

Employee Information

Name: _____
First Middle Last

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

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

Phone #: Home (____) _____ Cell (____) _____

Email: _____

Gender: ☐ Male ☐ Female Date of Birth: _____ Social Security#: ____-____-____

Employment Relationships

Name of Participant: _____

Name of Participant's Guardian (if exists): _____

Employee's relationship to Participant/Employer*: _____

☐ Yes ☐ No – I am currently employed by another Participant in the Idaho Self Direction Program.

**The Participant is the Employer of Record. By program rule the spouse of the Participant is not allowed to be a paid employee.*

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



	/ /	
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. ☐ Employee-Employer Relationship Determination
4. ☐ Employee-Participant Live-in Determination
5. ☐ I-9 Form - *Additional I-9 instructions are available on the CDCN Idaho website under the Resources tab*
6. ☐ W-4 Employee's Withholding Allowance Certificate (federal)
7. ☐ ID W-4 Employee's Withholding Allowance Certificate (state)
8. ☐ Pay Selection Form - Attachment may be required, see form instructions
9. ☐ Participant-Community Support Worker Employment Agreement
10. ☐ Medicaid-Community Support Worker Agreement
11. ☐ 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: ____/____/____



EMPLOYEE-EMPLOYER RELATIONSHIP DETERMINATION

(Determine if employee is exempt from some payroll taxes)

Employee Name	Participant (Employer of Record) Name

Domestic service employees may be exempt from some payroll taxes if they are related to their Employer. Consumer Direct Care Network (CDCN) will apply exemptions based on the relationship identified below.

Employee-Employer Relationship

Employee answers each question below with Yes or No

☐ Yes ☐ No – Are you the spouse of the Employer? <i>Not allowed to be an employee by Idaho Medicaid rules.</i>
☐ Yes ☐ No – Are you the parent of the Employer? <i>Including adoptive and step parent. Exempt from FICA, FUTA and SUTA; subject to FICA if all 3 boxes checked below.</i> <u>If you answered YES</u> check any of the following that apply: ☐ I provide care for my grandchild or step grandchild that lives in my Employer's (my child's) home. ☐ My grandchild or step grandchild is less than 18 years old or has a physical or mental condition that requires personal care of an adult for at least 4 straight weeks in 3 months. ☐ My Employer, who is my child, is (1) widowed or divorced and not re-married; or (2) lives with a spouse, but the spouse can't care for my grandchild or step grandchild for at least 4 straight weeks in 3 months due to a physical or mental condition.
☐ Yes ☐ No – Are you the child of the Employer? <u>If you answered YES</u> check one option below: ☐ I am 21 years of age or older - <i>Subject to FICA, FUTA, and SUTA.</i> ☐ I am less than 21 years old - <i>Exempt from FICA, FUTA, and SUTA.</i>
☐ Yes ☐ No – I am NOT related to the Employer <u>or</u> my relationship is NOT listed above. <i>Subject to FICA, FUTA, and SUTA.</i>

Acknowledgement: The Employee and Employer agree the relationship selected above is accurate. If this information changes, the Employee must notify CDCN. If CDCN is not notified of changes, the Employee may have to pay back money that should have been withheld from pay.

Employee Signature

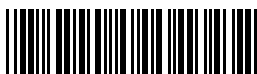
Date

Participant/Legal G. Signature

Date

Please note:

- ¹FICA – Federal Insurance Contributions Act (Social Security and Medicare); ²FUTA – Federal Unemployment Tax Act; ³SUTA – State Unemployment Tax
- Exemptions identified cannot be waived. If the Employee's earnings are exempt from these taxes, they may not qualify for related benefits. An example is unemployment insurance.
- Incorrectly filling out this form may result in inaccurate tax withholdings.





