Community Support Worker Employee Packet Instructions

The Employee Packet includes all the necessary forms for an individual to become an employee of the participant. The Employee Packet includes some forms that are completed by the employee, some that are completed by the employee and the participant/guardian, and some that require the help of the participant's Support Broker.

> **!** The complete Community Support Worker Employee Packet must be submitted to Consumer Direct Care Network (CDCN) before services are provided to the participant.

As the employer, the participant/legal guardian's role is to:

- Take on the responsibilities of being an employer which includes following state and federal labor laws.
- Recruit, hire, train, supervise and dismiss employees.
- Complete Employment Agreements with all employees. These describe the services the employee will provide and the rate of pay.
- Create a schedule and schedule employees.
- Submit timesheets only for services approved on the Participant's Support and Spending Plan.
- Pay the employee out of pocket for any work performed that is not approved on the Support and Spending Plan.
- Approve and sign timesheets.
- Make sure timesheets are submitted to CDCN on time.
- Treat employees consistently and fairly.
- Keep required records and receipts.

CDCN has two (2) business days to process a complete employee packet, provided that the participant is already fully enrolled with CDCN. The employee will receive a CDCN ID number once they are set up in our system.

An explanation and instructions for completing each form is provided below. If you have any questions, please ask a CDCN representative.

Employee Data Form

This form gathers basic information about the community support worker so an employee file can be set up in CDCN's payroll system. When filling in this form:

- Complete all the blanks in the *Employee Information* section (name, physical address, mailing address, phone and so on).
- In the *Employment Relationship* section, enter the participant's name, participant's guardian's name, if exists, and your relationship to the participant.
- Employee signs and dates to indicate that all the information is correct.

New Employee Checklist

This lists all of the forms in the Employee Packet that need to be submitted to CDCN. Use this checklist to keep track of which forms you have finished. Check off items as they are completed. The participant/guardian also signs the bottom of the form when all paperwork has been completed. At the bottom of the form, write the date the packet was submitted to CDCN.

Employee-Employer Relationship Determination

This form is used to determine if an employee's relationship to their employer exempts them from some federal and state payroll taxes. When filling in this form:

- Write the name of the employee and the participant/employer in the boxes on the top of the form.
- The employee checks one box that describes their relationship to the participant/employer. If the employee is the parent or child of the participant, they answer the additional questions.
- Both employee and participant/guardian sign and date the form.

Employee-Participant Live-in Determination

This form is used to determine (1) an employee's Fair Labor Standards Act overtime pay status, and (2) for employees who live with the participant, whether they qualify for the Difficulty of Care income tax exclusion. When filling in this form:

- Write the name of the employee and the participant/employer in the boxes on the top of the form.
- The employee checks Yes or No as to whether they live with the participant.
- If you answered yes that you live with the participant, answer the additional question about Difficulty of Care income tax exclusion status. Please refer to IRS Notice 2014-7 for additional information at *https://www.irs.gov/pub/irs-drop/n-14-07.pdf.*
- Both employee and participant/guardian resign and date the form.

I-9 Employment Eligibility Verification

This documents that you are authorized to work in the United States. Section 1 of the form is filled out by the employee. Section 2 is completed by the participant/guardian, who must review original documents that prove the employee's identity. Additional I-9 instructions are available on the CDCN Idaho website under the Forms tab.

W-4 Form (federal)

This determines the amount of federal income tax to be withheld from your pay. You will need to fill out and sign page 1 of the form. Pages 2-4 are instructions and worksheets to help you complete the form.

Step 1: Enter Personal Information. Enter your demographic information, including (a) Name, (b) Social Security number, and (c) Filing status – check only one box for filing status.

Step 2: Multiple Jobs or Spouse works. Complete only if applicable. Applies if you hold more than one job, or are married filing jointly and your spouse also works. Refer to the Multiple Jobs Worksheet on page 3 of Form W-4.

Note: If you have multiple jobs and will submit multiple W-4s to different employers, ensure steps 3 through 4b are only completed on one W-4.

Step 3: Claim Dependents. Complete only if applicable. Enter total dollar amount for all claimed dependents on line 3.

Step 4: Other Adjustments. Complete only if applicable.

a. Enter amount on line 4a for other income (not from jobs) you expect in the coming year that won't have tax withheld. This could be interest or dividends.

b. Enter the amount on line 4b from the Deductions Worksheet line 5.

c. Enter the amount on line 4c any additional tax you want withheld for each pay period (including any amount determined from the multiple jobs worksheet).

