



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#: _____-_____-_____

Name of Participant (Child Receiving Services): _____

Name of Child's Parent/Guardian: _____

Employee's relationship to Child/Employer*: _____

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

**The child receiving services is the Employer of Record. By program rule, the parent, step parent, or guardian of the program recipient (child named above) is not allowed to be a paid employee in the Family Directed Services option.*

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

Date _____





Family-Directed Services
NEW EMPLOYEE (CSW) CHECKLIST

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

Parent/Legal Rep. Signature

Date

Printed Name

Date submitted to CDCN: ____/____/____





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 no later than your first day of work for pay. Print clearly. Sign and date when you are finished. Numbered explanations below are shown in the pictured example.

- ① Print your full legal name: Last, First and Middle Initial. Provide any other last names used, such as maiden name. Enter "N/A" if you have never had another name.
- ② Print your physical address. A PO Box is not allowed. Enter "N/A" if you have no apartment number.
- ③ Print your Date of Birth.
- 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 one box that describes your citizenship or immigration status in the United States. Enter additional information if you check boxes 3 or 4.
- ⑧ Sign and ⑨ date the form. **No later than first day of work for pay.**
- ⑩ Submit Supplement A (*Preparer and/or Translator Certification*) if a preparer or translator assisted you.

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

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 (if any) Q	Other Last Names Used (if any) N/A
Address (Street Number and Name) ② 123 Main St.		Apt. Number (if any) N/A	City or Town Anytown		State ID ZIP Code 85032
Date of Birth (mm/dd/yyyy) ③ 03/13/1964	U.S. Social Security Number ④ 1 2 3 4 5 6 7 8 9		Employee's Email 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 the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.		⑦ Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):			
		<input checked="" type="checkbox"/> 1. A citizen of the United States			
		<input type="checkbox"/> 2. A noncitizen national of the United States (See instructions)			
		<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)			
		<input type="checkbox"/> 4. A noncitizen (other than Item Numbers 2. and 3. above) authorized to work until (exp. date, if any)			
		If you check Item Number 4., enter one of these:			
		USCIS A-Number		OR	Form I-94 Admission Number
				OR	Foreign Passport Number and Country of Issuance
Signature of Employee ⑧ Jane Doe			Today's Date (mm/dd/yyyy) ⑨ 09/15/2023		
If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.					

Note: Refer to Form I-9 Instructions for detailed information.

Instructions for Completing Form I-9 Section 2

(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. See **LISTS OF ACCEPTABLE DOCUMENTS**.

Employer: Examine and record the documents your employee provides. The employee must be present while you examine them. Numbered explanations below are shown in the pictured example.

- ① Examine each document. Print the details in the appropriate List column(s). Only accept unexpired, original documents (no photocopies).
You may accept one document from List A **OR** one from List B and one from List C.
- ② Print the date of the employee's first day of work.
- ③ Print your last name, first name and title. Title is "Employer."
- ④ Sign and ⑤ date the form. **Must be completed and signed within 3 days of employee's first day of work.**
- ⑥ Print your first and last name.
- ⑦ Print physical address where services are provided (the Participant's home).

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS , documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.			
	List A	OR	List B AND List C
Document Title 1		①	<i>Driver's License</i> <i>Social Security Card</i>
Issuing Authority			<i>State of Residence</i> <i>SSA</i>
Document Number (if any)			<i>0123456789abode</i> <i>123-45-6789</i>
Expiration Date (if any)			<i>08/17/2027</i> <i>N/A</i>
Document Title 2 (if any)		Additional Information	
Issuing Authority		<div style="text-align: center; font-size: 4em; color: #8B0000;">Example</div> <div style="text-align: center; color: red; font-weight: bold;">⚡ Do not check. You must physically examine documents.</div> <div><input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.</div>	
Document Number (if any)			
Expiration Date (if any)			
Document Title 3 (if any)			
Issuing Authority			
Document Number (if any)			
Expiration Date (if any)			
Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.			First Day of Employment (mm/dd/yyyy): ② <i>09/15/2023</i>
Last Name, First Name and Title of Employer or Authorized Representative ③ <i>Smith, Ronald Employer</i>		Signature of Employer or Authorized Representative ④ <i>Ronald Smith</i>	Today's Date (mm/dd/yyyy) ⑤ <i>09/15/2023</i>
Employer's Business or Organization Name ⑥ <i>Ronald Smith</i>	Employer's Business or Organization Address, City or Town, State, ZIP Code ⑦ <i>500 Fictional Street, Anytown ID 85018</i>		

For reverification or rehire, complete [Supplement B, Reverification and Rehire](#) on Page 4.