EMPLOYEE-PARTICIPANT LIVE-IN DETERMINATION

(Determine if employee is exempt from overtime pay and income tax)

Employee Name	Participant Name

Domestic service workers may be exempt from overtime pay requirements and from paying income taxes. Consumer Direct Care Network (CDCN) will apply exemptions based on your answers below.

Employee-Participant Live-in Status

Employee answers below with Yes or No

- ☐ Yes ☐ No – **Do you live permanently in the same home as the above-named Participant, or temporarily, but for extended periods of time (at least 120 hours per week or 5 consecutive days or nights per week)?**

If you answered YES:

- Overtime hours worked are paid at the regular pay rate.
- Declare your Difficulty of Care income tax exemption status.
☐ Yes ☐ No – **I declare under penalties of perjury that I am an individual care provider receiving payments under a state Medicaid Waiver program as defined in IRS Notice 2014-7.** I provide care to the Participant named above. The Participant resides in my home. I am not required to report income earned under this Medicaid program. Federal and state income taxes should not be withheld from my pay. If non-taxable wages have been reported by CDCN in Box 1 of my Form W-2, I can deduct the nontaxable wages from my taxable income when I file my tax return. If I no longer qualify for IRS Notice 2014-7, I will notify CDCN. At that time, federal and state income tax withholding will resume. If the IRS deems I was not eligible for 2014-7 and taxes were not paid, I agree that I will be liable for any back taxes owed.

Note: IRS Notice 2014-7 directs that payments received under a Home and Community-based Medicaid Waiver program for providing Personal Care or Habilitation services are considered "Difficulty of Care" payments excludable from income taxation when the Medicaid recipient lives in the care provider's home. Respite and skilled services do not qualify. For more information please refer to <https://www.irs.gov/pub/irs-drop/n-14-07.pdf>.

If you answered NO:

- You cannot work overtime (more than 40 hours per week) per Idaho Medicaid rules unless you submit a Companionship Services exemption form.

Acknowledgement: The Employee and Employer agree the declaration(s) above are accurate. If living arrangements change, the Employee must notify CDCN. Regardless of overtime status identified above, working overtime requires prior approval.

Employee Signature

Date

Participant/Legal G. Signature

Date



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		USCIS Form I-9	
Department of Homeland Security U.S. Citizenship and Immigration Services		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) ① Doe		First Name (Given Name) Jane	Middle Initial Q
Other Last Names Used (if any) N/A			
Address (Street Number and Name) ② 123 Main St.		Apt. Number N/A	City or Town Anytown
State ID		ZIP Code 12345	
Date of Birth (mm/dd/yyyy) ③ 03/13/1964		U.S. Social Security Number ④ 123-45-6789	Employee's E-mail Address ⑤ employee@email.com
		Employee's Telephone Number ⑥ 555-123-4567	
I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.			
I attest, under penalty of perjury, that I am (check one of the following boxes):			
☒ 1. A citizen of the United States			
☐ 2. A noncitizen national of the United States (See instructions)			
☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number):			
☐ 4. An alien authorized to work until (expiration date of approval mm/dd/yyyy) Some aliens may write "N/A" in the expiration date field. (See instructions)			
Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.			
1. Alien Registration Number/USCIS Number: _____ OR			
2. Form I-94 Admission Number: _____ OR			
3. Foreign Passport Number: _____ Country of Issuance: _____			
Signature of Employee ⑧ Jane Doe		Today's Date (mm/dd/yyyy) 02/05/2017	
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			
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)	First Name (Given Name)	M.I.
		① Doe	Jane	
List A Identity and Employment Authorization		OR	List B Identity	AND List C Employment Authorization
Document Title	③ Driver's License	Document Title	Social Security Card	
Issuing Authority	State of Residence	Issuing Authority	SSA	
Document Number	0123456789abcde	Document Number	123-45-6789	
Expiration Date (if any)(mm/dd/yyyy)	08/17/2020	Expiration Date (if any)(mm/dd/yyyy)	N/A	
Document Title	Additional Information			
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				
Document Title	OR Code - Sections 2 & 3 Do Not Write In This Space			
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): ④ 02/05/2017 (See instructions for exemptions)				
Signature of Employer or Authorized Representative		Today's Date(mm/dd/yyyy)	Title of Employer or Authorized Representative	
⑤ Ronald Smith		⑥ 02/05/2017	⑦ Employer	
Last Name of Employer or Authorized Representative		First Name of Employer or Authorized Representative	Employer's Business or Organization Name	
⑧ Smith		Ronald	⑨ Ronald Smith	
Employer's Business or Organization Address (Street Number and Name)		City or Town	State	ZIP Code
⑩ 500 Fictional St.		Anytown	1D	85018