Step 5: Sign Here. Sign and date the form.

ID W-4 Form (state)

This determines the amount of state income tax to be withheld from your pay. Page two of the form has instructions for determining the number of allowances to claim and a worksheet to determine if you wish to have any additional amount of money deducted from each paycheck.

When completing the form, make sure to:

- Check only one box, A, B or C for your withholding status.
- Line 1. Enter the total number of allowances you will claim on line 1. This is based on dependent children and marital status. See instructions on page 2. Write "exempt" on line 1 if you meet the criteria as described in the accompanying instructions.
- Line 2. If you wish to have additional money deducted from each paycheck, enter the amount here.
- Demographic information. Enter you Social Security Number, name and address information in the boxes provided.
- Sign and date the form.

Pay Selection Form

Choose how you will receive your paycheck. CDCN offers two pay options: direct deposit to a bank or credit union account or to a pay card. Pay stubs an W-2s are sent by first class mail to your address on file or electronically. When filling in this form:

- Read the descriptions of each option. Place a check mark next to the desired pay option.

- For a checking or savings account, enter the name of the bank/credit union in the box provided. Attach a voided check, counter check, or documentation from the bank/credit union showing the account and routing numbers (please note, a deposit slip is not acceptable). Handwritten numbers will not be accepted.
- Sign and date the bottom of the form.

Participant-Community Support Worker Employment Agreement

This is a Department of Health and Welfare form that the employee completes with the participant to document the specific services the employee will perform. It also documents how often and how long the employee is to provide each service as well as the rate of pay. Please note the community support worker age requirements on page 4 of the agreement.

When filling in the Agreement:

Page 1:

- Write in the participant's legal name and the employee's legal name.
- Read through the agreement

Page 2:

- Read through the agreement

> **!** An employee can only be paid for more than 40 hours of work per week if they meet the companionship worker or live-in worker exemption. Refer to the companionship and live-in worker exemption sections for more information.

Page 3: Refer to SSP or Support Broker as needed:

- Column A – provide job description.
- Column B – mark a service code to indicate which support the employee will be providing. Check only one box per row.
- Column C – fill in the number of hours or miles to be used for the year.
- Column D – write in the employee's rate of pay. Do not include the rate with employer taxes as listed on the SSP. Example: use $13.00/hour not $13.36/ hour.
- Column E –multiply amounts from column C by column D.
- In the upper right hand corner, write in the date this agreement is to go into effect.

Page 4:

- Section 14: must state what makes the employee qualified to work for the participant. Examples: the employee is a family member and understands the participant's needs, must maintain valid driver's license and automobile insurance, must have CPR certification, must have a cell phone at all times to maintain contact, etc.
- Employee must meet age requirement.

- Indicate if the employee is getting a background check or if this requirement will be waived.
- Participant/guardian signs and dates.
- Employee signs and dates.

A new Participant – Community Support Worker Employment Agreement must be completed and submitted to CDCN for every CSW each plan year.

Medicaid-Community Support Worker Agreement

This Department of Health and Welfare agreement describes things that the worker will do as an employee. The employee agrees that the participant will pay only for work done in accordance with program rules and terms of the Participant-Community Support Worker Employment Agreement.

When filling in this form:

- Employee prints name on page 1.
- Check the 'yes' or 'no' box to indicate if the employee is connected with an agency.
- Review the form carefully
- Sign and date on page 2 - the employee's signature indicates they agree with the conditions outlined in the Agreement.

Criminal History Check

When a participant is hiring a new employee there is a mandatory requirement to perform a Criminal History Check on that employee. Under the My Voice, My Choice and Family-Directed Services programs a participant can choose to waive the background check requirement for community support workers by completing the Criminal history Check Waiver Form (see next section).

To get a background check:

- The participant must contact the Department of Health and Welfare Criminal History Unit and request a Criminal History Check on the prospective employee (applicant). At that time the participant can either set up an appointment for the applicant, or the applicant can set up his/her own appointment.
- The agency code used is 1710.
- The cost of the Criminal History Check is paid by the employee at the time the person's fingerprints and identification information are taken by the Department of Health and Welfare. This cannot be paid from the participant's budget.
- After the check is complete, the Notice of Clearance letter must be provided with the employee packet.

