have other credits, see Worksheet 1-6 of Pub. 505 and enter the amount from that worksheet here . . . **G** _____
- H** Add lines A through G and enter the total here **H** _____

For accuracy, **complete all worksheets that apply.**

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, or if you have a large amount of nonwage income and want to increase your withholding, see the **Deductions, Adjustments, and Additional Income Worksheet** below.
- If you **have more than one job at a time** or are **married filing jointly and you and your spouse both work**, and the combined earnings from all jobs exceed \$52,000 (\$24,000 if married filing jointly), see the **Two-Earners/Multiple Jobs Worksheet** on page 4 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 above.

Deductions, Adjustments, and Additional Income Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income.

- 1** Enter an estimate of your 2018 itemized deductions. These 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. See Pub. 505 for details **1** \$ _____
- 2** Enter: {
 - \$24,000 if you're married filing jointly or qualifying widow(er)
 - \$18,000 if you're head of household
 - \$12,000 if you're single or married filing separately} **2** \$ _____
- 3** **Subtract** line 2 from line 1. If zero or less, enter "-0-" **3** \$ _____
- 4** Enter an estimate of your 2018 adjustments to income and any additional standard deduction for age or blindness (see Pub. 505 for information about these items) **4** \$ _____
- 5** **Add** lines 3 and 4 and enter the total **5** \$ _____
- 6** Enter an estimate of your 2018 nonwage income (such as dividends or interest) **6** \$ _____
- 7** **Subtract** line 6 from line 5. If zero, enter "-0-". If less than zero, enter the amount in parentheses **7** \$ _____
- 8** **Divide** the amount on line 7 by \$4,150 and enter the result here. If a negative amount, enter in parentheses. Drop any fraction **8** _____
- 9** Enter the number from the **Personal Allowances Worksheet**, line H above **9** _____
- 10** **Add** lines 8 and 9 and enter the total here. If zero or less, enter "-0-". If you plan to use the **Two-Earners/Multiple Jobs Worksheet**, also enter this total on line 1, page 4. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 **10** _____



Two-Earners/Multiple Jobs Worksheet

Note: Use this worksheet *only* if the instructions under line H from the **Personal Allowances Worksheet** direct you here.

- 1 Enter the number from the **Personal Allowances Worksheet**, line H, page 3 (or, if you used the **Deductions, Adjustments, and Additional Income Worksheet** on page 3, the number from line 10 of that worksheet) **1** _____
 - 2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However**, if you're married filing jointly and wages from the highest paying job are \$75,000 or less and the combined wages for you and your spouse are \$107,000 or less, don't enter more than "3" **2** _____
 - 3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet **3** _____
- Note:** If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.
- 4 Enter the number from line 2 of this worksheet **4** _____
 - 5 Enter the number from line 1 of this worksheet **5** _____
 - 6 **Subtract** line 5 from line 4 **6** _____
 - 7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here **7** \$ _____
 - 8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed **8** \$ _____
 - 9 **Divide** line 8 by the number of pay periods remaining in 2018. For example, divide by 18 if you're paid every 2 weeks and you complete this form on a date in late April when there are 18 pay periods remaining in 2018. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck **9** \$ _____