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

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



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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States	
☐ 2. A noncitizen national of the United States <i>(See instructions)</i>	
☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ Some aliens may write "N/A" in the expiration date field. <i>(See instructions)</i>	
<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> 1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____	QR Code - Section 1 Do Not Write In This Space

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



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

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

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)				
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)
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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
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LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

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

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

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

Refer to the instructions for more information about acceptable receipts.



Employee's Withholding Certificate

OMB No. 1545-0074

2021

- ▶ **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.**

**Step 1:
Enter
Personal
Information**

(a) First name and middle initial	Last name	(b) Social security number
Address		▶ Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov .
City or town, state, and ZIP code		
(c) ☐ Single or Married filing separately ☐ Married filing jointly or Qualifying widow(er) ☐ Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the estimator at www.irs.gov/W4App, and privacy.

**Step 2:
Multiple Jobs
or Spouse
Works**

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

Do **only one** of the following.

- (a) Use the estimator at www.irs.gov/W4App for most accurate withholding for this step (and Steps 3–4); **or**
 (b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**
 (c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld ▶ ☐

TIP: To be accurate, submit a 2021 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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

**Step 3:
Claim
Dependents**

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

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

Multiply the number of other dependents by \$500 ▶ \$ _____

Add the amounts above and enter the total here **3** \$ _____

**Step 4
(optional):
Other
Adjustments**

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

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

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

**Step 5:
Sign
Here**

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

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

**Employers
Only**

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

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2021 if you meet both of the following conditions: you had no federal income tax liability in 2020 **and** you expect to have no federal income tax liability in 2021. You had no federal income tax liability in 2020 if (1) your total tax on line 24 on your 2020 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, 29, and 30), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2021 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2022.

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

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

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

1. Expect to work only part of the year;
2. Have dividend or capital gain income, or are subject to additional taxes, such as Additional Medicare Tax;
3. Have self-employment income (see below); or
4. Prefer the most accurate withholding for multiple job situations.

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

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

Specific Instructions

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

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

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

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



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

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

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2021 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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



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

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

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

- 1 Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 **1** \$ _____
- 2 Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.
 - a** Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a **2a** \$ _____
 - b** Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b **2b** \$ _____
 - c** Add the amounts from lines 2a and 2b and enter the result on line 2c **2c** \$ _____
- 3** Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3** _____
- 4 Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) **4** \$ _____

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

- 1** Enter an estimate of your 2021 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 10% of your income **1** \$ _____
- 2** Enter: $\left\{ \begin{array}{l} \bullet \$25,100 \text{ if you're married filing jointly or qualifying widow(er)} \\ \bullet \$18,800 \text{ if you're head of household} \\ \bullet \$12,550 \text{ if you're single or married filing separately} \end{array} \right\}$ **2** \$ _____
- 3** If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" **3** \$ _____
- 4** Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information **4** \$ _____
- 5 Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 **5** \$ _____

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

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

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

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

00540



Married Filing Jointly or Qualifying Widow(er)

