EMPLOYER MANUAL

FAMILY DIRECTED SERVICES

FISCAL EMPLOYER AGENT

Idaho Consumer Direct
280 East Corporate Drive, Suite 210
Meridian, ID 83642-2953

Phone: (208) 898-0470
Toll Free Phone: 888-898-0470
Fax: (208) 898-0417
Toll Free Fax: 877-898-0417

Website: www.consumerdirectID.com
Email: infoCDID@consumerdirectonline.net

Revised October 13, 2014

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Idaho Consumer Direct Contacts

280 East Corporate Drive, Suite 210
Meridian, ID 83642-2953
Phone: (208) 898-0470 Fax: (208) 898-0417
E-mail: infoCDID@consumerdirectonline.net
Website: www.ConsumerDirectID.com

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Office Coordinator

Shelly Gray	Front Desk	Main Line

Program Manager

Janilee Macleod	Main Line

Provide quality services to individuals and families so they can remain in their homes and communities.

Consumer Direct 2014

Time Sheets Due

Pay Day

1 Post Office Holiday

Daylight Saving Time

Paychecks are mailed on the Thursday prior to Friday Pay Day. Delivery to you depends on your local postal service. If USPS delivery is a problem, please consider Direct Deposit.

JANUARY

Sun	Mon	Tues	Wed	Thurs	Fri	Sat
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
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FEBRUARY

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MARCH

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APRIL

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MAY

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JUNE

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JULY

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AUGUST

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SEPTEMBER

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OCTOBER

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NOVEMBER

Sun	Mon	Tues	Wed	Thurs	Fri	Sat
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DECEMBER

Sun	Mon	Tues	Wed	Thurs	Fri	Sat
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7	8	9	10	11	12	13
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21	22	23	24	25	26	27
28	29	30	31			

Consumer Direct Idaho

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Toll free: 1-888-898-0470 Fax toll free: 1-877-898-0417

www.ConsumerDirectID.com InfoCDID@ConsumerDirectOnline.net

2014 Pay Periods, Pay Dates and Holidays

IMPORTANT

Work weeks are Sundays through Saturdays. Paper time sheets are due **no later** than **MIDNIGHT** on the **Monday following the pay period**. Online time must be approved no later than midnight on the Wednesday following the pay period. Due to office closures and time constraints on holidays, time sheets submitted late or with errors will not be processed until the following pay period.

Please consider Direct Deposit

Pay Period-Week 1 Sun through Sat	**Pay Period**-Week 2 Sun through Sat	**Timesheets Due into CDID**	**Pay Date** (for Week 1 and Week 2)
12/15/13 to 12/21/13	12/22/13 to 12/28/13	12/30/13	01/10/14
12/29/13 to 01/04/14	01/05/14 to 01/11/14	01/13/14	01/24/14
01/12/14 to 01/18/14	01/19/14 to 01/25/14	01/27/14	02/07/14
01/26/14 to 02/01/14	02/02/14 to 02/08/14	02/10/14	02/21/14
02/09/14 to 02/15/14	02/16/14 to 02/22/14	02/24/14	03/07/14
02/23/14 to 03/01/14	03/02/14 to 03/08/14	03/10/14	03/21/14
03/09/14 to 03/15/14	03/16/14 to 03/22/14	03/24/14	04/04/14
03/23/14 to 03/29/14	03/30/14 to 04/05/14	04/07/14	04/18/14
04/06/14 to 04/12/14	04/13/14 to 04/19/14	04/21/14	05/02/14
04/20/14 to 04/26/14	04/27/14 to 05/03/14	05/05/14	05/16/14
05/04/14 to 05/10/14	05/11/14 to 05/17/14	05/19/14	05/30/14
05/18/14 to 05/24/14	05/25/14 to 05/31/14	06/02/14	06/13/14
06/01/14 to 06/07/14	06/08/14 to 06/14/14	06/16/14	06/27/14
06/15/14 to 06/21/14	06/22/14 to 06/28/14	06/30/14	07/11/14
06/29/14 to 07/05/14	07/06/14 to 07/12/14	07/14/14	07/25/14
07/13/14 to 07/19/14	07/20/14 to 07/26/14	07/28/14	08/08/14
07/27/14 to 08/02/14	08/03/14 to 08/09/14	08/11/14	08/22/14
08/10/14 to 08/16/14	08/17/14 to 08/23/14	08/25/14	09/05/14
08/24/14 to 08/30/14	08/31/14 to 09/06/14	09/08/14	09/19/14
09/07/14 to 09/13/14	09/14/14 to 09/20/14	09/22/14	10/03/14
09/21/14 to 09/27/14	09/28/14 to 10/04/14	10/06/14	10/17/14
10/05/14 to 10/11/14	10/12/14 to 10/18/14	10/20/14	10/31/14
10/19/14 to 10/25/14	10/26/14 to 11/01/14	11/03/14	11/14/14
11/02/14 to 11/08/14	11/09/14 to 11/15/14	11/17/14	11/28/14
11/16/14 to 11/22/14	11/23/14 to 11/29/14	12/01/14	12/12/14
11/30/14 to 12/06/14	12/07/14 to 12/13/14	12/15/14	12/26/14
12/14/14 to 12/20/14	12/21/14 to 12/27/14	12/29/14	01/09/15
12/28/14 to 01/03/15	01/04/15 to 01/10/15	01/12/15	01/23/15

2014 Bank & Post Office Holidays

- **New Year's Day-** Wednesday, Jan. 1
- **Martin Luther King Day-** Monday, Jan. 20
- **President's Day-** Monday, Feb. 17
- **Memorial Day-** Monday, May 26
- **Independence Day-** Friday, July 4
- **Labor Day-** Monday, Sept. 1
- **Columbus Day-** Monday, Oct. 13
- **Veteran's Day-** Tuesday, Nov. 11
- **Thanksgiving-** Thursday, Nov. 27
- **Christmas Day-** Thursday, Dec. 25

Consumer Direct Office Holidays and Closures

- **New Year's Day-** Wednesday, Jan. 1
- **Memorial Day-** Monday, May 26
- **Independence Day-** Friday, July 4
- **Labor Day-** Monday, Sept. 1
- **Thanksgiving-** Thursday, Nov. 27
- **Christmas Day-** Thursday, Dec. 25

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this Company properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This Notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed below.

Privacy Officer:
Mickey Ogg, Compliance Officer
(406) 532-1900; (888) 532-1907

Effective Date:
April 1, 2003; Revised March 26, 2013

1. Below is a description, including at least one (1) example, of the types of uses and disclosures that this Company is permitted to make for each of the following purposes: treatment, payment and health care operations.

   Disclosures to other health care providers, including, for example, to patients' attending physicians. Submission of claims and supporting documentation including, for example, to organizations responsible to pay for services provided by this Company. Disclosures to conduct the operations of this Company, including, for example, sharing information to supervisors of those who provide care to patients.

2. Below is a description of each of the other purposes for which this Company is permitted or required to use or disclose protected health information without an individual's written consent or authorization.

   To patients, incident to another permitted use or disclosure, by agreement, to the Secretary of the U.S. Department of Health and Human Services, as required by law, for public health activities, information about victims of abuse, neglect or domestic violence, health oversight activities, for judicial and administrative proceedings, for law enforcement proceedings, about decedents, for cadaveric organ, eye or tissue donation, for research purposes, to avert a serious threat to health or safety, for specific government functions, to business associates of this Company, to personal representatives, de-identified information, to workforce members who are victims of crimes, to

workers' compensation programs, for involvement in the individual's care and for notification purposes, with the individual present, for limited uses and disclosures when the individual is not present, and for disaster relief purposes.

3. Other uses and disclosures, such as disclosure of psychotherapy notes, use of protected health information for marketing activities and the sale of protected health information, will be made only with the individual's written authorization and the individual may revoke such authorization.

4. The Company may contact the individual to schedule visits and for other coordination of care activities.

5. The individual has the right to request further restrictions on certain uses and disclosures of protected health information, but this Company is not required to agree to any requested restriction(s), except disclosures must be restricted to health plans if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and the protected health information pertains solely to a health care item or service for which the individual or person other than the health plan, on behalf of the individual, has paid this Company in full.

6. The individual has the right to receive confidential communications of protected health information, the right to inspect and copy protected health information, the right to amend protected health information, the right to receive an accounting of disclosures of protected health information and the right to obtain a paper copy of this Notice from the Company upon request.

7. This Company is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information and to notify affected individuals following a breach of unsecured protected health information.