There are two forms in the employee packet related to the criminal history check. If the participant/guardian chooses not to have the criminal history check done, the Criminal History Check: Waiver of Liability - Assumption of Risk Form must be completed. If a worker has failed a criminal history background check, the participant/guardian still can consider employing the person, but in this situation the Criminal History Check: Waiver of Liability - Assumption of Risk - Failed Criminal History Check Form must be used.

Criminal History Check – Waiver of Liability – Assumption of Risk

This is ONLY REQUIRED IF the participant/guardian wishes to waive the employee from being subject to a criminal history check prior to providing service.

When filling in this form:

- Complete all sections.
- Document the reason for the waiver as well as how the participant will maintain their health and safety.
- Participant/legal guardian signs and dates.
- Support Broker must sign and date.

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

This is ONLY REQUIRED IF an employee has failed a criminal history check, yet the participant/guardian still wishes for this person to be their employee. On the form, the participant or their representative will need to document the reason for the waiver as well as how they will maintain their health and safety.

The Community Support Worker is not an employee of CDCN or the State of Idaho!

CONSUMER DIRECT CARE NETWORK

My Voice, My Choice

EMPLOYEE DATA FORM

Sample Completed Forms

Employee Information

Name: Alfred (First) Tom (Middle) Smith (Last)

Physical Address: 887 Paradise Rd (Street) Goober (City) ID (State) 12345 (Zip Code)

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

Phone #: Home (208) 555-5578 Cell (____) _____

Email: emailgoeshere@fakemail.com

Gender: ☑ Male ☐ Female Date of Birth: 12/25/1948 Social Security#: 123-45-6789

Employment Relationships

Name of Participant: Tad Phol

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

Employee's relationship to Participant/Employer*: Grandparent

☐ 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.

Alfred Smith _____ *1/5/2021* _____

Employee Signature *Date*

CONSUMER DIRECT CARE NETWORK

My Voice, My Choice

NEW EMPLOYEE (CSW) CHECKLIST

Alfred T Smith	/ /	Tad Phol
Employee Name	Estimated Start Date	Participant Name

Sample Completed Forms

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.

Tad Phol	*1/5/2021*	Tad Phol
Participant Signature	*Date*	*Printed Name*

Date submitted to CDCN: 1/6/2021

00848

CONSUMER DIRECT CARE NETWORK

EMPLOYEE-EMPLOYER RELATIONSHIP DETERMINATION

(Determine if employee is exempt from some payroll taxes)

Alfred T Smith	Tad Phol
Employee Name	Participant (Employer of Record) Name

Background: Employees providing domestic services may be exempt from some payroll taxes. This is based on the Employee's age and relationship to the Employer of Record (Employer). Consumer Direct Care Network (CDCN) will apply any exemptions based on the relationships identified below. **Incorrectly filling this form out may result in inaccurate tax withholdings.**

Note: If the Employee and Employer qualify for tax exemptions, they must be taken. Exemptions 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.

Employee-Employer Relationship

*Employee select **one** relationship below.*

☐ **I am the spouse of the Employer.**
Not allowed to be an employee by Idaho Medicaid rules.

☐ **I am the parent of the Employer** (including adoptive and stepparent).
If parent checked, check any of the following that apply:
- ☐ I provide care for the Employer's child or stepchild that lives in the home.
- ☐ The Employer's child or stepchild is less than 18 years old or requires personal care of an adult for at least 4 straight weeks in 3 months.
- ☐ The Employer is a widow, widower, divorced or married and lives with a spouse, but the spouse has a physical or medical condition that prevents them from caring for the child at least 4 straight weeks in 3 months.

Exempt from FUTA[1] and SUTA[2]. Subject to FICA[3] if all three boxes checked above; else FICA exempt.

☐ **I am the child of the Employer.**
If child checked, check one option below:
- ☐ I am 21 years of age or older. *Subject to FICA, FUTA, and SUTA.*
- ☐ I am less than 21 years old. *Exempt from FICA, FUTA, and SUTA.*

☑ **I am not related to the Employer or my relationship is not described above.**
Subject to FICA, FUTA, and SUTA.

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.

Alfred Smith	1/5/2021	Tad Phol	1/5/2021
Employee Signature	*Date*	*Participant or Legal G. Signature*	*Date*

[1]FUTA – Federal Unemployment Tax Act
[2]SUTA – State Unemployment
[3]FICA – Federal Insurance Contributions Act (Social Security and Medicare)

10897

Sample Completed Forms

CONSUMER DIRECT CARE NETWORK

EMPLOYEE-PARTICIPANT LIVE-IN DETERMINATION

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

Alfred T Smith	Tad Phol
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.