Note: Refer to 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 07/31/2026

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

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

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

Last Name (Family Name)		First Name (Given Name)		Middle Initial (if any)	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number (if any)	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number <div></div>		Employee's Email Address			Employee's Telephone Number
I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.		Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):				
		<input type="checkbox"/> 1. A citizen of the United States				
		<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)				
		<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)				
		<input type="checkbox"/> 4. A noncitizen (other than Item Numbers 2. and 3. above) authorized to work until (exp. date, if any)				
		If you check Item Number 4. , enter one of these:				
		USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance
Signature of Employee					Today's Date (mm/dd/yyyy)	

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

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

List A		OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)		Additional Information			
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority		Check here if you used an alternative procedure authorized by DHS to examine documents.			
Document Number (if any)					
Expiration Date (if any)					
Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.					First Day of Employment (mm/dd/yyyy):
Last Name, First Name and Title of Employer or Authorized Representative			Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)
Employer's Business or Organization Name			Employer's Business or Organization Address, City or Town, State, ZIP Code		

For reverification or rehire, complete [Supplement B, Reverification and Rehire](#) on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.

* Documents extended by the issuing authority are considered unexpired.

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

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND LIST C Documents that Establish Employment Authorization
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (2) An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 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 		<ol style="list-style-type: none"> 1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority 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 	<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security <p style="margin-left: 20px;">For examples, see Section 7 and Section 13 of the M-274 on uscis.gov/i-9-central.</p> <p style="margin-left: 20px;">The Form I-766, Employment Authorization Document, is a List A, Item Number 4. document, not a List C document.</p>
Acceptable Receipts May be presented in lieu of a document listed above for a temporary period. For receipt validity dates, see the M-274.			
<ul style="list-style-type: none"> • Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee. 	OR	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on [I-9 Central](#) for more information.





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

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

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

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

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

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

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

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

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

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

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

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

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



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.

2024**Step 1:**
Enter
Personal
Information

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

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

Step 2:
Multiple Jobs
or Spouse
Works

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

Do **only one** of the following.

- (a) Use the estimator at www.irs.gov/W4App for most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**
- (b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**
- (c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate ☐

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

Step 3: Claim Dependent and Other Credits	If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly): Multiply the number of qualifying children under age 17 by \$2,000 \$ _____ Multiply the number of other dependents by \$500 \$ _____ Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here	3	\$			
	Step 4 (optional): Other Adjustments			(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income	4(a)	\$
	(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here			4(b)	\$	
	(c) Extra withholding. Enter any additional tax you want withheld each pay period . .	4(c)	\$			

Step 5:
Sign
Here

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

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

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

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2024 if you meet both of the following conditions: you had no federal income tax liability in 2023 **and** you expect to have no federal income tax liability in 2024. You had no federal income tax liability in 2023 if (1) your total tax on line 24 on your 2023 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2024 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2025.

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

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

1. Expect to work only part of the year;
2. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or
3. Prefer the most accurate withholding for multiple job situations.

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

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

Specific Instructions

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

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

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

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



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

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2024 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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



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

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

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

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

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

- 1** Enter an estimate of your 2024 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 7.5% of your income **1** \$ _____
- 2** Enter:

{	• \$29,200 if you're married filing jointly or a qualifying surviving spouse • \$21,900 if you're head of household • \$14,600 if you're single or married filing separately	}	2 \$ _____
---	--	---	-----------	-------------------
- 3** If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" **3** \$ _____
- 4** Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information **4** \$ _____
- 5 Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 **5** \$ _____