8. This Company is required to abide by the terms of this Notice currently in effect.

9. This Company reserves the right to change the terms of its Notice and to make the new notice provisions effective for all protected health information that it maintains. Individuals may obtain a revised copy of this Notice upon request.

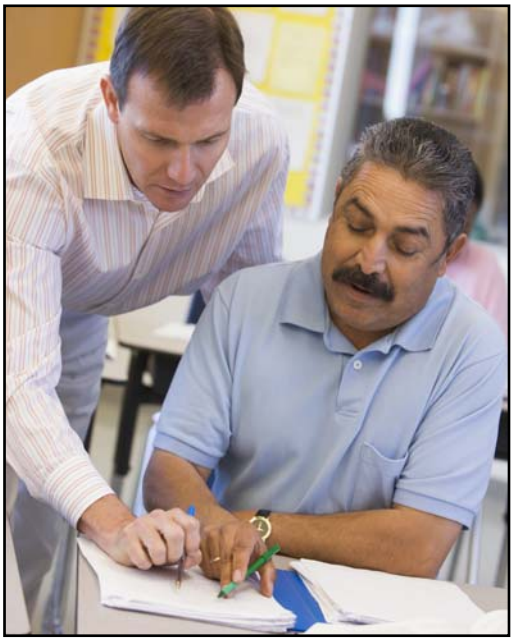
10. Individuals may complain to this Company and to the Secretary of the U.S. Department of Health and Human Services if they believe their privacy rights have been violated. Complaints should be directed to Mickey Ogg, Compliance Officer, at this Company at the following telephone numbers (406) 532-1900 or (888) 532-1907. Individuals will not be retaliated against for filing a complaint.

Family-Directed Services Option

FISCAL EMPLOYER AGENT SERVICES

Greetings!

Consumer Direct is very pleased to have the opportunity to work with you in the Family-Directed Services (FDS) option. We are here to assist you in directing your services. This folder contains four packets to get you started. In the Packets, any reference made to "Participant" refers to your child, the parent representing the child (family representative) or the legal guardian of the child.



We have divided the information into four different packets. We hope that this will make it easier to find what you need. The Employer Packet includes the forms and information you need to get set up as the employer. The Employee Packet includes the forms and information you need to get people started as your employees. The Packet for Other Service Providers includes forms that other people (besides employees) need to sign to provide services for you. The Paying for Your Supports Packet includes information about: 1) how to pay your employees and 2) how to pay agencies, businesses or other people (besides employees) who provide your services.

This is how the Packets work.

- The first thing in each Packet is the directions. They describe the forms and other information in the Packet.
- The second thing is a checklist that lists all of the forms you need to fill out. You can use the checklist to make sure you fill out all the forms. As you finish a form, please put a check on the line to show that you have finished it. Then sign your name at the bottom to show that you have done everything on the checklist.
- The forms you need to fill out come next. There are three copies of each form that go together: 1) an example form that shows you how it should look when you finish the form, 2) a form with boxes that tells you what to write in the spaces and 3) a blank form for you to fill out. We hope this gives you enough information so you know how to fill out each form correctly. If you have any questions at all or would like any help filling out a form, please call our office at 1-888-898-0470.
- After the forms there is some extra information that could be useful for you.

When you have finished the blank forms in each Packet, please mail them back to Consumer Direct. There is a self-addressed envelope in each Packet for you to use to mail the forms back.

If you need to mail forms to Consumer Direct later, please mail them to:

Consumer Direct
280 E. Corporate Drive, Suite 210
Meridian, Idaho 83642-2953

You also can email or fax completed forms to Consumer Direct at:

Email: InfoCDID@ConsumerDirectOnline.net
Fax: (208) 898-0417
Toll Free Fax: 1-877-898-0417

If you prefer, you can drop off materials at the office Monday - Friday, 8:00 - 5:00 (during work hours) or use our drop box (mail slot) after hours.

EMPLOYER PACKET

This Employer Packet includes all of the forms that you need to fill out to be the employer.

These forms are:

- ✓ Family-Directed Services Enrollment Checklist
- ✓ Participant Data Form
- ✓ Fiscal Employer Agent Services Agreement
- ✓ Monthly Reports Preference Form
- ✓ IRS Form SS-4 Application for Employer Identification Number
- ✓ IRS Form 2678 Employer Appointment of Agent
- ✓ IBR-1 Idaho Business Registration Form
- ✓ EFO00104 Idaho Tax Commission Power of Attorney
- ✓ Status Change Form
- ✓ Employee Termination Form
- ✓ Participant/Employee Feedback Form

These forms will set you up as an employer and will give Consumer Direct permission to file employee and employer taxes for you. Most employees must pay taxes (for example, Social Security, Medicare, State and Federal income taxes). These taxes are taken out of your employee's paychecks. Consumer Direct produces a summary of all the employee taxes on a W-2 Wage Statement and mails it to your employees at the end of the year. Employers also pay taxes. Employers match employee payments to Social Security and Medicare. Employers also must pay State and Federal Unemployment. Consumer Direct makes these tax payments with funds from your budget, just like payments for your employees' wages.

You can fill out these forms by looking at the examples in the packet. For each state and federal tax form, the Employer Packet includes:

1) an example of a completed form (so you can see what things should be written on the form),
2) an example form with grey boxes that explains how you should fill out the form,
3) a blank form for you to fill out.

Important

! If you are not the parent of the child receiving services, Consumer Direct needs a copy of the guardianship paperwork to verify your legal authority to speak and act for the enrolled child.

If you have questions about how to fill out any of the forms, please call Consumer Direct right away so we can help you. Our toll free number is 1-888-898-0470. If you want more help, you also can stop by the Consumer Direct office at 280 E. Corporate Drive, Suite 210, Meridian, Monday - Friday, 8:00 am - 5:00 pm.

SS-4 Application for Employer Identification Number

When you have completed all the forms, please mail, email, or fax them to Consumer Direct at:

Consumer Direct
280 E. Corporate Drive, Suite 210
Meridian, Idaho 83642-2953

Email: InfoCDID@ConsumerDirectOnline.net
Fax: (208) 898-0417
Toll Free Fax: 1-877-898-0417

You also can drop completed forms off at our office.

The forms in the Employer Packet are:

1. Family-Directed Services Enrollment Checklist: This Checklist lists all of the forms in the Employer Packet that **you need to fill out**. You can use this Checklist to keep track of which forms you have finished. When you finish each form, write down the date on the line next to the form on the Checklist. Also write your initials to show that you have finished the form. Put a check (✓) to show if you want copies of the forms mailed to you. Consumer Direct will send you copies of the forms if you want copies. (It usually is a good idea to get copies of the forms so you know what you signed.) There is space on the form to tell Consumer Direct how you want us to get in touch with you. If we have a question, should we phone you? Email you? Or mail you a letter? Please print your name and then sign the bottom of the form.

2. Participant Data Form: This form gives Consumer Direct basic information about the Participant and their parent or guardian so you can be set up in our system as an employer. Please fill out the form completely. The blanks are labeled to tell you what to write in each of them.

3. Fiscal Employer Agent Services Agreement: This is an agreement between Consumer Direct and you. It defines the responsibilities and roles of each party in the My Voice/My Choice Program.

4. Monthly Reports Preference Form: Consumer Direct will provide you with monthly reports detailing your Support and Spending Plan account balances. Use this form to let us know if you would like to receive paper reports through the US mail or if you prefer to view reports online through the web portal, mydirectcare.com.

5. IRS Form SS-4 Application for Employer Identification Number: This form tells the IRS that you are going to be an employer (household employer). The SS-4 is used to

get an Employer Identification Number (EIN). The EIN is needed for filing and reporting taxes. When you fill out this form, please make sure to:

- Fill in each box as explained on the example form.
- Make an estimate (your best guess) for Lines 11 and 15.
- Please make sure that the name you write in Line 7 is your legal name as it appears on your Social Security card. Don't use a nickname.
- Sign and date the form at the bottom, and include your phone number and fax number.

PLEASE MAKE SURE… THE NAME YOU WRITE ON LINE 1 OF THE SS-4 IS THE NAME YOU USE ON ALL THE OTHER FEDERAL AND STATE TAX FORMS.