Alfred Smith	*1/5/2021*	*Tad Phol*	*1/5/2021*
Employee Signature	*Date*	*Participant/Legal G. Signature*	*Date*

Sample Completed Forms

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.

Sample Completed Forms

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)*
Smith	Alfred	T	

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code
887 Paradise Rd		Goober	ID	12345

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
12/25/1948	123-45-6789	emailgoeshere@fakemail.com	208 555-5578

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):

- [x] 1. A citizen of the United States
- [ ] 2. A noncitizen national of the United States *(See instructions)*
- [ ] 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____
- [ ] 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
  Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*
Alfred Smith	*1/5/2021*

Preparer and/or Translator Certification (check one):

- [x] I did not use a preparer or translator.
- [ ] A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

03149

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
	Smith	Alfred	T	1

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title: *Driver's License*		Document Title: *Social Security Card*
Issuing Authority		Issuing Authority: *State of Idaho*		Issuing Authority: *SSA*
Document Number		Document Number: *DDFGH11122233344*		Document Number: *123-45-6789*
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*: *12/25/2026*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

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

The employee's first day of employment *(mm/dd/yyyy)*: *1/5/2021* ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
Tad Phol	*1/5/2021*	Employer

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
Phol	Tad	Tad Phol

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code
4505 Frogger Lane	Goober	ID	12345

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

Sample Completed Forms

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

▶ **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
▶ **Give Form W-4 to your employer.**
▶ **Your withholding is subject to review by the IRS.**

OMB No. 1545-0074

2021

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Alfred, T	Smith	123-45-6789

Address: 887 Paradise Rd

City or town, state, and ZIP code: Goober ID, 12345

▶ **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*.

(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 ▶ $ 0

Multiply the number of other dependents by $500 . . . . ▶ $ 0

Add the amounts above and enter the total here . . . . . **3** $ 0

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.

Alfred Smith
Employee's signature (This form is not valid unless you sign it.)

1/5/2021
Date

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)
Tad Pohl, 4505 Frogger Lane, Goober ID, 12345		

Sample Completed Forms

IDAHO State Tax Commission

Form ID W-4
Employee's Withholding Allowance Certificate

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

IDAHO State Tax Commission

Form ID W-4
Employee's Withholding Allowance Certificate

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 0
2. Additional amount (if any) you need withheld from each paycheck (Enter whole dollars) 0

Your Social Security number (required)
123-45-6789

Your first name and initial	Last name
Alfred, T	Smith

Current mailing address		
887 Paradise Rd		
City	State	ZIP Code
Goober	ID	12345

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
Alfred Smith	*1/5/2021*

Sample Completed Forms

CONSUMER DIRECT CARE NETWORK

PAY SELECTION FORM

Employee Name: Alfred T Smith Date of Birth: 12/25/1948

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: Pasco Savings and Loan

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.