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$190	\$850	\$890	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,100	\$1,870	\$1,870
\$10,000 - 19,999	190	1,190	1,890	2,090	2,220	2,220	2,220	2,220	2,300	3,300	4,070	4,070
\$20,000 - 29,999	850	1,890	2,750	2,950	3,080	3,080	3,080	3,160	4,160	5,160	5,930	5,930
\$30,000 - 39,999	890	2,090	2,950	3,150	3,280	3,280	3,360	4,360	5,360	6,360	7,130	7,130
\$40,000 - 49,999	1,020	2,220	3,080	3,280	3,410	3,490	4,490	5,490	6,490	7,490	8,260	8,260
\$50,000 - 59,999	1,020	2,220	3,080	3,280	3,490	4,490	5,490	6,490	7,490	8,490	9,260	9,260
\$60,000 - 69,999	1,020	2,220	3,080	3,360	4,490	5,490	6,490	7,490	8,490	9,490	10,260	10,260
\$70,000 - 79,999	1,020	2,220	3,160	4,360	5,490	6,490	7,490	8,490	9,490	10,490	11,260	11,260
\$80,000 - 99,999	1,020	3,150	5,010	6,210	7,340	8,340	9,340	10,340	11,340	12,340	13,260	13,460
\$100,000 - 149,999	1,870	4,070	5,930	7,130	8,260	9,320	10,520	11,720	12,920	14,120	15,090	15,290
\$150,000 - 239,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,830	14,030	15,230	16,190	16,400
\$240,000 - 259,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,830	14,030	15,270	17,040	18,040
\$260,000 - 279,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,870	14,870	16,870	18,640	19,640
\$280,000 - 299,999	2,040	4,440	6,500	7,900	9,230	10,470	12,470	14,470	16,470	18,470	20,240	21,240
\$300,000 - 319,999	2,040	4,440	6,500	7,940	10,070	12,070	14,070	16,070	18,070	20,070	21,840	22,840
\$320,000 - 364,999	2,720	5,920	8,780	10,980	13,110	15,110	17,110	19,110	21,190	23,490	25,560	26,860
\$365,000 - 524,999	2,970	6,470	9,630	12,130	14,560	16,860	19,160	21,460	23,760	26,060	28,130	29,430
\$525,000 and over	3,140	6,840	10,200	12,900	15,530	18,030	20,530	23,030	25,530	28,030	30,300	31,800

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	\$440	\$940	\$1,020	\$1,020	\$1,410	\$1,870	\$1,870	\$1,870	\$1,870	\$2,030	\$2,040	\$2,040
\$10,000 - 19,999	940	1,540	1,620	2,020	3,020	3,470	3,470	3,470	3,640	3,840	3,840	3,840
\$20,000 - 29,999	1,020	1,620	2,100	3,100	4,100	4,550	4,550	4,720	4,920	5,120	5,120	5,120
\$30,000 - 39,999	1,020	2,020	3,100	4,100	5,100	5,550	5,720	5,920	6,120	6,320	6,320	6,320
\$40,000 - 59,999	1,870	3,470	4,550	5,550	6,690	7,340	7,540	7,740	7,940	8,140	8,150	8,150
\$60,000 - 79,999	1,870	3,470	4,690	5,890	7,090	7,740	7,940	8,140	8,340	8,540	9,190	9,990
\$80,000 - 99,999	2,000	3,810	5,090	6,290	7,490	8,140	8,340	8,540	9,390	10,390	11,190	11,990
\$100,000 - 124,999	2,040	3,840	5,120	6,320	7,520	8,360	9,360	10,360	11,360	12,360	13,410	14,510
\$125,000 - 149,999	2,040	3,840	5,120	6,910	8,910	10,360	11,360	12,450	13,750	15,050	16,160	17,260
\$150,000 - 174,999	2,220	4,830	6,910	8,910	10,910	12,600	13,900	15,200	16,500	17,800	18,910	20,010
\$175,000 - 199,999	2,720	5,320	7,490	9,790	12,090	13,850	15,150	16,450	17,750	19,050	20,150	21,250
\$200,000 - 249,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,820	20,930	22,030
\$250,000 - 399,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,820	20,930	22,030
\$400,000 - 449,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,910	21,220	22,520
\$450,000 and over	3,140	6,250	8,830	11,330	13,830	15,790	17,290	18,790	20,290	21,790	23,100	24,400