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

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

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

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



Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$0	\$780	\$850	\$940	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,370
\$10,000 - 19,999	0	780	1,780	1,940	2,140	2,220	2,220	2,220	2,220	2,220	2,570	3,570
\$20,000 - 29,999	780	1,780	2,870	3,140	3,340	3,420	3,420	3,420	3,420	3,770	4,770	5,770
\$30,000 - 39,999	850	1,940	3,140	3,410	3,610	3,690	3,690	3,690	4,040	5,040	6,040	7,040
\$40,000 - 49,999	940	2,140	3,340	3,610	3,810	3,890	3,890	4,240	5,240	6,240	7,240	8,240
\$50,000 - 59,999	1,020	2,220	3,420	3,690	3,890	3,970	4,320	5,320	6,320	7,320	8,320	9,320
\$60,000 - 69,999	1,020	2,220	3,420	3,690	3,890	4,320	5,320	6,320	7,320	8,320	9,320	10,320
\$70,000 - 79,999	1,020	2,220	3,420	3,690	4,240	5,320	6,320	7,320	8,320	9,320	10,320	11,320
\$80,000 - 99,999	1,020	2,220	3,620	4,890	6,090	7,170	8,170	9,170	10,170	11,170	12,170	13,170
\$100,000 - 149,999	1,870	4,070	6,270	7,540	8,740	9,820	10,820	11,820	12,830	14,030	15,230	16,430
\$150,000 - 239,999	1,960	4,360	6,760	8,230	9,630	10,910	12,110	13,310	14,510	15,710	16,910	18,110
\$240,000 - 259,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
\$260,000 - 279,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
\$280,000 - 299,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,380
\$300,000 - 319,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,980	17,980	19,980
\$320,000 - 364,999	2,040	4,440	6,840	8,310	9,710	11,280	13,280	15,280	17,280	19,280	21,280	23,280
\$365,000 - 524,999	2,720	6,010	9,510	12,080	14,580	16,950	19,250	21,550	23,850	26,150	28,450	30,750
\$525,000 and over	3,140	6,840	10,540	13,310	16,010	18,590	21,090	23,590	26,090	28,590	31,090	33,590

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$240	\$870	\$1,020	\$1,020	\$1,020	\$1,540	\$1,870	\$1,870	\$1,870	\$1,870	\$1,910	\$2,040
\$10,000 - 19,999	870	1,680	1,830	1,830	2,350	3,350	3,680	3,680	3,680	3,720	3,920	4,050
\$20,000 - 29,999	1,020	1,830	1,980	2,510	3,510	4,510	4,830	4,830	4,870	5,070	5,270	5,400
\$30,000 - 39,999	1,020	1,830	2,510	3,510	4,510	5,510	5,830	5,870	6,070	6,270	6,470	6,600
\$40,000 - 59,999	1,390	3,200	4,360	5,360	6,360	7,370	7,890	8,090	8,290	8,490	8,690	8,820
\$60,000 - 79,999	1,870	3,680	4,830	5,840	7,040	8,240	8,770	8,970	9,170	9,370	9,570	9,700
\$80,000 - 99,999	1,870	3,690	5,040	6,240	7,440	8,640	9,170	9,370	9,570	9,770	9,970	10,810
\$100,000 - 124,999	2,040	4,050	5,400	6,600	7,800	9,000	9,530	9,730	10,180	11,180	12,180	13,120
\$125,000 - 149,999	2,040	4,050	5,400	6,600	7,800	9,000	10,180	11,180	12,180	13,180	14,180	15,310
\$150,000 - 174,999	2,040	4,050	5,400	6,860	8,860	10,860	12,180	13,180	14,230	15,530	16,830	18,060
\$175,000 - 199,999	2,040	4,710	6,860	8,860	10,860	12,860	14,380	15,680	16,980	18,280	19,580	20,810
\$200,000 - 249,999	2,720	5,610	8,060	10,360	12,660	14,960	16,590	17,890	19,190	20,490	21,790	23,020
\$250,000 - 399,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
\$400,000 - 449,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
\$450,000 and over	3,140	6,450	9,110	11,610	14,110	16,610	18,430	19,930	21,430	22,930	24,430	25,870