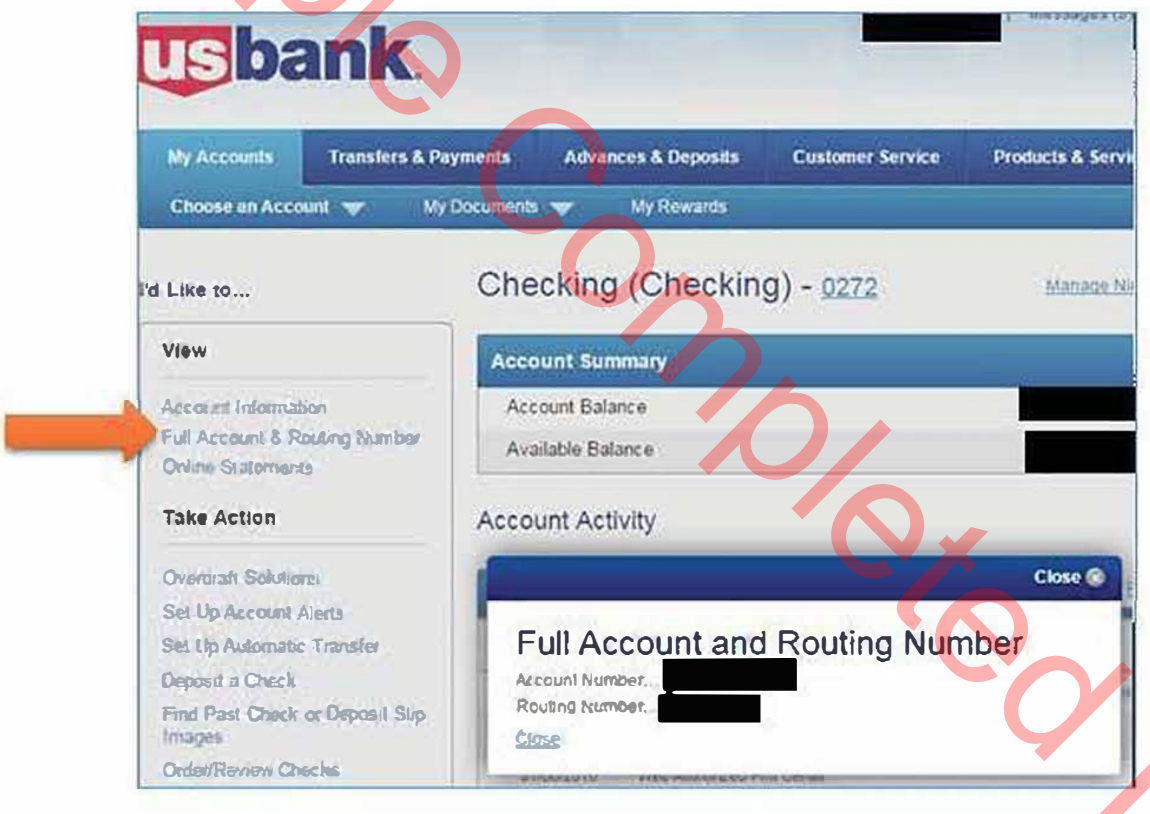
Alfred Smith 1/5/2021

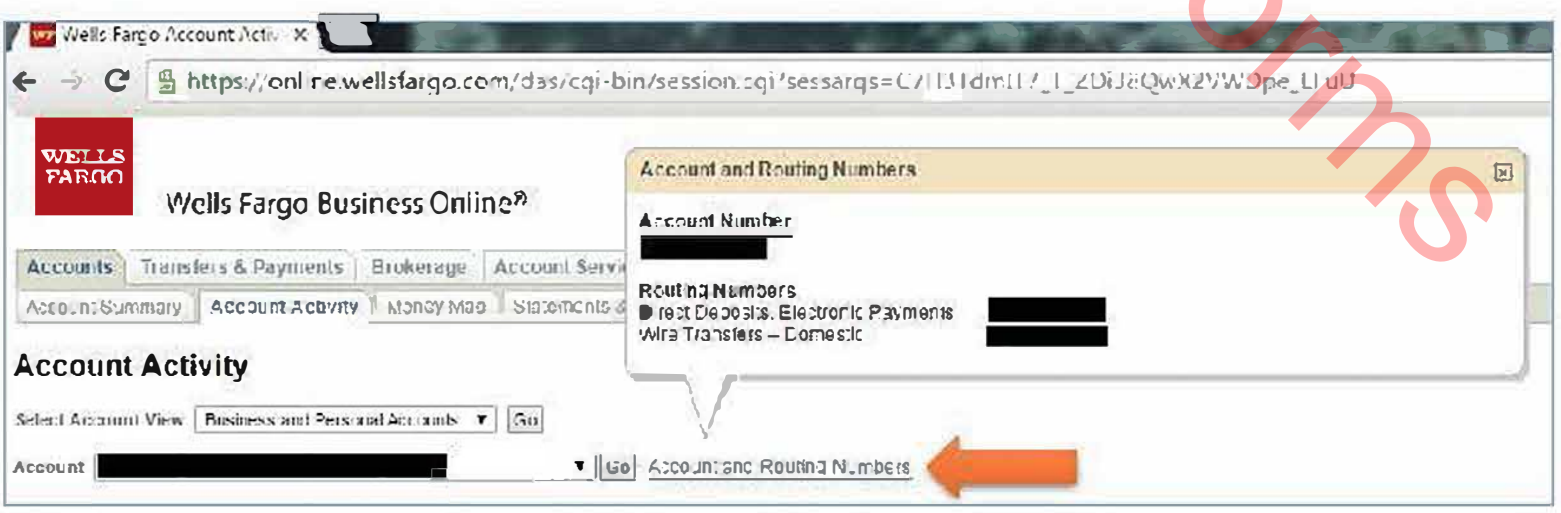
Employee Signature *Date*

Sample Completed Forms

Account and Routing Numbers for Pay Selection Form

Step 1) Login to online banking account.
Step 2) Choose the Account you want numbers for.
Step 3) Find and open the Account & Routing Number section (may have to search for this).
Step 4) Take a screen shot of the numbers and submit with the packet.