6. IRS Form 2678 Employer Appointment of Agent: This form tells the IRS that you give Consumer Direct permission to do work for you. You give us permission to withhold taxes from your employees' paychecks and deposit (pay in) those taxes with the IRS. With this form you appoint Consumer Direct to take care of employer tax responsibilities. When you fill out this form, please make sure that you:

- Write your name the same way that you did on Line 1 of the SS-4.
- Sign and date the form at the bottom of page 1. Don't forget to include your phone number.
- DO NOT write in the box on page 2 where it says "Sign your name here". That box is for Consumer Direct to write in.

7. IBR-1: The IBR-1 Form (Idaho Business Registration Form) is used to get an Idaho unemployment number and a withholding number that are needed to take care of payroll reports. Complete the form by:

- Writing your name, signing and dating the form at the bottom of the first page so your name matches what you have written on the other IRS forms.
- Filling in each box as explained on the example form.

8. EFO00104: The Idaho Tax Commission Power of Attorney Form (EFO00104) gives your permission to Consumer Direct to receive information from the Idaho Tax Commission and the Idaho Commerce and Labor Department regarding payroll taxes.

Please:

- Write your name and make sure it matches what you have written on the other IRS and State forms.
- Fill in each box as explained on the example form.
- Sign the bottom of the form.

9. Medicaid-Support Broker Employment Agreement: The Medicaid-Support Broker Agreement is a State form which the Support Broker must review and sign because the Support Broker is an employee of the

family (Participant). Ask the Support Broker to please review the form carefully. To complete the form, the Support Broker prints his/her name in the blank on page 1. Then, the Support Broker signs and dates the form at the bottom. The Support Broker's signature indicates that he/she agrees with the conditions outlined in the Agreement.

10. Participant-Support Broker Agreement: This is the State form that the Support Broker develops with you. You write the specific services you want the Support Broker to do. You also write how often and how long you want the Support Broker to provide the services. Then you write what you will pay the Support Broker. The directions are attached to the form. Please read them carefully and follow the directions to complete the Participant-Support Broker Agreement with the Support Broker.

11. Medicaid-Community Support Worker Agreement: The Medicaid-Community Support Worker Agreement is a State form which a person must review and sign to enroll as your employee. This Agreement describes things that the worker will do as an employee. The employee agrees that you will pay him/her only for work he/she does according to program rules, this Agreement and your Support and Spending Plan. To complete the Agreement: print the employee's name in the blank on page 1. Check the correct box to indicate if the employee is connected with an agency. Ask the employee to review the form carefully. Then, the employee signs and dates the form at the bottom. The employee's signature indicates that he/she agrees with the conditions outlined in the Agreement.

12. Participant-Community Support Worker Employment Agreement: This is the State form that you develop with your employee. You write the specific services you want the employee to do. You also write how often and how long you want the employee to provide the services. Then you write what you will pay the employee. The directions are attached to the form. Please read them carefully and follow the directions to complete the Participant-Community Support Worker Employment Agreement.

13. Criminal History Check: A family (Participant) can choose not to have a criminal history background check on an employee. This means the criminal history background check is waived. If you choose this option, you have to complete a written statement that explains your choice. There are two forms in the packet related to the criminal history check. If you choose not to have the criminal history check done, you must complete the Criminal History Check: Waiver of Liability - Assumption of Risk Form. If a worker has failed a criminal history background check, you still can consider employing the person. But, in this situation, you have to fill out the Criminal History Check: Waiver of Liability - Assumption of Risk - Failed Criminal History

Check Form. These forms are attached to the Participant-Community Support Worker Employment Agreement. You and the employee both need to read these forms carefully.

When a family (Participant) is hiring a new employee (Community Support Worker or Support Broker), there is a mandatory requirement to perform a Criminal History Check (CHC) unless the Participant has signed a CHC waiver for the employee. This means:

a. The Family Representative or Legal Guardian (Participant) must contact the Department of Health and Welfare (DHW), Criminal History Unit and request a Criminal History Check on the potential employee. At that time the Participant can either set up an appointment for the potential employee (applicant), or the employee (applicant) can set up his/her own appointment.
b. Under this program, the cost of the CHC is paid by the employee (applicant) at the time the person's fingerprints and identification information are taken by the DHW.

14. Wages and Cost to You: It costs you (the employer) more to employ a worker than just the person's wage. By law the employer has to match the employee's Social Security and Medicare. The employer also has to pay federal unemployment taxes (FUTA) and state unemployment taxes (SUTA). The amount the employer pays is a percentage of payroll. This form outlines what the total cost is for each employee. The total cost = wage + additional payment (Social Security, Medicare, FUTA, SUTA). The total cost is different for each wage. This form helps you know what the total cost is per hour for each wage you might pay.

The last three forms do not need to be filled out right away. Please keep them and use them later if you need to. You also can call the Consumer Direct office at any time if you want more forms.

Status Change Form: This form is used to tell Consumer Direct if there is new information about (1) you, the employer, (2) the child receiving services under the Family Directed Services option, or (3) an employee. Has someone's name or address changed? Has someone's phone number or email address changed? When you fill out this form, please:

- At the top of the form, write the name of the person for whom the change applies to and the Effective Date of the change. Then, check the appropriate box to identify if the person named is a Service Recipient, a Managing Party (such as a legal representative of a program recipient) or an Employee.
- If your name has changed, write in your "old" name and your "new" name.
- If your mailing or email address has changed, write in your new address.
- If your phone number has changed, put a ✓ to show which number changed. Then write in the new phone number.
- Sign and date the form to tell us that this new information is correct.

If you need more Status Change Forms please call, fax or email Consumer Direct.

Employee Termination Form: The Termination Form serves two purposes. It notifies Consumer Direct when you have terminated an employee or when the employee has decided to stop working for you. It also provides information about where the employee's last check should be sent and any special instructions about the last check. You should fill it out when necessary for an employee. The label in each box clearly shows what should be filled out. You and the employee complete this form together, and sign and date it at the bottom. Mail, fax or drop off the completed form to Consumer Direct.

Feedback Form: Consumer Direct **always** is interested in feedback from you. Your feedback helps us improve our services. We want to hear about things that worked well for you (compliments or comments), ideas you have for doing things better and any concerns you have with Consumer Direct services. To give us feedback you can:

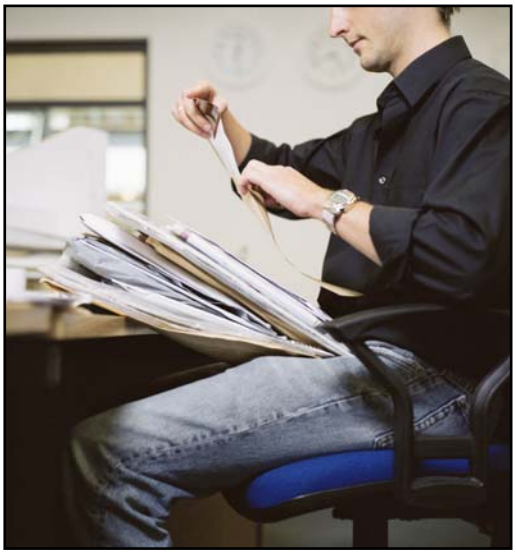
- Call a Program Coordinator in Idaho (the toll free number 1-888-898-0470). The Program Coordinator will listen to your feedback and respond to it quickly. She/he will appreciate hearing things that are working well for you, because we want to keep doing these things! The Program Coordinator also will want to hear your ideas for new ways to do things, because that will make our services better. If there is a concern, she/he will work with the Family Representative (or Legal Guardian), employees or other service providers to fix problems.
- Fill out the Feedback Form in the Employer Packet and mail it or fax it to the Consumer Direct office.
- Contact the Idaho Consumer Direct Program Manager or Vice President (the toll free number is 1-888-898-0470), if your feedback is about the Program Coordinator.
- Also contact the Idaho Consumer Direct Program Manager or Vice President if you talked with the Program Coordinator first, but you would like to talk with someone else about your feedback. He will discuss your feedback with you. If there is a problem, he will talk with you about ways to deal with your concern.

To complete the Feedback Form please fill out the blanks at the top. Then in the white box write:

- What has worked well for you (your compliment or comment),
- What things we should do differently (your suggestion) or
- What you are unhappy about (your complaint).

PLEASE, if you are unhappy (dissatisfied) about the services you are getting from Consumer Direct, let us know right away. Don't let the problem get bigger. We will try to work out the problem with you.

To enroll Participants and their employees, Consumer Direct needs to have all the required employer and employee forms completed and mailed or faxed back to us. You also can drop them off at our office.



We will be glad to send you copies of all the forms. Please let us know if you want copies. On the Enrollment Checklist, check “yes” where it says “Please send me copies of all signed forms”.