| Table 1 | | | | Table 2 | | | |
|---|-----------------------|---|-----------------------|--|-----------------------|--|-----------------------|
| Married Filing Jointly | | All Others | | Married Filing Jointly | | All Others | |
| If wages from LOWEST paying job are— | Enter on line 2 above | If wages from LOWEST paying job are— | Enter on line 2 above | If wages from HIGHEST paying job are— | Enter on line 7 above | If wages from HIGHEST paying job are— | Enter on line 7 above |
| \$0 - \$5,000 | 0 | \$0 - \$7,000 | 0 | \$0 - \$24,375 | \$420 | \$0 - \$7,000 | \$420 |
| 5,001 - 9,500 | 1 | 7,001 - 12,500 | 1 | 24,376 - 82,725 | 500 | 7,001 - 36,175 | 500 |
| 9,501 - 19,000 | 2 | 12,501 - 24,500 | 2 | 82,726 - 170,325 | 910 | 36,176 - 79,975 | 910 |
| 19,001 - 26,500 | 3 | 24,501 - 31,500 | 3 | 170,326 - 320,325 | 1,000 | 79,976 - 154,975 | 1,000 |
| 26,501 - 37,000 | 4 | 31,501 - 39,000 | 4 | 320,326 - 405,325 | 1,330 | 154,976 - 197,475 | 1,330 |
| 37,001 - 43,500 | 5 | 39,001 - 55,000 | 5 | 405,326 - 605,325 | 1,450 | 197,476 - 497,475 | 1,450 |
| 43,501 - 55,000 | 6 | 55,001 - 70,000 | 6 | 605,326 and over | 1,540 | 497,476 and over | 1,540 |
| 55,001 - 60,000 | 7 | 70,001 - 85,000 | 7 | | | | |
| 60,001 - 70,000 | 8 | 85,001 - 90,000 | 8 | | | | |
| 70,001 - 75,000 | 9 | 90,001 - 100,000 | 9 | | | | |
| 75,001 - 85,000 | 10 | 100,001 - 105,000 | 10 | | | | |
| 85,001 - 95,000 | 11 | 105,001 - 115,000 | 11 | | | | |
| 95,001 - 130,000 | 12 | 115,001 - 120,000 | 12 | | | | |
| 130,001 - 150,000 | 13 | 120,001 - 130,000 | 13 | | | | |
| 150,001 - 160,000 | 14 | 130,001 - 145,000 | 14 | | | | |
| 160,001 - 170,000 | 15 | 145,001 - 155,000 | 15 | | | | |
| 170,001 - 180,000 | 16 | 155,001 - 185,000 | 16 | | | | |
| 180,001 - 190,000 | 17 | 185,001 and over | 17 | | | | |
| 190,001 - 200,000 | 18 | | | | | | |
| 200,001 and over | 19 | | | | | | |

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 who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and

U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You aren't required to provide the information requested on a form that's 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.



Employee Name: _____
(please print)

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

CDCN offers the following pay options. Please select one option below.

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



- Bank or Credit Union Direct Deposit** – I authorize CDCN 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 CDCN to process my selected method of pay as indicated above. In the event that funds are deposited mistakenly to my account, I authorize CDCN 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 CDCN 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



Your Pay

FASTER. SAFER. EASIER.



With the U.S. Bank Focus Card™ Your Funds Are:



Immediately loaded
to your card on payday



Available to use
right away



Protected if
lost or stolen¹

About the Focus Card

It is a Visa® prepaid debit card that is a convenient alternative to receiving paper checks. Your payments will automatically be direct deposited to your card each payday. You have access to your funds right away and you can use it to make purchases or get cash wherever Visa debit cards are accepted. It's that simple!

MAKE PURCHASES | RELOAD | GET CASH
PAY BILLS | TRACK SPENDING

Getting Started is Easy

1. Sign up today.
2. Your pay will be automatically deposited to your card. Go online to check your balance.
3. Use your card anywhere Visa debit cards are accepted!

Sign Up!

\$0.00 No cost to sign up.



No credit check or bank account required.²

And Save!



Keep more of your money. No fees to cash a paycheck.



No waiting for your paycheck or extra trips to the bank.

To enroll, please select the US Bank Focus Card Direct Deposit option on your Consumer Direct Care Network Pay Selection Form.



¹ The Visa Zero Liability Policy protects you against unauthorized purchases. U.S.-issued cards only. This does not apply to ATM transactions or to PIN transactions not processed by Visa. You must immediately report any unauthorized use.

² Successful identity verification required. To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. If necessary, we may also ask to see your driver's license or other identifying documents.



Getting Started



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



Follow the activation instructions that accompany your card.

Features



Cash Back Rewards

For purchases at certain retail and restaurant locations.



Savings Account

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



Cash Reload Networks⁵

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



Text and Email Alerts⁴

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



Mobile Banking App⁴

Quickly see your account balance and transaction history.