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$510	\$850	\$1,020	\$1,020	\$1,020	\$1,020	\$1,220	\$1,870	\$1,870	\$1,870	\$1,960
\$10,000 - 19,999	510	1,510	2,020	2,220	2,220	2,220	2,420	3,420	4,070	4,070	4,160	4,360
\$20,000 - 29,999	850	2,020	2,560	2,760	2,760	2,960	3,960	4,960	5,610	5,700	5,900	6,100
\$30,000 - 39,999	1,020	2,220	2,760	2,960	3,160	4,160	5,160	6,160	6,900	7,100	7,300	7,500
\$40,000 - 59,999	1,020	2,220	2,810	4,010	5,010	6,010	7,070	8,270	9,120	9,320	9,520	9,720
\$60,000 - 79,999	1,070	3,270	4,810	6,010	7,070	8,270	9,470	10,670	11,520	11,720	11,920	12,120
\$80,000 - 99,999	1,870	4,070	5,670	7,070	8,270	9,470	10,670	11,870	12,720	12,920	13,120	13,450
\$100,000 - 124,999	2,020	4,420	6,160	7,560	8,760	9,960	11,160	12,360	13,210	13,880	14,880	15,880
\$125,000 - 149,999	2,040	4,440	6,180	7,580	8,780	9,980	11,250	13,250	14,900	15,900	16,900	17,900
\$150,000 - 174,999	2,040	4,440	6,180	7,580	9,250	11,250	13,250	15,250	16,900	18,030	19,330	20,630
\$175,000 - 199,999	2,040	4,510	7,050	9,250	11,250	13,250	15,250	17,530	19,480	20,780	22,080	23,380
\$200,000 - 249,999	2,720	5,920	8,620	11,120	13,420	15,720	18,020	20,320	22,270	23,570	24,870	26,170
\$250,000 - 449,999	2,970	6,470	9,310	11,810	14,110	16,410	18,710	21,010	22,960	24,260	25,560	26,860
\$450,000 and over	3,140	6,840	9,880	12,580	15,080	17,580	20,080	22,580	24,730	26,230	27,730	29,230



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, 2024. 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:	\$15	\$31	\$33	\$67

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 2024? (Don't count your primary job.)
2. Multiply the number on line 1 by \$13,850
3. Enter an estimate of your 2024 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 \$3,534.....
7. Subtract line 6 from line 4
8. Multiply line 7 by 5.8% (.058). 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 2024. 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



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 and W-2s are sent to you by mail to your address on file or electronically.

Please check one pay option below.

Note: You will be enrolled in the Wisely Pay card option if (1) you make no selection below, or (2) you select direct deposit to a bank account but provide invalid account information or your account is closed.

- ☐ **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, or an improper payment is made, 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





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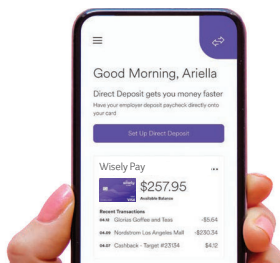


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² You must log in to the myWisely app or mywisely.com to opt-in to early direct deposit. Early direct deposit of funds is not guaranteed and is subject to the timing of payor's payment instruction. Faster funding claim is based on a comparison of our policy of making funds available upon our receipt of payment instruction with the typical banking practice of posting funds at settlement. Please see full disclosures on mywisely.com or the myWisely app. If you have a Wisely Pay or Wisely Cash card (see back of your card), this feature requires an upgrade which may not be available to all cardholders. Please allow up to 3 weeks after your initial setup of direct deposit for your pay to start loading to your card.