If you have any questions or would like any help filling out a form, please call our office (1-888-898-0470) or stop by the office at 280 E. Corporate Drive, Suite 210, Meridian, ID.

IDAHO Fiscal Employer Agent
FAMILY-DIRECTED SERVICES ENROLLMENT CHECKLIST

Child's Name	Parent/Legal Guardian's Name (FEIN Holder)

Welcome to Consumer Direct!

Please complete all the forms on the list below including this one. Date and initial each item below as it is completed. Send originals to Consumer Direct. If you are unable to make copies, please send all forms to Consumer Direct, and upon your request, we will copy and return forms to you.

Forms required for all Participants:

	Date	Initial	
1.	_____	_____	Family Directed Services Enrollment Checklist (this form)
2.	_____	_____	Participant Data Form (name, address, phone, etc.)
3.	_____	_____	Fiscal Employer Agent Services Agreement
4.	_____	_____	Monthly Reports Preference Form
5.	_____	_____	SS-4 Application for Employer Identification Number (EIN)
6.	_____	_____	Court-appointed Guardianship documents (if applicable)
7.	_____	_____	2678 Employer/Payer Appointment of Agent
8.	_____	_____	IBR-1 Idaho Business Registration
9.	_____	_____	ID State Tax Commission Power of Attorney (EFO00104)

Use the following forms as needed and submit to Consumer Direct:

_____	_____	Medicaid-Support Broker Agreement
_____	_____	Participant-Support Broker Employment Agreement
_____	_____	Medicaid-Community Support Worker Agreement
_____	_____	Participant-CSW Agreement, including Criminal History Check Waiver Forms
_____	_____	Status Change Form
_____	_____	Consumer Direct Feedback Form

Please send me copies of all signed forms: ____Yes ____No

I want Consumer Direct to contact me by:

Phone: ___Yes ___ No Email: ___ Yes ___ No Mail: ___ Yes ___ No

I have reviewed all of these materials and agree the information is correct, complete and readable.

_____ _____

Parent/Legal Guardian Signature *Date*

00888

CONSUMER DIRECT

IDAHO FAMILY-DIRECTED SERVICES

PARTICIPANT DATA FORM

Participant Information (Minor Child)

Name _____ _____ _____
First *Middle* *Last*

Street Address _____ *(Physical address where services will be provided, No PO Box)*

City _____ **State** _____ **Zip** _____ **County** _____

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

Medicaid # _____ **Region** _____

Parent/Guardian Information (FEIN Holder)

Name _____ _____ _____
First *Middle* *Last*

Street Address _____

City _____ **State** _____ **Zip** _____

Mailing Address _____

City _____ **State** _____ **Zip** _____

Phone (_____) _____ (_____) _____ (_____) _____ **Email** _____
Home *Cell* *Fax*

Date of Birth _____ **Social Security #** _____-___-_____

Prior Relationships/Business Accounts

1. ❒ Yes ❒ No - Participant is **Transferring** from another Fiscal Provider? If yes, Provider name: _____

2. ❒ Yes ❒ No - Participant is **Switching** FEIN holders? If yes, previous FEIN holder name: _____

3. ❒ Yes ❒ No - Are **Prior Business Accounts** established? If yes, enter account information below:

   → ____-_____ _____ _____ _____
   FEIN **State Unemployment Tax Account #** **SUTA Rate** **Business Tax Withholding Account #**

   → ❒ Yes ❒ No - If previous FEIN, does FEIN holder have employees other than caregivers?

4. **Budget/Auth Start Date** _____

Notes

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

FISCAL EMPLOYER AGENT SERVICES AGREEMENT

This Fiscal Employer Agent Services Agreement ("Agreement") is made and entered into as of _____("Start Date") between Idaho Consumer Direct Personal Care, LLC ("Consumer Direct") and _____ Client and _____ Client's Legal Guardian.

DEFINITIONS

1. The "Managing Party" is the individual, Client, who has a disability or is elderly and who receives services through the My Voice/My Choice or Family-Directed Services Program, or the Client's Legal Guardian who manages day-to-day activities on the Client's behalf. The Federal Employer Identification Number ("FEIN") Holder will be the Employer of Record and Employer of Fact and can employ individual(s) to provide services to the Client in their home.

2. Consumer Direct Fiscal Vendor Agent for Idaho, LLC is the "Fiscal Employer Agent" ("FE/A"), working in conjunction with Consumer Direct, and serving as the Fiscal Employer Agent as authorized under IRS Revenue Procedure 70-6, for the purpose of payroll and payroll reporting services filing on behalf of the Employer of Record's FEIN Holder.

3. The "Authorizing Entity" is the entity that governs the services and authorizes Care Plans or Client Budgets. In this case, the Authorizing Entity is Idaho Medicaid and its agents associated with the My Voice/My Choice and Family-Directed Services Programs. The Authorizing Entity recognizes that Consumer Direct, acting as the FE/A, will provide payroll service assistance to the Managing Party pursuant to IDAPA 16. Title 03. Chapter 13.

RESPONSIBILITIES OF THE MANAGING PARTY

1. Choose Consumer Direct as its FE/A.
2. Complete all of the forms required by Consumer Direct for its FE/A services. This includes accurately filling out all required IRS and Idaho State Tax forms (e.g. exempt status, Unemployment, etc.).
3. Obtain a Federal Employer Identification Number (FEIN) with the assistance of Consumer Direct.
4. Follow all Federal and State employment laws, regulations, and rules; including:
    a. Recruiting, interviewing, checking references, hiring, training, scheduling, managing, and terminating their Employee(s). This includes directing the day-to-day care of the Client and addressing conflicts between Employees.
    b. Employee cannot be a paid guardian.
    c. When a guardianship relationship exists, Guardianship papers must be provided to Consumer Direct prior to the initiation of services.
    d. Submit all new employee paperwork to Consumer Direct prior to the initiation of service. All required documents must be completed and submitted as a complete packet in order for them to be processed timely. Any incomplete documents may delay an employee's start date.
    e. Provide equal employment opportunities to all Employees and interested Employees without

discrimination as to race, creed, color, national origin, gender, age, disability, marital status, sexual orientation, or any other legally protected status in all employment decisions, including recruitment, hiring, changing schedules and number of hours worked, layoffs, and terminations, and all other terms and conditions of employment. The Managing Party accepts full and specific responsibility for following Equal Opportunity laws and requirements regarding Employees. Each Employee is to be treated fairly and consistently, e.g., if the Managing Party decides to do a criminal background check or reference check on one Employee, it must be done on all Employees.

f. An Employee may not provide services while the Client is hospitalized or receiving any other Medicaid-reimbursed service.

g. Review and approve time sheets which authorize the Authorizing Entity to be billed. Submit time sheets in a timely manner (within 15 days of due date) in accordance with the Consumer Direct payroll schedule. The Managing Party and Employee signatures/approval, on the time sheets (or Web Portal) mean that the information on the time sheet is accurate and true. If the Managing Party signs/approves and the hours have not been worked, it is considered fraud. The Managing Party can be held accountable for approving time sheets that contain fraudulent information that result in over-billing the Authorizing Entity.

h. The Managing Party is responsible for monitoring the monthly Spending Summary Report provided by Consumer Direct and for keeping all expenditures within Client's authorized budget amount.

i. If the Managing Party authorizes use of all funds/hours before the end of the period, the Managing Party will need to make other service arrangements, e.g. use non-paid support staff, etc. The Managing Party is responsible for the payment of any wages and expenses that exceed the amount authorized in the Client's Authorized Plan/budget.

j. Inform Consumer Direct, within one working day, of any changes in the Clients' status, e.g., name, address, telephone number, hospitalization, terminations, etc.

k. Inform Consumer Direct of the standard rate of pay for the Employee, including timely notification of any changes in the rate.

l. Maintain compliance with Authorizing Entity's approved utilization amounts for the Client.

5. Reimburse Consumer Direct for any payment of wages and expenses that exceed the amount authorized in Client's Authorized Plan.

6. Immediately Report:
   a. Any possible fraud/Medicaid fraud to Consumer Direct.
   b. Abuse, neglect and exploitation or impairment or health risk to the appropriate authorities, i.e., Adult Protective Services, Medicaid, and Consumer Direct.
   c. Employee changes, including name, address, contact number, and/or employment status.

7. Appoint a temporary representative if the Client or their Legal Guardian is not capable or available to direct the care.

8. The Managing Party agrees to accept and allow Consumer Direct to transmit information electronically pursuant to the uniform Electronic Business Act and HIPAA.