Track Spending

Online | Phone | Email | Text⁴ | Mobile App

Fee Schedule

| Activity | Cost | | |
|---|---|-------------------------------|--|
| Monthly Account Maintenance | Free | | |
| Purchases at Point-of-Sale (Domestic) | Free | | |
| Cash Back with Purchases (Domestic) | Free | | |
| ATM Transactions | Cash <u>Withdrawal</u> | Declined <u>Withdrawal</u> | Balance <u>Inquiry</u> |
| The owner of any Non-U.S. Bank or Non-MoneyPass ATM may assess an additional surcharge fee for any ATM transaction that you complete. | U.S. Bank ATM | Free | Free |
| | MoneyPass [®] ATM | Free | Free |
| | Allpoint [®] ATM | Free | Free |
| | Other ATM | \$2.00 | \$1.00 |
| | International ATM | \$3.00 | \$1.00 |
| Teller Cash Withdrawal | Free | | |
| Teller Cash Withdrawal Decline | \$0.00 | | |
| Customer Service Automated Phone Service, Online, Live Phone Representative | Free | | |
| Text or Email Alerts⁴ | Free | | |
| Inactivity After 90 consecutive days. Not assessed if balance is \$0.00. | \$2.00 Per Month | | |
| Monthly Paper Statement | If requested – \$2.00 | | |
| Card Replacement Non-Personalized Issued by employer (If applicable to your program) Personalized | \$5.00 Standard \$5.00; Expedited \$15.00; Overnight \$25.00 | | |
| ChekToday Convenience Checks (If applicable to your program) | Check Authorization | Free | |
| | Check Order | Free; Expedited \$35.00 | |
| | Check Return | \$25.00 | |
| | Stop Payment | \$25.00 | |
| | Lost/Stolen Check | \$25.00 | |
| | Void Check | Free | |
| | Check Reversal | \$25.00 | |
| | Check Copy | \$10.00 | |
| Foreign Transaction | Up to 3% of transaction amount | | |
| Transaction Limits | | Count | Amount |
| Maximum Card Balance | | N/A | \$40,000 |
| Purchases (includes cash back) | | 20 per day | \$4,000 per day |
| Cash Loads (If applicable to your program) | | 3 per day | \$950 per day |
| Teller Cash Withdrawal | | 5 per day | \$2,525 per day |
| ATM Withdrawal | | 5 per day | \$1,525 per day; \$1,025 max transaction |
| Loads or Deposits | | 10 per day | \$20,000 per day |
| Signature-based POS returns | | 4 per day | N/A |
| Pending ACH Credits | | 5 per day | \$5,000 per day |
| ACH Loads | | 5 per day | \$20,000 per day |

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

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

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



IDAHO DEPARTMENT OF
HEALTH & WELFARE

**PARTICIPANT-COMMUNITY SUPPORT WORKER
EMPLOYMENT AGREEMENT**

This agreement is hereby made between _____, a Participant of
the Self Directed Community Supports (SDCS) Option, a Medicaid Option administered by the
Department of Health and Welfare (Department), and _____,
a Community Support Worker (CSW).

Participant's Name

CSW's Name

The Participant desires to engage CSW for services under the SDCS Option. In exchange, the CSW desires to be paid for services provided to the Participant. Both parties understand and agree that payment is made through a fiscal employer agent (FEA), using Medicaid monies and based on time sheets submitted by the CSW and approved by the Participant.

To these mutual purposes, the parties promise and agree as follows:

1. CSW services are to be provided in accordance with the Participant's SDCS Support and Spending Plan, and the SDCS rules, outlined in IDAPA 16.03.13, "Consumer-Directed Services."
2. It is mutually understood that CSW is the employee of the Participant, and that the Participant directs, controls and approves the CSW's work.
3. The CSW is hired to assist the Participant and assumes no legal liability for the Participant's conduct.
4. The CSW promises that he/she meets the following minimum qualifications to be a CSW, as outlined in Section 136 of IDAPA 16.03.13, "Consumer-Directed Services."
5. The parties mutually agree that CSW is an employee of the Participant and is not an employee of the SDCS Option or the Fiscal Employer Agent (FEA), and agree that the CSW is not entitled to nor will make claim for any employee benefits from the SDCS Option or the FEA, including but not limited to, worker's compensation, disability, life or health insurance.
6. The CSW agrees to notify the Participant immediately in the event he/she is unable to provide the agreed services due to sickness, injury or personal emergency. The CSW must obtain the Participant's written approval in advance for any pre-planned absence.
7. The Participant shall train the CSW on the duties and responsibilities of the CSW and shall be responsible for approving the accuracy of CSW's time records.



8. The CSW agrees to provide services in a safe, courteous and professional manner. The CSW acknowledges that any physical, sexual or mental abuse or neglect of the Participant by the CSW will result in the immediate termination of this Agreement and a report being made according to the requirements in Section 39-5303, Idaho Code.

9. The CSW agrees to report any observed physical, sexual or mental abuse, exploitation or neglect of Participant to adult protection authorities immediately.