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	\$820	\$930	\$1,020	\$1,020	\$1,020	\$1,420	\$1,870	\$1,870	\$1,910	\$2,040	\$2,040
\$10,000 - 19,999	820	1,900	2,130	2,220	2,220	2,620	3,620	4,070	4,110	4,310	4,440	4,440
\$20,000 - 29,999	930	2,130	2,360	2,450	2,850	3,850	4,850	5,340	5,540	5,740	5,870	5,870
\$30,000 - 39,999	1,020	2,220	2,450	2,940	3,940	4,940	5,980	6,630	6,830	7,030	7,160	7,160
\$40,000 - 59,999	1,020	2,470	3,700	4,790	5,800	7,000	8,200	8,850	9,050	9,250	9,380	9,380
\$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,850	11,050	11,250	11,520	12,320
\$80,000 - 99,999	1,880	4,280	5,710	7,000	8,200	9,400	10,600	11,250	11,590	12,590	13,520	14,320
\$100,000 - 124,999	2,040	4,440	5,870	7,160	8,360	9,560	11,240	12,690	13,690	14,690	15,670	16,770
\$125,000 - 149,999	2,040	4,440	5,870	7,240	9,240	11,240	13,240	14,690	15,890	17,190	18,420	19,520
\$150,000 - 174,999	2,040	4,920	7,150	9,240	11,240	13,290	15,590	17,340	18,640	19,940	21,170	22,270
\$175,000 - 199,999	2,720	5,920	8,150	10,440	12,740	15,040	17,340	19,090	20,390	21,690	22,920	24,020
\$200,000 - 249,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,880	24,980
\$250,000 - 349,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,880	24,980
\$350,000 - 449,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,900	25,200
\$450,000 and over	3,140	6,840	9,570	12,160	14,660	17,160	19,660	21,610	23,110	24,610	26,050	27,350



Complete Form ID W-4 so your employer can withhold the correct amount of state income tax from your paycheck. Sign the form and give it to your employer. **Use the information on the back** to calculate your Idaho allowances and any additional amount you need withheld from each paycheck. If you plan to itemize deductions, use the worksheet at tax.idaho.gov/w4.

Withholding Status

Check the **"A"** box (Single) if you're:

- Single with one job or single with multiple jobs
- Filing as head of household

Check the **"B"** box (Married) if you're:

- Married filing jointly with one job and your spouse doesn't work
- A qualifying widow(er)

Check the **"C"** box (Married, but withhold at Single rate) if you're:

- Married filing jointly and both people work (or you have multiple jobs)
- Married filing separately



WITHHOLDING STATUS (see information above)

A ☐ (Single) **B** ☐ (Married) **C** ☐ (Married, but withhold at Single rate)

1. Total number of Idaho allowances you're claiming _____
2. Additional amount (if any) you need withheld from each paycheck (Enter whole dollars) _____

Your Social Security number (required)

Your first name and initial

Last name

Current mailing address

City

State

ZIP Code

Under penalties of perjury, I declare that to the best of my knowledge and belief I can claim the number of withholding allowances on line 1 above.

Your signature

Date



1. Total number of allowances you're claiming.

Enter the number of children in your household age 16 or under as of December 31, 2021. If you have no qualifying children, enter "0." If your filing status will be head of household on your tax return, add "2" to the number of qualifying children. **Don't claim allowances for you or your spouse.** You can claim fewer allowances but not more.

If you're married, claim your allowances on the W-4 for the highest-paying job for the most accurate withholding. If you're married filing jointly, only one of you should claim the allowances. The other should claim zero allowances.

If you work for more than one employer at the same time, you should claim zero allowances on your W-4 with any employer other than your principal employer.