RESPONSIBILITIES OF CONSUMER DIRECT

1. Provide the Client with an Enrollment Packet, Employee Packet(s) and Employee training materials.
2. Pay wages to Employee on a bi-weekly schedule, in accordance with the time sheets approved, in writing (or electronically through the Web Portal), by the Managing Party.
3. Deposit Employer-related taxes, in the aggregate, using the FE/A's designated FEIN.
4. Follow all IRS and State reporting guidelines. This will begin with the client's Start Date even though this date is prior to the formal IRS authorization.
5. Obtain Fiscal Employer Agency authorization pursuant to IRS Revenue Procedure 70-6 and follow all IRS guidelines including obtaining all proper Federal and State authorizations.
6. Follow all tax exemptions and withholdings as stated on Employee's W-4, and process all tax withholdings & filings including Federal and State income taxes, FICA, Medicare tax, FUTA, and SUTA, and any other mandated withholding, as appropriate, on behalf of the Client.
7. Track expenditures and send a report each month. This information is also maintained on the Web-Portal. The Managing Party is responsible for monitoring the spending reports and not using more service hours or budget amounts than approved.
8. Submit all claims for services to the Authorizing Entity on behalf of the Client.
9. Consumer Direct will not pay for tasks that are not authorized on the Support & Spending Plan until approved by the Authorizing Entity.
10. Upon termination of this Agreement, Consumer Direct will complete all required Federal and State filing requirements related to services rendered from the Start Date to the Date of Termination, even though these filings are made subsequent to the termination date, pursuant to Federal and State laws.
11. Consumer Direct will adjust payroll deductions to reflect that the State of Idaho exempts an FEIN Holder, designated as a "Household Employer," from the State requirement for employers to maintain Workers' Compensation and Unemployment Insurance.

Additional Agreement Terms and Conditions

Indemnification: Because the Managing Party is in a better position than Consumer Direct to monitor, supervise and watch over the Employees in the performance of their duties, the Managing Party agrees to indemnify, which means to repay, defend and hold harmless Consumer Direct from any claims, causes of actions, complaints, lawsuits claiming any damages or liability against Consumer Direct, as the result of any actions, inactions, or any conduct by the Employee, while employed by the Managing Party. This Indemnification Agreement includes any claims for damage to the Client's property or person, or the property or person of any third party. The Managing Party understands that this means that the Managing Party will be required to pay for all claims of damages caused by their Employee(s) while employed by the Managing Party, made against Consumer Direct, including the costs that Consumer Direct incurs in defending itself against such claims.

Partial Invalidity: If something in this Agreement does not apply or changes with time that does not mean the rest of the Agreement does not apply. If one part of this Agreement is determined to be invalid, the rest of the Agreement remains in place.

Conflicts/Complaints: The Managing Party agrees to abide by the Complaint Process defined by Authorizing Entity and Consumer Direct's complaint process described in the enrollment materials.

Arbitration: Consumer Direct and the Managing Party agree that they will attempt to resolve any complaints, misunderstandings and other issues between themselves. If Consumer Direct or the Managing Party decides that they cannot settle a disagreement by working together, they will choose someone together to work out the disagreement. This is called arbitration. The cost of arbitration will be paid equally between Consumer Direct and the Managing Party. The decision of the Arbitrator may be given to a judge, in the event the decision is not accepted by either party.

State Law: If Managing Party cannot solve a problem through negotiation or talking about the problem, then State laws will apply. Any legal action related to this Agreement will be conducted in the County where the Client resides.

Duration and Modification of Agreement: This Agreement will go into effect on the date indicated on the first page of this Agreement. Services may not begin until approved by the Authorizing Entity ("Start Date"). Any changes to this Agreement must be in writing, signed and dated by both the Managing Party and Consumer Direct. The Agreement may be terminated as described in the Termination section.

Timely Notification: The Managing Party and Consumer Direct agree that all contact should occur in a timely manner. Any notice will be given immediately, so that the Managing Party or Consumer Direct is not hurt by a delay.

Entire Agreement: This Agreement and other written materials provided by Consumer Direct to the Managing Party describe the complete understanding between Consumer Direct and Managing Party. Any verbal agreements do not apply. All Agreements must be in writing.

Termination: This Agreement can be terminated in three ways:

a. **Mutual Agreement* -** At any time, with written documentation.
b. **Termination Without Cause* -** By either Party, for any reason or no reason at all. The Party wishing to terminate must give written notice of its decision to terminate this Agreement at least 30 days prior to any such termination, per IDAPA 16.03.13, Sections 210.01 and 313.02.
c. **Termination for Cause*** - If any Party to this Agreement does not comply with the terms of this Agreement or follow the policies and procedures established by the Authorizing Entity, the other Party may provide written notice of the non-compliance and terminate this Agreement.

* In the event the Agreement termination is related to a switch to a different FE/A, the switch must occur in a manner so that the tax transition for employee records may be made accurately.

Assignment: Neither this Agreement nor any of the rights, benefits, duties or obligations provided for in this Agreement may be assigned by the Managing Party to someone else without the prior, written consent of Consumer Direct.

HIPAA Consent: The Managing Party authorizes Consumer Direct to submit Protected Health Information ("PHI") to: the authorizing entity, entities that Consumer Direct has a Referral Source Agreement with, and contractors in order to facilitate access to services and secure an authorization needed to initiate services. Consumer Direct will handle PHI in accordance with their published Privacy Practices – a copy of which is included in the enrollment materials.

CONCLUSION: The FEIN Holder is the Employer of Fact and the Employer of Record. The Managing Party understands and accepts responsibility for recruiting, hiring, training, supervising and terminating their Employee(s). The Managing Party is responsible for the actions of their Employees while they are providing services.

Acceptance of this Agreement is shown by signing below.

IDAHO CONSUMER DIRECT PERSONAL CARE, LLC

_____
(Print name)

_____ _____
(*Signature*) (Date)

CLIENT

_____
(Print name)

_____ _____
(*Signature*) (Date)

LEGAL GUARDIAN (*if applicable*)

_____
(Print name)

_____ _____
(*Signature*) (Date)

IDAHO Fiscal Employer Agent
Monthly Reports – Preference Form

Consumer Direct Idaho is responsible for providing Participants a monthly *Support and Spending Plan Budget Report* and *Spending Detail Report*. The reports provide a snap-shot of the Participant's budget category and account balances.

These reports can be viewed in two ways – view them online or wait to receive them by mail. As a Participant's Representative in the Family-Directed Services option with Consumer Direct you have secure access to our online Web Portal which allows you and your support broker to monitor your budget balances in *real time*. This means that as every payment is processed, the balance information is automatically updated. Users of the Web Portal can immediately know the balance and status of each budget category.

In order to increase efficiency and reduce waste, we are offering each Participant the option of not receiving a paper version of the budget reports each month. No matter which option you choose, you will always have access to the electronic reports on the Web Portal.

How would you prefer to review your monthly *Support and Spending Plan Budget Report* and *Spending Detail Report*?

I would like to (choose one):

☐ Receive the paper reports monthly from Consumer Direct Idaho via US Mail

OR

☐ Review my reports on the Web Portal at www.MyDirectCare.com

_____

Participant's Parent/Legal Rep. Printed Name

_____ _____

Participant's Parent/Legal Rep. Signature Date

02378

Rev 09/07/2011

Form **SS-4**
(Rev. January 2010)
Department of the Treasury
Internal Revenue Service

Application for Employer Identification Number

(For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, Indian tribal entities, certain individuals, and others.)

▶ **See separate instructions for each line.** ▶ **Keep a copy for your records.**

OMB No. 1545-0003

EIN

Type or print clearly.

1 Legal name of entity (or individual) for whom the EIN is being requested
John B. Smith HHCSR

2 Trade name of business (if different from name on line 1)

3 Executor, administrator, trustee, "care of" name
c/o Consumer Direct

4a Mailing address (room, apt., suite no. and street, or P.O. box)
607 SW Higgins Ave Ste 104

5a Street address (if different) (Do not enter a P.O. box.)
123 Apple St.

4b City, state, and ZIP code (if foreign, see instructions)
Missoula, MT 59803

5b City, state, and ZIP code (if foreign, see instructions)
Boise Idaho 83645

6 County and state where principal business is located
Boise Idaho

7a Name of responsible party
John B. Smith

7b SSN, ITIN, or EIN
123-45-6789

8a Is this application for a limited liability company (LLC) (or a foreign equivalent)? ☐ Yes ☑ No

8b If 8a is "Yes," enter the number of LLC members ▶

8c If 8a is "Yes," was the LLC organized in the United States? ☐ Yes ☐ No

9a **Type of entity** (check only one box). **Caution.** If 8a is "Yes," see the instructions for the correct box to check.