Sample Completed Forms

IDAHO DEPARTMENT OF
HEALTH & WELFARE

PARTICIPANT-COMMUNITY SUPPORT WORKER EMPLOYMENT AGREEMENT

This agreement is hereby made between Tad Phol (Participant's Name), a Participant of the Self Directed Community Supports (SDCS) Option, a Medicaid Option administered by the Department of Health and Welfare (Department), and Alfred T Smith (CSW's Name), a Community Support Worker (CSW).

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.

Sample Completed Forms

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.

Sample Completed Forms

13. Terms and conditions of work. **Effective Date:** 1/5/2021.

COLUMN A Service needed	B Type of Support ☑ **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
	☑ Personal PSS ☐ Job JSS ☐ Transportation TSS (hourly) ☐ Learning LSS ☐ Emotional ESS ☐ Skilled Nursing SNS ☐ Relationship RSS ☐ Transportation Mileage Reimbursement (MR)	260	x	$ 10.00	=	$ 2,600.00 Sub-Total
	☐ Personal PSS ☐ Job JSS ☐ Transportation TSS (hourly) ☐ Learning LSS ☐ Emotional ESS ☐ Skilled Nursing SNS ☐ Relationship RSS ☐ Transportation Mileage Reimbursement (MR) ☑ **Code for second rate of pay/hour** PS2 **Fill in code**	192	x	$ 7.25	=	$ 1,392.00 Sub-Total
	☐ Personal PSS ☐ Job JSS ☐ Transportation TSS (hourly) ☐ Learning LSS ☐ Emotional ESS ☐ Skilled Nursing SNS ☐ Relationship RSS ☑ Transportation Mileage Reimbursement (MR) ☐ **Code for second rate of pay/hour** ______ **Fill in code** ☐ **Code for third rate of pay/hour** ______ **Fill in code**	5,000	x	$ 0.50	=	$ 2,500.00 Sub-Total
	☐ Personal PSS ☐ Job JSS ☐ Transportation TSS (hourly) ☐ Learning LSS ☐ Emotional ESS ☐ Skilled Nursing SNS ☐ Relationship RSS ☐ 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		=	$ Sub-Total
	☐ Personal PSS ☐ Job JSS ☐ Transportation TSS (hourly) ☐ Learning LSS ☐ Emotional ESS ☐ Skilled Nursing SNS ☐ Relationship RSS ☐ 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		=	$ Sub-Total
	☐ Personal PSS ☐ Job JSS ☐ Transportation TSS (hourly) ☐ Learning LSS ☐ Emotional ESS ☐ Skilled Nursing SNS ☐ Relationship RSS ☐ 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		=	$ Sub-Total
					Total Cost of Agreement:	$ 6,492.00

Sample Completed Forms

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:

Alfred has knowledge of participant's needs add knows how to handle them.

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. *Tad Phol*
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.

Tad Phol	*1/5/2021*
PARTICIPANT	Date
LEGAL GUARDIAN (IF APPLICABLE)	Date
Alfred Smith	*1/5/2021*
CSW	Date

04889

Sample Completed Forms

IDAHO DEPARTMENT OF HEALTH & WELFARE

Idaho Department of Health and Welfare
Self ~ Directed Community Supports Option

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 Alfred T Smith, 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.

00860

Sample Completed Forms

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.

Alfred T Smith

Printed name of CSW

Alfred Smith *1/5/2021*

Signature of CSW Date

Note: Each CSW must sign personally.

Sample Completed Forms

00861

IDAHO DEPARTMENT OF
HEALTH & WELFARE

Criminal History Check
Waiver of Liability - Assumption of Risk

Participant Name: Tad Phol **MID #** _____ **Date:** 1/5/2021

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

Relationship to the Participant: Grandparent

Description of Service: CSW

Reason:

He is family and I trust him.

I Will Make Sure I am Healthy and Safe by: I will let my family know if I don't feel safe.

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.

Tad Phol 1/5/2021
Signature of Individual Date

Signature of Legal Guardian (if applicable) Date

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

Comments:

Stanley Cupp 1/5/2021
Signature of Support Broker Date

Sample Completed Forms