Write **Exempt** on line 1 if you meet **both** of the following conditions:

- Last year I had no Idaho income tax liability **and**
- This year I expect to have no Idaho income tax liability

Nonresident Aliens

Exempt income. If you're a nonresident alien and all your income is exempt from withholding, write "Exempt" on line 1.

Exempt income from a treaty. If a treaty exempts a portion of your income from withholding, complete federal Form 8233 to claim your treaty benefits and complete the Idaho W-4 to withhold on income that's not exempt by your treaty.

Idaho taxable income. If you're a nonresident alien and have Idaho taxable income, do all of these:

1. Check the "Single" withholding status box regardless of your marital status.
2. Enter 0 on line 1.
3. Using the Pay Period table below, enter the additional amount of income tax to be withheld for each pay period on line 2. *Exception:* If you're a student or business apprentice from India, report \$0 on line 2.

Pay Period Table				
If your pay period is:	Weekly	Biweekly	Semimonthly	Monthly
Enter this amount on line 2:	\$17	\$33	\$36	\$72

The withholding table calculations for employers include the standard deduction. Because nonresident aliens don't qualify for the standard deduction, the Pay Period table helps ensure that employers withhold enough.

2. Additional amount, if any, you need withheld from each paycheck.

If you're single or married filing separately and have more than one job at a time, complete the worksheet below to calculate any additional amount you need withheld from each paycheck.

1. Other than your primary job, how many jobs do you expect to have at the same time during 2021? (Don't count your primary job.)
2. Multiply the number on line 1 by \$12,400
3. Enter an estimate of your 2021 income from other jobs (not including your primary job)
4. Enter the smaller of lines 2 or 3
5. If you completed the itemized deduction worksheet for Idaho (tax.idaho.gov/w4), enter the number from line 4. Otherwise, enter "0"
6. Multiply the number on line 5 by \$2,960.....
7. Subtract line 6 from line 4
8. Multiply line 7 by 6.925% (.06925). This is the additional amount you need to withhold annually
9. Divide the amount on line 8 by the number of your remaining pay periods in 2021. Enter the number on line 2 of the W-4 as the additional amount you need withheld from each paycheck

Contact us:

In the Boise area: (208) 334-7660 | Toll free: (800) 972-7660
Hearing impaired (TDD) (800) 377-3529
tax.idaho.gov/contact

00540





PAY SELECTION FORM

Employee Name: _____

Date of Birth: _____

Consumer Direct Care Network (CDCN) issues pay by direct deposit to a bank account or pay card. Pay stubs (summaries) are sent to you by mail to your address on file.

Please check one pay option below.

No selection will result in automatic enrollment in the Wisely Pay card option.

- ☐ **Direct Deposit to a Wisely Pay Card Account.** I authorize CDCN to issue me a Wisely Pay card. The card will be tied to my identification on file. CDCN will make payroll deposits to my card account. I will receive the card in 7 to 10 business days after initial processing.
- ☐ **Direct Deposit to an Existing Checking, Savings or Pay Card Account.** I authorize CDCN to initiate payroll deposits to my bank or financial institution.

The Name of my bank is:

The Account Type is (check one): ☐ Checking ☐ Savings ☐ Pay Card

AN ATTACHMENT IS REQUIRED.

For a Checking Account. Please attach a voided check. This is preferred. A bank-issued direct deposit form or bank letter* is ok too.

For a Savings Account or Pay Card. Please attach a bank-issued direct deposit form or bank letter.*

**Do not submit a deposit slip. The routing numbers differ from direct deposit routing numbers.*

Acknowledgement. I authorize CDCN to process my selected method of pay. I understand that:

- CDCN reserves the right to refuse any direct deposit request.
- I am responsible to confirm that each deposit has occurred. I must pay any fees caused by overdrafts on my account.
- All direct deposits are made through an Automated Clearing House (ACH). Processing is subject to ACH terms. The terms of my bank also apply.
- If funds are deposited to my account in error, I authorize CDCN to debit my account to correct the error. If my account cannot be debited due to closure or insufficient balance, then CDCN may withhold future payments until the erroneous deposited amounts are repaid.
- I may receive a paper check while my selected method of pay is being set up.
- I must submit a new Pay Selection Form to CDCN if I wish to change my Direct Deposit option.