- ☐ Sole proprietor (SSN) ___
- ☐ Partnership
- ☐ Corporation (enter form number to be filed) ▶ ___
- ☐ Personal service corporation
- ☐ Church or church-controlled organization
- ☐ Other nonprofit organization (specify) ▶ ___
- ☑ Other (specify) ▶ HHCSR
- ☐ Estate (SSN of decedent) ___
- ☐ Plan administrator (TIN) ___
- ☐ Trust (TIN of grantor) ___
- ☐ National Guard ☐ State/local government
- ☐ Farmers' cooperative ☐ Federal government/military
- ☐ REMIC ☐ Indian tribal governments/enterprises

Group Exemption Number (GEN) if any ▶

9b If a corporation, name the state or foreign country (if applicable) where incorporated | State | Foreign country

10 **Reason for applying** (check only one box)

- ☐ Started new business (specify type) ▶ ___
- ☐ Hired employees (Check the box and see line 13.)
- ☐ Compliance with IRS withholding regulations
- ☑ Other (specify) ▶ HHCSR
- ☐ Banking purpose (specify purpose) ▶ ___
- ☐ Changed type of organization (specify new type) ▶ ___
- ☐ Purchased going business
- ☐ Created a trust (specify type) ▶ ___
- ☐ Created a pension plan (specify type) ▶ ___

11 Date business started or acquired (month, day, year). See instructions.
6/11/2012

12 Closing month of accounting year **December**

13 Highest number of employees expected in the next 12 months (enter -0- if none).
If no employees expected, skip line 14.

Agricultural	Household	Other
0	0	0

14 If you expect your employment tax liability to be $1,000 or less in a full calendar year **and** want to file Form 944 annually instead of Forms 941 quarterly, check here. (Your employment tax liability generally will be $1,000 or less if you expect to pay $4,000 or less in total wages.) If you do not check this box, you must file Form 941 for every quarter. ☐

15 First date wages or annuities were paid (month, day, year). **Note.** If applicant is a withholding agent, enter date income will first be paid to nonresident alien (month, day, year) ▶ N/A

16 Check **one** box that best describes the principal activity of your business.
☐ Health care & social assistance ☐ Wholesale-agent/broker
☐ Construction ☐ Rental & leasing ☐ Transportation & warehousing ☐ Accommodation & food service ☐ Wholesale-other ☐ Retail
☐ Real estate ☐ Manufacturing ☐ Finance & insurance ☑ Other (specify) HHCSR

17 Indicate principal line of merchandise sold, specific construction work done, products produced, or services provided.
HHCSR

18 Has the applicant entity shown on line 1 ever applied for and received an EIN? ☐ Yes ☐ No
If "Yes," write previous EIN here ▶

Third Party Designee

Complete this section **only** if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form.

Designee's name: Peter Bensen
Designee's telephone number (include area code): (406) 532-1900
Address and ZIP code: 607 SW Higgins Ave Missoula, MT 59803
Designee's fax number (include area code): (406) 532-1921

Under penalties of perjury, I declare that I have examined this application, and to the best of my knowledge and belief, it is true, correct, and complete.
Name and title (type or print clearly) ▶ John B. Smith Home Health Care Service Recipient
Applicant's telephone number (include area code): (208) 898-0000
Signature ▶ John B. Smith Date ▶ 5/29/12
Applicant's fax number (include area code): (208) 898-1111

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 16055N

00853

Example

Form **SS-4**

(Rev. January 2010)

Department of the Treasury
Internal Revenue Service

Form SS-4 allows Consumer Direct to obtain your Federal Employer Identification Number (FEIN) needed for reporting/tax filing and/or to receive your previously assigned FEIN if not known.

(For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, Indian tribal entities, certain individuals, and others.)

► **See separate instructions for each line.** ► **Keep a copy for your records.**

This form is **REQUIRED, EVEN IF THERE IS A PREVIOUS FEIN.** If the FEIN Holder has a previous FEIN, check 'Yes' on line 18 and enter FEIN (if known).

Type or print clearly.

Every gray box must be completed by you unless noted that Consumer Direct will complete the box.

1 Legal name of entity (or individual) for whom the EIN is being requested

Enter FEIN Holder's Name - **FIRST NAME, MIDDLE INITIAL, LAST NAME**

3 Executor, administrator, trustee
c/o Consumer Direct

4a Mailing address (room, apt., suite no. and street, or P.O. box)
607 SW Higgins Ave Ste 104

5a Street address (if different) (Do

Enter Physical Business Location - Street **(NO P.O. BOX)**

4b City, state, and ZIP code (if foreign, see instructions)
Missoula, MT 59803

Enter Physical Business City, State, and Zip Code

6 County and state where principal business is located

Enter Physical Business County, State

Box 7b must be Box 7a's social security number

7a Name of responsible party

7b SSN, ITIN, or EIN

Enter FEIN Holder's Name - **AS SHOWN ON SS Card, even if different than name shown on line 1**

Enter Social Security Number of FEIN Holder

8a a foreign equivalent)? . . . . . ☐ **Yes** ☑ **No**

8b If 8a is "Yes," enter the number of LLC members . . . . ►

8c If 8a is "Yes," was the LLC organized in the United States? . . . . . ☐ **Yes** ☐ **No**

9a **Type of entity** (check only one box). **Caution.** If 8a is "Yes," see the instructions for the correct box to check.

- ☐ Sole proprietor (SSN) ___
- ☐ Partnership
- ☐ Corporation (enter form number to be filed) ►___
- ☐ Personal service corporation
- ☐ Church or church-controlled organization
- ☐ Other nonprofit organization (specify) ►___
- ☑ Other (specify) ►**HHCSR**
- ☐ Estate (SSN of dec
- ☐ Plan administrator
- ☐ Trust (TIN of grant
- ☐ National Guard
- ☐ Farmers' cooperative ☐ Federal government/military
- ☐ REMIC ☐ Indian tribal governments/enterprises

Group Exemption Number (GEN) if any ►

DO NOT COMPLETE Lines 2, 8b, 8c, 9b, or 14. Those lines do not apply to Home Health Care Service Recipients.

9b If a corporation, name the state or foreign country (if applicable) where incorporated

State

Foreign country

10 **Reason for applying** (check only one box)

- ☐ Started new business (specify type) ►___
- ☐ Hired employees (Check the box and see line 13.)
- ☐ Compliance with IRS withholding regulations
- ☑ Other (specify) ►**HHCSR**
- ☐ Banking purpose (specify purpose) ►___
- ☐ Changed type of organization (specify new type) ►___
- ☐ Purchased going business
- ☐ Created a trust (specify type) ►___
- ☐ Created a pension plan (specify type) ►___

11 Date business started or acquired (month, day, year). See instructions.

Leave blank - First employee pay date will be entered as business start date.

12 Closing month of accounting year **December**

13 If no employees expected, skip line 14.

Agricultural	Household	Other
0	0	0

14 If you expect your employment tax liability to be $1,000 or less in a full calendar year **and** want to file Form 944 annually instead of Forms 941 quarterly, check here. (Your employment tax liability generally will be $1,000 or less if you expect to pay $4,000 or less in total wages.) If you do not check this box, you must file Form 941 for every quarter. ☐

15 First date wages or annuities were paid (month, day, year). **Note.** If applicant is a withholding agent, enter date income will first be paid to nonresident alien (month, day, year) . . . . . ► **N/A**

16 Check **one** box that best describes the principal activity of your business.

☐ Health care & social assistance ☐ Wholesale-agent/broker
☐ Construction ☐ Rental & leasing ☐ Transportation & warehousing ☐ Accommodation & food service ☐ Wholesale-other ☐ Retail
☐ Real estate ☐ Manufacturing ☐ Finance & insurance ☑ Other (specify) **HHCSR**

17 Indicate principal line of merchandise sold, specific construction work done, products produced, or services provided.
HHCSR

18 Has the applicant entity shown on line 1 ever applied for and received an EIN? ☐ **Yes** ☐ **No**

Check yes if the FEIN Holder has a previous FEIN and enter FEIN.

Third Party Designee

Complete this section **only** if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form.