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

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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 Family-Directed Community Supports (FDCS) 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 FDCS 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 FDCS Support and Spending Plan, and the Consumer Directed Community Supports 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 FDCS 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 FDCS 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 FDCS 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
	<input type="checkbox"/> Personal PSS <input type="checkbox"/> Emotional ESS <input type="checkbox"/> Job JSS <input type="checkbox"/> Skilled Nursing SNS <input type="checkbox"/> Transportation TSS (hourly) <input type="checkbox"/> Relationship RSS <input type="checkbox"/> Learning LSS <input type="checkbox"/> Transportation Mileage Reimbursement (MR)		x	= \$
	<input type="checkbox"/> Personal PSS <input type="checkbox"/> Emotional ESS <input type="checkbox"/> Job JSS <input type="checkbox"/> Skilled Nursing SNS <input type="checkbox"/> Transportation TSS (hourly) <input type="checkbox"/> Relationship RSS <input type="checkbox"/> Learning LSS <input type="checkbox"/> Transportation Mileage Reimbursement (MR) <input type="checkbox"/> Code for second rate of pay/hour _____ Fill in code		x	= \$
	<input type="checkbox"/> Personal PSS <input type="checkbox"/> Emotional ESS <input type="checkbox"/> Job JSS <input type="checkbox"/> Skilled Nursing SNS <input type="checkbox"/> Transportation TSS (hourly) <input type="checkbox"/> Relationship RSS <input type="checkbox"/> Learning LSS <input type="checkbox"/> Transportation Mileage Reimbursement (MR) <input type="checkbox"/> Code for second rate of pay/hour _____ Fill in code <input type="checkbox"/> Code for third rate of pay/hour _____ Fill in code		x	= \$
	<input type="checkbox"/> Personal PSS <input type="checkbox"/> Emotional ESS <input type="checkbox"/> Job JSS <input type="checkbox"/> Skilled Nursing SNS <input type="checkbox"/> Transportation TSS (hourly) <input type="checkbox"/> Relationship RSS <input type="checkbox"/> Learning LSS <input type="checkbox"/> Transportation Mileage Reimbursement (MR) <input type="checkbox"/> Code for second rate of pay/hour _____ Fill in code <input type="checkbox"/> Code for third rate of pay/hour _____ Fill in code		x	= \$
	<input type="checkbox"/> Personal PSS <input type="checkbox"/> Emotional ESS <input type="checkbox"/> Job JSS <input type="checkbox"/> Skilled Nursing SNS <input type="checkbox"/> Transportation TSS (hourly) <input type="checkbox"/> Relationship RSS <input type="checkbox"/> Learning LSS <input type="checkbox"/> Transportation Mileage Reimbursement (MR) <input type="checkbox"/> Code for second rate of pay/hour _____ Fill in code <input type="checkbox"/> Code for third rate of pay/hour _____ Fill in code		x	= \$
	<input type="checkbox"/> Personal PSS <input type="checkbox"/> Emotional ESS <input type="checkbox"/> Job JSS <input type="checkbox"/> Skilled Nursing SNS <input type="checkbox"/> Transportation TSS (hourly) <input type="checkbox"/> Relationship RSS <input type="checkbox"/> Learning LSS <input type="checkbox"/> Transportation Mileage Reimbursement (MR) <input type="checkbox"/> Code for second rate of pay/hour _____ Fill in code <input type="checkbox"/> Code for third rate of pay/hour _____ Fill in code		x	= \$
	<input type="checkbox"/> Personal PSS <input type="checkbox"/> Emotional ESS <input type="checkbox"/> Job JSS <input type="checkbox"/> Skilled Nursing SNS <input type="checkbox"/> Transportation TSS (hourly) <input type="checkbox"/> Relationship RSS <input type="checkbox"/> Learning LSS <input type="checkbox"/> Transportation Mileage Reimbursement (MR) <input type="checkbox"/> Code for second rate of pay/hour _____ Fill in code <input type="checkbox"/> Code for third rate of pay/hour _____ Fill in code		x	= \$
Total Cost of Agreement:				\$

04888



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

Age Criteria for CSWs (applies to Non-Waiver and Waiver eligible participants):

- Minimum age of in-home worker, with adult caretaker present: 16
- Minimum age of community support, skill building or behavior management: 18
- Minimum age to transport into community: 18

☐ The CSW meets the above age criteria.

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.
- Completion of a 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. _____

Parent or Legal Guardian Signature

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

PARTICIPANT

Date

LEGAL GUARDIAN (IF APPLICABLE)

Date

CSW

Date

04889





Family-Directed Community Supports Option

MEDICAID – COMMUNITY SUPPORT WORKER AGREEMENT

This agreement is hereby made between the Family-Directed Community Supports (FDCS) 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 FDCS Option, the Department, through the Fiscal Employer Agent (FEA) is the source of payment for the CSW's wages for services performed under the FDCS 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 FDCS 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 FDCS 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 FDCS rules, the employment agreement with the participant, and 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 FDCS Option. As a provider the CSW agrees to accept payment received by the FEA as payment in full for services rendered under the FDCS 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 FDCS 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





IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

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

Relationship to the Participant: _____

Description of Service: _____

Reason: _____

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

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

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

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

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

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

Comments: _____

Signature of Support Broker _____ Date _____





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

In the My Voice, My Choice and Family Directed Services programs, Idaho Medicaid prohibits employees from working more than 40 hours per week unless they are 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. 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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00540 - Delete



2024 Payroll Calendar

Symbol Key:



Time Due



Pay Day



Postal and Bank Holiday

JANUARY							FEBRUARY							MARCH						
Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat
	1	2	3	4	5	6					1	2	3						1	2
7	8	9	10	11	12	13	4	5	6	7	8	9	10	3	4	5	6	7	8	9
14	15	16	17	18	19	20	11	12	13	14	15	16	17	10	11	12	13	14	15	16
21	22	23	24	25	26	27	18	19	20	21	22	23	24	17	18	19	20	21	22	23
28	29	30	31				25	26	27	28	29			24	25	26	27	28	29	30
														31						
APRIL							MAY							JUNE						
Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat
	1	2	3	4	5	6				1	2	3	4							1
7	8	9	10	11	12	13	5	6	7	8	9	10	11	2	3	4	5	6	7	8
14	15	16	17	18	19	20	12	13	14	15	16	17	18	9	10	11	12	13	14	15
21	22	23	24	25	26	27	19	20	21	22	23	24	25	16	17	18	19	20	21	22
28	29	30					26	27	28	29	30	31		23	24	25	26	27	28	29
														30						
JULY							AUGUST							SEPTEMBER						
Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat
	1	2	3	4	5	6					1	2	3	1	2	3	4	5	6	7
7	8	9	10	11	12	13	4	5	6	7	8	9	10	8	9	10	11	12	13	14
14	15	16	17	18	19	20	11	12	13	14	15	16	17	15	16	17	18	19	20	21
21	22	23	24	25	26	27	18	19	20	21	22	23	24	22	23	24	25	26	27	28
28	29	30	31				25	26	27	28	29	30	31	29	30					
OCTOBER							NOVEMBER							DECEMBER						
Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat
		1	2	3	4	5						1	2	1	2	3	4	5	6	7
6	7	8	9	10	11	12	3	4	5	6	7	8	9	8	9	10	11	12	13	14
13	14	15	16	17	18	19	10	11	12	13	14	15	16	15	16	17	18	19	20	21
20	21	22	23	24	25	26	17	18	19	20	21	22	23	22	23	24	25	26	27	28
27	28	29	30	31			24	25	26	27	28	29	30	29	30	31				

2024 Bank & Post Office Holidays

*Consumer Direct Care Network office closures

*New Year's Day - Monday, January 1

*Martin Luther King, Jr. Day - Monday, January 15

Presidents Day - Monday, February 19

*Memorial Day - Monday, May 27

*Juneteenth - Wednesday, June 19

*Independence Day - Thursday, July 4

*Labor Day - Monday, September 2

Columbus Day - Monday, October 14

*Veterans Day - Monday, November 11

*Thanksgiving Day - Thursday, November 28

*Christmas Day - Wednesday, December 25



Work weeks are Sunday through Saturday. Time must be submitted by MONDAY at MIDNIGHT following the two-week pay period. Late time or time with mistakes may result in late pay. Thank you!

Two Week Pay Period		Timesheet Due	Pay Date
Start Date	End Date		
Sunday	Saturday	Monday	Friday
12/17/2023	12/30/2023	1/1/2024	1/12/2024
12/31/2023	1/13/2024	1/15/2024	1/26/2024
1/14/2024	1/27/2024	1/29/2024	2/9/2024
1/28/2024	2/10/2024	2/12/2024	2/23/2024
2/11/2024	2/24/2024	2/26/2024	3/8/2024
2/25/2024	3/9/2024	3/11/2024	3/22/2024
3/10/2024	3/23/2024	3/25/2024	4/5/2024
3/24/2024	4/6/2024	4/8/2024	4/19/2024
4/7/2024	4/20/2024	4/22/2024	5/3/2024
4/21/2024	5/4/2024	5/6/2024	5/17/2024
5/5/2024	5/18/2024	5/20/2024	5/31/2024
5/19/2024	6/1/2024	6/3/2024	6/14/2024
6/2/2024	6/15/2024	6/17/2024	6/28/2024
6/16/2024	6/29/2024	7/1/2024	7/12/2024
6/30/2024	7/13/2024	7/15/2024	7/26/2024
7/14/2024	7/27/2024	7/29/2024	8/9/2024
7/28/2024	8/10/2024	8/12/2024	8/23/2024
8/11/2024	8/24/2024	8/26/2024	9/6/2024
8/25/2024	9/7/2024	9/9/2024	9/20/2024
9/8/2024	9/21/2024	9/23/2024	10/4/2024
9/22/2024	10/5/2024	10/7/2024	10/18/2024
10/6/2024	10/19/2024	10/21/2024	11/1/2024
10/20/2024	11/2/2024	11/4/2024	11/15/2024
11/3/2024	11/16/2024	11/18/2024	11/27/2024 (Wed.)
11/17/2024	11/30/2024	12/2/2024	12/13/2024
12/1/2024	12/14/2024	12/16/2024	12/27/2024
12/15/2024	12/28/2024	12/30/2024	1/10/2025
12/29/2024	1/11/2025	1/13/2025	1/24/2025

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