10. The CSW understands and agrees that they cannot provide or bill for services until:

- an authorized Support and Spending Plan has been submitted to the FEA,
- the signed Employment Agreement has been submitted to the FEA
- the signed Medicaid-CSW Agreement has been submitted to the FEA

11. The CSW understands and agrees that no payment for services will be made until both the CSW and the Participant have signed the appropriate time sheets, acknowledging their accuracy, and have submitted them to the FEA.

12. It is mutually understood that Medicaid funding can only pay for services rendered. Under the Self Direction Waiver option, the CSW will not receive payment for any vacation time, holiday time, overtime or sick time. Medicaid will not pay wages at an hourly amount in excess of this agreement.

Please check this box if the employer is requiring the Community Support Worker to specifically document activities that support billable time in writing in a manner agreed upon between the employer and the Community Support Worker.

More than forty (40) hours per week of paid work are allowed only if the CSW meets the criteria for employees that are exempted from overtime pay and minimum wage requirements as per the Fair Labor Standards Act.

The participant must obtain and follow guidance from the Idaho Department of Labor and Commerce to determine if the CSW is exempt from these requirements. It is the responsibility of the participant to ensure that the CSW is exempt if the participant requires the CSW to work more than forty (40) hours per week.

The CSW will be paid only for the specific services authorized as per the Support and Spending Plan.

The signing of this Employment Agreement by the participant and the CSW signifies that the parties acknowledge that the criteria for exemption from overtime and minimum wage requirements will be met prior to scheduling work hours in excess of forty (40) hours per week or agreeing to wages less than minimum wage standards.



13. Terms and conditions of work. **Effective Date:** _____.

| COLUMN A Service needed | B Type of Support <input checked="" type="checkbox"/> only one box per row | C Number of hours per year OR Number of miles/year | D Wage per hour OR Wage per mile | | E Annual Cost |
|---------------------------------|--|---|-------------------------------------|---|-------------------|
| | <input type="checkbox"/> Personal PSS <input type="checkbox"/> Emotional ESS <input type="checkbox"/> Job JSS <input type="checkbox"/> Skilled Nursing SNS <input type="checkbox"/> Transportation TSS (hourly) <input type="checkbox"/> Relationship RSS <input type="checkbox"/> Learning LSS <input type="checkbox"/> Transportation Mileage Reimbursement (MR) | | | x | = \$ |
| | <input type="checkbox"/> Personal PSS <input type="checkbox"/> Emotional ESS <input type="checkbox"/> Job JSS <input type="checkbox"/> Skilled Nursing SNS <input type="checkbox"/> Transportation TSS (hourly) <input type="checkbox"/> Relationship RSS <input type="checkbox"/> Learning LSS <input type="checkbox"/> Transportation Mileage Reimbursement (MR) <input type="checkbox"/> Code for second rate of pay/hour _____ Fill in code | | | x | = \$ Sub-Total |
| | <input type="checkbox"/> Personal PSS <input type="checkbox"/> Emotional ESS <input type="checkbox"/> Job JSS <input type="checkbox"/> Skilled Nursing SNS <input type="checkbox"/> Transportation TSS (hourly) <input type="checkbox"/> Relationship RSS <input type="checkbox"/> Learning LSS <input type="checkbox"/> Transportation Mileage Reimbursement (MR) <input type="checkbox"/> Code for second rate of pay/hour _____ Fill in code <input type="checkbox"/> Code for third rate of pay/hour _____ Fill in code | | | x | = \$ Sub-Total |
| | <input type="checkbox"/> Personal PSS <input type="checkbox"/> Emotional ESS <input type="checkbox"/> Job JSS <input type="checkbox"/> Skilled Nursing SNS <input type="checkbox"/> Transportation TSS (hourly) <input type="checkbox"/> Relationship RSS <input type="checkbox"/> Learning LSS <input type="checkbox"/> Transportation Mileage Reimbursement (MR) <input type="checkbox"/> Code for second rate of pay/hour _____ Fill in code <input type="checkbox"/> Code for third rate of pay/hour _____ Fill in code | | | x | = \$ Sub-Total |
| | <input type="checkbox"/> Personal PSS <input type="checkbox"/> Emotional ESS <input type="checkbox"/> Job JSS <input type="checkbox"/> Skilled Nursing SNS <input type="checkbox"/> Transportation TSS (hourly) <input type="checkbox"/> Relationship RSS <input type="checkbox"/> Learning LSS <input type="checkbox"/> Transportation Mileage Reimbursement (MR) <input type="checkbox"/> Code for second rate of pay/hour _____ Fill in code <input type="checkbox"/> Code for third rate of pay/hour _____ Fill in code | | | x | = \$ Sub-Total |
| | <input type="checkbox"/> Personal PSS <input type="checkbox"/> Emotional ESS <input type="checkbox"/> Job JSS <input type="checkbox"/> Skilled Nursing SNS <input type="checkbox"/> Transportation TSS (hourly) <input type="checkbox"/> Relationship RSS <input type="checkbox"/> Learning LSS <input type="checkbox"/> Transportation Mileage Reimbursement (MR) <input type="checkbox"/> Code for second rate of pay/hour _____ Fill in code <input type="checkbox"/> Code for third rate of pay/hour _____ Fill in code | | | x | = \$ Sub-Total |
| Total Cost of Agreement: | | | | | \$ |