Designee's name
Mariah Folda

Address and ZIP code
607 SW Higgins Ave **Missoula, MT 59803**

(**406**) **532-8588**

SIGN NAME SHOWN AS FIRST NAME, MIDDLE INTIAL, LAST NAME - **Use SAME name & SAME address on all Federal & State Tax Forms.**

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

Name and titl

Print FEIN Holder's Name - **FIRST NAME, MIDDLE INITIAL, LAST NAME.**

Enter Physical Location Business Telephone Number

Signature ►

Have the above named person sign & date. **SIGNATURE MUST BE FIRST NAME, MIDDLE INITIAL, LAST NAME.**

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 16055N

Form **SS-4**
(Rev. January 2010)
Department of the Treasury
Internal Revenue Service

Application for Employer Identification Number

(For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, Indian tribal entities, certain individuals, and others.)

► **See separate instructions for each line.** ► **Keep a copy for your records.**

OMB No. 1545-0003

EIN

Type or print clearly.

1 Legal name of entity (or individual) for whom the EIN is being requested
HHCSR

2 Trade name of business (if different from name on line 1)

3 Executor, administrator, trustee, "care of" name
c/o Consumer Direct

4a Mailing address (room, apt., suite no. and street, or P.O. box)
607 SW Higgins Ave Ste 104

5a Street address (if different) (Do not enter a P.O. box.)

4b City, state, and ZIP code (if foreign, see instructions)
Missoula, MT 59803

5b City, state, and ZIP code (if foreign, see instructions)

6 County and state where principal business is located

7a Name of responsible party

7b SSN, ITIN, or EIN
- -

8a Is this application for a limited liability company (LLC) (or a foreign equivalent)? ☐ **Yes** ☑ **No**

8b If 8a is "Yes," enter the number of LLC members ►

8c If 8a is "Yes," was the LLC organized in the United States? ☐ **Yes** ☐ **No**

9a **Type of entity** (check only one box). **Caution.** If 8a is "Yes," see the instructions for the correct box to check.

- ☐ Sole proprietor (SSN)
- ☐ Partnership
- ☐ Corporation (enter form number to be filed) ►
- ☐ Personal service corporation
- ☐ Church or church-controlled organization
- ☐ Other nonprofit organization (specify) ►
- ☑ Other (specify) ► **HHCSR**
- ☐ Estate (SSN of decedent)
- ☐ Plan administrator (TIN)
- ☐ Trust (TIN of grantor)
- ☐ National Guard ☐ State/local government
- ☐ Farmers' cooperative ☐ Federal government/military
- ☐ REMIC ☐ Indian tribal governments/enterprises

Group Exemption Number (GEN) if any ►

9b If a corporation, name the state or foreign country (if applicable) where incorporated — State — Foreign country

10 **Reason for applying** (check only one box)

- ☐ Started new business (specify type) ►
- ☐ Hired employees (Check the box and see line 13.)
- ☐ Compliance with IRS withholding regulations
- ☑ Other (specify) ► **HHCSR**
- ☐ Banking purpose (specify purpose) ►
- ☐ Changed type of organization (specify new type) ►
- ☐ Purchased going business
- ☐ Created a trust (specify type) ►
- ☐ Created a pension plan (specify type) ►

11 Date business started or acquired (month, day, year). See instructions.

12 Closing month of accounting year **December**

13 Highest number of employees expected in the next 12 months (enter -0- if none).

If no employees expected, skip line 14.

Agricultural	Household	Other
0	0	0

14 If you expect your employment tax liability to be $1,000 or less in a full calendar year **and** want to file Form 944 annually instead of Forms 941 quarterly, check here. (Your employment tax liability generally will be $1,000 or less if you expect to pay $4,000 or less in total wages.) If you do not check this box, you must file Form 941 for every quarter. ☐

15 First date wages or annuities were paid (month, day, year). **Note.** If applicant is a withholding agent, enter date income will first be paid to nonresident alien (month, day, year) ► **N/A**

16 Check **one** box that best describes the principal activity of your business.

☐ Construction ☐ Rental & leasing ☐ Transportation & warehousing ☐ Health care & social assistance ☐ Accommodation & food service ☐ Wholesale-agent/broker ☐ Wholesale-other ☐ Retail ☐ Real estate ☐ Manufacturing ☐ Finance & insurance ☑ Other (specify) **HHCSR**

17 Indicate principal line of merchandise sold, specific construction work done, products produced, or services provided.
HHCSR

18 Has the applicant entity shown on line 1 ever applied for and received an EIN? ☐ **Yes** ☐ **No**
If "Yes," write previous EIN here ►

Third Party Designee

Complete this section **only** if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form.

Designee's name: **Dorothy Vosnick**

Designee's telephone number (include area code): **(406) 532-1900**

Address and ZIP code: **607 SW Higgins Ave Missoula, MT 59803**

Designee's fax number (include area code): **(406) 532-8588**

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

Name and title (type or print clearly) ► **Home Health Care Service Recipient**

Applicant's telephone number (include area code): ( )

Applicant's fax number (include area code): ( )

Signature ► Date ►

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 16055N

Form **2678** **Employer/Payer Appointment of Agent**

(Rev. June 2011) Department of the Treasury — Internal Revenue Service

OMB No. 1545-0748

Use this form if you want to request approval to have an agent file returns and make deposits or payments of employment or other withholding taxes or if you want to revoke an existing appointment.

- If you are an employer or payer who wants to request approval, complete Parts 1 and 2 and sign Part 2. Then give it to the agent. Have the agent complete Part 3 and sign it.

  Note. This appointment is not effective until we approve your request. See the instructions for filing Form 2678 on page 3.

- If you are an employer, payer, or agent who wants to revoke an existing appointment, complete all three parts. In this case, only one signature is required.

For IRS use:

Part 1: Why you are filing this form...

(Check one)

☑ You want to **appoint** an agent for tax reporting, depositing, and paying.

☐ You want to **revoke** an existing appointment.

Part 2: Employer or Payer Information: Complete this part if you want to appoint an agent or revoke an appointment.

1 **Employer identification number (EIN)** ☐☐ – ☐☐☐☐☐☐☐

2 **Employer's or payer's name** (not your trade name) John B. Smith HHCSR

3 **Trade name** (if any)

4 **Address** c/o Consumer Direct 607 SW Higgins Ave Ste 104

Number Street Suite or room number

Missoula MT 59803

City State ZIP code

Example

5 **Forms for which you want to appoint an agent or revoke the agent's appointment to file.** (*Check all that apply.*)	**For ALL employees/ payees**	**For SOME employees/ payees**
Form 940, 940-PR (Employer's Annual Federal Unemployment (FUTA) Tax Return)*	☑	☐
Form 941, 941-PR, 941-SS (Employer's QUARTERLY Federal Tax Return)	☑	☐
Form 943, 943-PR (Employer's Annual Federal Tax Return for Agricultural Employees)	☐	☐
Form 944, 944-PR, 944-SS, 944(SP) (Employer's ANNUAL Federal Tax Return)	☐	☐
Form 945 (Annual Return of Withheld Federal Income Tax)	☐	☐
Form CT-1 (Employer's Annual Railroad Retirement Tax Return)	☐	☐
Form CT-2 (Employee Representative's Quarterly Railroad Tax Return)	☐	☐

*Generally you cannot appoint an agent to report, deposit, and pay taxes reported on Form 940, Employer's Annual Federal Unemployment (FUTA) Tax Return, unless you are a home care service recipient.

☑ Check here if you are a home care service recipient, and you want to appoint the agent to report, deposit, and pay FUTA taxes for you. See the instructions.

I am authorizing the IRS to disclose otherwise confidential tax information to the agent relating to the authority granted under this appointment, including disclosures required to process Form 2678. The agent may contract with a third party, such as a reporting agent or certified public accountant, to prepare or file the returns covered by this appointment, or to make any required deposits and payments. Such contract may authorize the IRS to disclose confidential tax information of the employer/payer and agent to such third party. If a third party fails to file the returns or make the deposits and payments, the agent and employer/payer remain liable.

X **Sign your name here** John B. Smith

Date 5/29/12

Print your name here John B. Smith

Print your title here HHCSR - Household Employer

Best daytime phone 208-898-0000

Now give this form to the agent to complete. ■▶

Part 3: Agent Information: If you will be an agent for an employer or payer, or want to revoke an appointment, complete this part.