Employee Signature

Date





The Wisely logo, featuring the word "wisely" in a white, lowercase, sans-serif font with a small icon of three dots above the 'i'.

Sign up for the Wisely® Pay card today!

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

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



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



No Charge for Direct Deposit — Get paid up to 2 days early⁴ for your pay and other sources of income.⁵ A no-fee⁶ upgrade is required.⁷



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



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

¹ Adding funds from other sources requires additional cardholder identification verification.

² Wisely Pay is not a credit card and does not build credit.

³ Additional terms and third-party fees may apply.

⁴ You must opt into early direct deposit on myWisely.com/pay or myWisely mobile app. Early direct deposit of funds is not guaranteed and is subject to payer's support and the timing of payer's payment instruction. Faster-funding claim is based on a comparison of our policy of making funds available upon our receipt of payment instruction with the typical banking practice of posting funds at settlement. Please see full disclosures on myWisely.com or myWisely app. Please allow up to 3 weeks for funds to be loaded to the card after initial setup of direct deposit to your card.

⁵ Please allow up to 3 weeks for your pay to be loaded to the card after initial setup of direct deposit to your card.

⁶ While this feature is available at no additional charge, certain other transaction fees and costs, terms, and conditions are associated with the use of this Card. See the cardholder agreement for more details.

⁷ Additional verification required and may not be available to all cardholders.

⁸ You must notify us immediately and assist us in our investigation if your card is lost or stolen or you believe someone is using your card without your permission.

⁹ Standard text message fees and data rates may apply.

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

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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"
 - o 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

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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 as 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 _____





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

Relationship to the Participant: _____

Description of Service: _____

Reason: _____

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

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
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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 exempted from overtime pay requirements under the Fair Labor Standards Act (FLSA). Please refer to 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 FLSA exemption and we have an exemption form on file, signed by both employer and employee.

- **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.

There are two FLSA overtime pay exemptions for domestic service employees

1. 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.

Note: a *Companionship Services Exemption* form is found on the CDCN Idaho website.

2. 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 either permanently, or for extended periods of time (120 hours or more per week). No family relationship needs to exist.

Note: an *Employee-Participant Live-in Determination* form is included in employee enrollment packets for both My Voice, My Choice and Family Directed Services programs.

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 Idaho website under the resources tab (Look for the link titled: Guide to DOL Home Care Rule).



Work Opportunity Tax Credits - Consumer Direct Care Network

Consumer Direct Care Network (CDCN) participates in the Work Opportunity Tax Credit (WOTC) program. WOTC is a Federal tax credit available to employers. ADP administers WOTC on behalf of CDCN. Please follow the steps listed below to screen for the WOTC program. We appreciate your cooperation.

Applicant Instructions

- Open <https://tcs.adp.com/consumerdirectcare> or scan the QR code below.
***Note: If using a shared screening device, ensure the device does not have an autofill/auto complete function enabled*
- Please answer each question to complete the voluntary screening.
- Eligible applicants will be asked to **Electronically Sign and click Submit** to complete the screening.
- Ineligible applicants will be asked to click **Submit** to finish the screening. You will not be asked to electronically sign.

****ADP will contact WOTC-eligible new hires via email or text to request proof of age or address documentation, when needed.***

*****If you are unable to screen via the Web Link please contact ADP at 1-800-237-3279 (1-800-ADP-EASY) available 6am-11 pm ET, 7 days a week and enter company code shown below to screen for Tax Credits.***

IVR CODE: 410849



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