04888



14. The CSW must meet the following specific qualifications in order to provide the following services including attaching copy of certification/licensure, if applicable, as outlined in IDAPA 16.03.13 Subsections 120.05 and 110.03:

Age Criteria for CSWs:

- CSWs 17 years of age and older may provide supervision, direct services or chore type services
- CSWs under 17 years of age may provide chore type services

I am under 17 and the support I provide aligns with the Department's guidance.

15. The CSW agrees to take all actions necessary to become Participant's employee, and to maintain the employment relationship by submitting necessary documents to the FEA, including:

- Completion of W-4, I-9 and other IRS required forms
- A copy of this agreement
- Time sheets approved by Participant recording hours worked.
- A completed criminal history check, including clearance in accordance with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks"
 - Unless the Criminal History Background Check is Waived, the CSW has applied for a Criminal History Background Check through the Department of Health and Welfare. **The CSW will list the Department as the agency/employer, using identification number 1710.**

The CSW gives permission to the fiscal employer agent to notify the Participant (Employer) of the results of the Criminal History Background Check. _____

CSW Signature

I am waiving the Criminal History Check requirement. I have completed the attached Waiver of Liability form. I understand that even if CHC is waived the CSW cannot receive Medicaid dollars if he is on a federal or state Medicaid exclusion list. _____

Participant or Legal Guardian Signature

The provisions of this agreement represent the entirety of the agreement between the parties. It may be amended only in writing with both parties consenting by their signatures. It is mutually understood that this is employment at will. Either party may terminate the employment relationship without cause upon two weeks notice. This agreement may be terminated at any time by the Participant due to unsatisfactory CSW performance.

PARTICIPANT

Date

LEGAL GUARDIAN (IF APPLICABLE)

Date

CSW

Date

04889





MEDICAID – COMMUNITY SUPPORT WORKER AGREEMENT

This agreement is hereby made between the Self Directed Community Supports (SDCS) Option, a Medicaid Option administered by the Department of Health and Welfare (Department), and

_____, a
Community Support Worker (CSW).

This CSW is associated with an Agency. Yes No.

The CSW acknowledges that even though he/she is the employee of a participant in the SDCS Option, the Department, through the Fiscal Employer Agent (FEA) is the source of payment for the CSW’s wages for services performed under the SDCS Option. Because of the unique relationships of the participant, the Department, and the FEA the CSW acknowledges and agrees to the following:

1. Services provided to any participant under the SDCS Option will be provided in compliance with the rules contained in IDAPA 16.03.13, “Consumer Directed Services.”

2. Payment will not be requested through the FEA or the Department for any service not performed in accordance with the SDCS rules, the employment agreement with the participant of the participant’s Support and Spending Plan. It is understood that neither the FEA nor the Department is liable to pay for any service performed that is not in conformance with the SDCS rules, the employment agreement with the participant of the participant’s Support and Spending Plan.

3. The CSW acknowledges that even though he/she is the employee of the Participant, they are also a Medicaid provider under the SDCS Option. As a provider the CSW agrees to accept payment received by the FEA as payment in full for services rendered under the SDCS Option.

4. The CSW acknowledges they are an employee of the participant and not an employee of the Department or the Fiscal/Employer Agent (F/EA) and agrees that the CSW is not entitled to nor will make claim for any employee benefits from the Department of the FEA, including but not limited to, workers’ compensation, disability life and/or health insurance.

5. To protect the confidentiality of personal and health information relating to the participant and his participation in the Medicaid Option, and to release that information only on request of the participant or as otherwise allowed by law.



I have read the foregoing agreement, I understand it, and agree to abide by its terms and conditions. I further understand and agree that violation of any of the terms or conditions of this agreement or the rules may result in termination of this Agreement, and thereby the source of payment for my employment to any SDCS participant.

Printed name of CSW

Signature of CSW

Date

Note: Each CSW must sign personally.





IDAHO DEPARTMENT OF
HEALTH & WELFARE

**Criminal History Check
Waiver of Liability - Assumption of Risk**

Participant Name: _____ **MID #** _____ **Date:** _____

Waiver: I do not want (name of community support worker) _____ to be subject to
Criminal History Check requirements.

Relationship to the Participant: _____

Description of Service: _____

Reason:

I Will Make Sure I am Healthy and Safe by: _____

Release of Liability means that I am giving up my right to sue the Department of Health and Welfare or make them pay for any costs associated with things such damages, liabilities, and attorney fees that happen because of my choice.

Assumption of Risk means that I understand that there things such as personal injury, property loss, abuse, neglect and exploitation that could happen in my life as a result of my choice even if I try to prevent them from happening.

I have read the definitions above and have talked to my Support Broker and/or Circle of Support and I understand the risks of what could happen if I decide not to make the provider of my Self-Directed services have a Criminal History Check. I agree that my choice is voluntary and that I knowingly assume all such risks.

Signature of Individual _____ Date _____ Signature of Legal Guardian (if applicable) _____ Date _____

I have provided education and counseling to _____ regarding the risks of waiving a criminal history check for this individual.

Comments:

Signature of Support Broker _____ Date _____





IDAHO DEPARTMENT OF
HEALTH & WELFARE

**Criminal History Check
Waiver of Liability - Assumption of Risk – Failed Criminal History Check**

Participant Name: _____ **MID #** _____ **Date:** _____

Waiver: I choose to hire (name of community support worker) _____ as my community support worker. I understand that they have failed the criminal history check per requirements at IDAPA 15.05.06, "Rules Governing Mandatory Criminal History Checks".

Relationship to the Participant: _____

Description of Service: _____

Reason: _____

I Will Make Sure I am Healthy and Safe by: _____

Release of Liability means that I am giving up my right to sue the Department of Health and Welfare or make them pay for any costs associated with things such damages, liabilities, and attorney fees that happen because of my choice.

Assumption of Risk means that I understand that there things such as personal injury, property loss, abuse, neglect and exploitation that could happen in my life as a result of my choice even if I try to prevent them from happening.

I have read the definitions above and have talked to my Support Broker and/or Circle of Support and I understand the risks of what could happen if I decide to hire a provider of my Self-Directed services who has a criminal history that would be precluded from providing services in the Idaho Medicaid program. I agree that my choice is voluntary and that I knowingly assume all such risks.

Signature of Individual _____ Date _____ Signature of Legal Guardian (if applicable) _____ Date _____

I have provided education and counseling to _____ regarding the risks of waiving a criminal history check for this individual.

Comments: _____

Signature of Support Broker _____ Date _____





Notice to Employer and Employee regarding working more than 40 hours a week

In the My Voice, My Choice and Family Directed Services programs, Idaho Medicaid prohibits employees from working more than 40 hours per week unless they are specifically exempted from Fair Labor Standard Act (FLSA) regulations (see page two of your Participant-CSW Employment Agreement).

Because of this restriction, Consumer Direct Care Network (CDCN) cannot pay an employee for any hours worked beyond 40 in a work week unless they qualify for an exemption – and an exemption form, signed by both employer and employee, is on file:

- **If CDCN has an exemption form on file...**Employee is eligible to work more than 40 hours in a work week - Hours worked beyond 40 are paid at the regular hourly rate.
- **If CDCN does not have an exemption form on file...** Employee is not eligible to work more than 40 hours in a work week - Hours worked beyond 40 will not be paid.

The two FLSA exemptions for domestic service employees are:

Companionship Services Exemption - Congress exempted minimum wage and overtime provisions to domestic service employees who provide “companionship services” to the elderly or to people with illness, injuries, or disabilities who require assistance in caring for themselves.

Criteria: Employee must perform at least 80% of their work on one or both of the following:

- Fellowship – engages participant in social, physical, and mental activities, such as conversation, reading, games and crafts; and /or accompanying participant on walks, errands, appointments and social events.
- Protection – be present with participant in home or accompany participant when outside of home, and monitor participant’s safety and well-being.

Live-in Exemption - Congress exempted overtime provisions to domestic service employees who have a “live-in relationship” with their employer. That is, they reside in the household in which they provide services.

Criteria: The employee resides in the participant’s home permanently OR resides in participant’s home for extended periods of time (120 hours or more per week). No family relationship needs to exist.



Guidance on these exemptions is available from the Department of Labor's website at https://www.dol.gov/whd/homecare/homecare_guide.htm and on the CDCN website under the resources tab (Look for the link titled: Guide to DOL Home Care Rule).

Exemption forms are available on the CDCN website at <http://consumerdirectid.com/forms/>, or can be obtained by calling the CDCN Meridian office.

Notice to Employees who have a Live-in Relationship with the Service Recipient

IRS Notice 2014-7 describes "Difficulty of Care Payments" in which income received for care provided under certain Medicaid Waiver programs is excludable from gross income if the service recipient lives in the care provider's home. This means that for qualifying individuals, federal and state income taxes are not withheld from their pay. For an employee to be eligible, the following must apply:

- Services must be provided under a qualified Medicaid Waiver Program providing non-medical support services under a plan of care.
- The service recipient must reside in the care provider's (employee's) home. No family relationship needs to exist.

Additional information on IRS Notice 2014-7 is available online:

https://www.irs.gov/irb/2014-4_IRB/ar06.html

<http://ihssadvocate.com/news/notice-2014-7-explained-by-regina-levy-cpa>

CDCN will need a **Statement of Compliance with IRS Notice 2014-7** on file, with both the employee's and participant's signature to ensure tax withholding are set up correctly. The form is available on the CDCN website at <http://consumerdirectid.com/forms/>, or can be obtained by calling the CDCN Meridian office.



Dear Community Support Worker,

The following is information regarding the Affordable Care Act related Health Insurance Marketplace. Key parts of the health care law took effect in 2014; as a result, there is a new way to buy health insurance:

the Health Insurance Marketplace.

The annual Open Enrollment Period for the Health Insurance Marketplace is usually scheduled to begin on November 1st each year for coverage starting January 1st of the following year. This is the **one** time of year where you can apply for private health insurance coverage through the Marketplace. To confirm Open Enrollment Period dates for this year, please contact www.HealthCare.gov. **NOTE:** *You can apply for Medicaid or CHIP (Children's Health Insurance Program) any time of year.*

To assist you as you evaluate options for you and your family, this information sheet provides some basic information about the new Marketplace.

If you have any questions about healthcare reform or the online application process, please contact the Health Insurance Marketplace Call Center at 1.800-318.2596 or visit www.HealthCare.gov.

Thank you,
Human Resources Department
Consumer Direct Care Network

Health Care Marketplace

PART A: General Information

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit ¹.

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

How Can I Get More Information?

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please call 1.800-318.2596 or visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

In the Idaho self-directed care model, the Participant is the employer of record and the managing employer.

Health insurance is not being offered by your employer. You and your family may be able to obtain health coverage through the Marketplace, with a credit that lowers your monthly premiums and with assistance for out-of-pocket costs.

Medicaid Coverage

In all states, Medicaid provides health coverage for some low-income people, families and children, pregnant women, the elderly, and people with disabilities. Idaho has chosen not to expand its Medicaid program at this time. You might not qualify for Medicaid or reduced costs on a private insurance plan; it will depend on where your income falls. Even though Idaho hasn't expanded Medicaid coverage, you should still apply. The Medicaid program provides health coverage to millions of lower-income individuals and families today. You may qualify under your state's existing rules.

There are two (2) ways that you can find out whether you qualify for Medicaid in Idaho:

- Contact your state Medicaid agency online at www.healthandwelfare.idaho.gov or call their Customer Service Center at 1.877.456.1233.
- Fill out an application for coverage in the Health Insurance Marketplace at www.healthcare.gov/marketplace.

If you live in Idaho, you'll use www.HealthCare.gov to apply and enroll in health coverage. For more information on resources available in your state, visit www.healthandwelfare.idaho.gov