6 **Agent's employer identification number (EIN)** 90-0436900

7 **Agent's name** (not trade name) Consumer Direct Fiscal Vendor Agent for ID, LLC

8 **Trade name** (if any)

9 **Address** 607 SW Higgins Ave
Number Street Suite or room number

Missoula | MT | 59803
City State ZIP code

☑ Check here if the employer is a home care service recipient receiving home care services through a program administered by a federal, state, or local government agency.

Under penalties of perjury, I declare that I have examined this form and any attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

X **Sign your name here**

Date / /

Print your name here Karen L. Wolf

Print your title here Payroll Lead Accountant

Best daytime phone (406) 532-1900

Example

00852

Form **2678** (Rev. October 2012)

Employer/Payer Appointment of Agent

Department of the Treasury — Internal Revenue Service

OMB No. 1545-0748

Use this form if you want to request approval to have an agent file returns and make deposits or payments of employment or other withholding taxes or if you want to revoke an existing appointment.

- If you are an employer or payer who wants to request approval, complete Parts 1 and 2 and sign Part 2. Then give it to the agent. Have the agent complete Part 3 and sign it.

  Note. This appointment is not effective until we approve your request. See the instructions for filing Form 2678 on page 3.

- If you are an employer, payer, or agent who wants to revoke an existing appointment, complete all three parts. In this case, only one signature is required.

Form 2678 allows you to appoint Consumer Direct as your Fiscal Vendor Agent to file Federal payroll tax reports on your behalf.

Every gray box must be completed by you unless noted that Consumer Direct will complete the box.

Part 1: Why you are filing this form...

(Check one)

☑ You want to **appoint** an agent for tax reporting, depositing, and paying.

☐ You want to **revoke** an existing appointment.

Part 2: Employer or Payer Information: Complete this part if you want to appoint an agent or revoke an appointment.

1 Employer identification number (EIN) — Consumer Direct will enter your FEIN

2 Employer's or payer's name (not your trade name) — Enter FEIN Holder's Name - **FIRST NAME, MIDDLE INITIAL, LAST NAME**

3 Trade name (if any)

4 Address

Number	Street	Suite or room number
c/o Consumer Direct	607 SW Higgins Ave	

City	State	ZIP code
Missoula	MT	59803

5 Forms for which you want to appoint an agent or revoke the agent's appointment to file. (*Check all that apply.*)

	For ALL employees/ payees	For SOME employees/ payees
Form 940, 940-PR (Employer's Annual Federal Unemployment (FUTA) Tax Return)*	☐	☐
Form 941, 941-PR, 941-SS (Employer's QUARTERLY Federal Tax Return)	☐	☐
Form 943, 943-PR (Employer's Annual Federal Tax Return for Agricultural Employees)	☐	☐
Form 944, 944(SP) (Employer's ANNUAL Federal Tax Return)	☐	☐
Form 945 (Annual Return of Withheld Federal Income Tax)	☐	☐
Form CT-1 (Employer's Annual Railroad Retirement Tax Return)	☐	☐
Form CT-2 (Employee Representative's Quarterly Railroad Tax Retur	☐	☐

Check 940 & 941 'For All' employees/payees **if there is no other business associated with your FEIN.**

Check 940 & 941 'For Some' employees/payees **if there is another business associated with your FEIN.**

*Generally you cannot appoint an agent to report, deposit, and pay taxes reported on Form 940, Unemployment (FUTA) Tax Return, unless you are a home care service recipient.

☑ Check here if you are a home care service recipient, and you want to appoint the agent to repor taxes for you. See the instructions.

I am authorizing the IRS to disclose otherwise confidential tax information to the agent relating to the

SIGN NAME SHOWN AS FIRST NAME, MIDDLE INITIAL, LAST NAME - **Use SAME name & SAME address on all Federal & State Tax Forms.**

ch as a ny

required deposits and payments. Such contract may authorize the IRS to disclose confidential tax information of the employer/payer and agent to such third party. If a third party fails to file the returns or make the deposits and payments, the agent and employer/payer remain liable.

✗ Sign your name here — Have FEIN Holder sign here. **SIGNATURE MUST BE FIRST NAME, MIDDLE INITIAL, LAST NAME.**

Print your name here — Print FEIN Holder's Name **FIRST NAME, MIDDLE INITIAL, LAST NAME.**

Print your title here — HHCSR - Household Employer

Date — Have the above named person enter date

Best daytime phone — Enter Physical Location Business Telephone Number

Now give this form to the agent to complete. ■▶

Part 3: **Agent Information: If you will be an agent for an employer or payer, or want to revoke an appointment, complete this part.**

6	**Agent's employer identification number (EIN)**	90-0436900
7	**Agent's name** (not trade name)	Consumer Direct Fiscal Vendor Agent for ID, LLC
8	**Trade name** (if any)	
9	**Address**	c/o Consumer Direct 607 SW Higgins Ave

Number Street Suite or room number

Missoula | MT | 59803

City State ZIP code

☑ Check here if the employer is a home care service recipient receiving home care services through a program administered by a federal, state, or local government agency.

Under penalties of perjury, I declare that I have examined this form and any attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

X Sign your name here DO NOT SIGN HERE Consumer Direct will sign

Date Consumer Direct will date

Print your name here: Karen L. Wolf

Print your title here: Payroll/FEA Manager

Best daytime phone: 406 532-1900

00852

Form **2678** **Employer/Payer Appointment of Agent**

(Rev. October 2012) Department of the Treasury — Internal Revenue Service

OMB No. 1545-0748

Use this form if you want to request approval to have an agent file returns and make deposits or payments of employment or other withholding taxes or if you want to revoke an existing appointment.

- If you are an employer or payer who wants to request approval, complete Parts 1 and 2 and sign Part 2. Then give it to the agent. Have the agent complete Part 3 and sign it.

  Note. This appointment is not effective until we approve your request. See the instructions for filing Form 2678 on page 3.

- If you are an employer, payer, or agent who wants to revoke an existing appointment, complete all three parts. In this case, only one signature is required.

For IRS use:

Part 1: Why you are filing this form...

(Check one)

☑ You want to **appoint** an agent for tax reporting, depositing, and paying.

☐ You want to **revoke** an existing appointment.

Part 2: Employer or Payer Information: Complete this part if you want to appoint an agent or revoke an appointment.

1 Employer identification number (EIN) ☐☐ – ☐☐☐☐☐☐☐

2 Employer's or payer's name (not your trade name) HHCSR

3 Trade name (if any)

4 Address c/o Consumer Direct 607 SW Higgins Ave

Number Street Suite or room number

Missoula MT 59803

City State ZIP code

5 Forms for which you want to appoint an agent or revoke the agent's appointment to file. (*Check all that apply.*)

	For ALL employees/ payees	For SOME employees/ payees
Form 940, 940-PR (Employer's Annual Federal Unemployment (FUTA) Tax Return)*	☐	☐
Form 941, 941-PR, 941-SS (Employer's QUARTERLY Federal Tax Return)	☐	☐
Form 943, 943-PR (Employer's Annual Federal Tax Return for Agricultural Employees)	☐	☐
Form 944, 944(SP) (Employer's ANNUAL Federal Tax Return)	☐	☐
Form 945 (Annual Return of Withheld Federal Income Tax)	☐	☐
Form CT-1 (Employer's Annual Railroad Retirement Tax Return)	☐	☐
Form CT-2 (Employee Representative's Quarterly Railroad Tax Return)	☐	☐

*Generally you cannot appoint an agent to report, deposit, and pay taxes reported on Form 940, Employer's Annual Federal Unemployment (FUTA) Tax Return, unless you are a home care service recipient.

☑ Check here if you are a home care service recipient, and you want to appoint the agent to report, deposit, and pay FUTA taxes for you. See the instructions.

I am authorizing the IRS to disclose otherwise confidential tax information to the agent relating to the authority granted under this appointment, including disclosures required to process Form 2678. The agent may contract with a third party, such as a reporting agent or certified public accountant, to prepare or file the returns covered by this appointment, or to make any required deposits and payments. Such contract may authorize the IRS to disclose confidential tax information of the employer/payer and agent to such third party. If a third party fails to file the returns or make the deposits and payments, the agent and employer/payer remain liable.

✗ **Sign your name here**

Print your name here

Print your title here HHCSR -

Date / /

Best daytime phone

Now give this form to the agent to complete. ■▶

Part 3: **Agent Information: If you will be an agent for an employer or payer, or want to revoke an appointment, complete this part.**

6	**Agent's employer identification number (EIN)**	90-0436900
7	**Agent's name** (not trade name)	Consumer Direct Fiscal Vendor Agent for ID, LLC
8	**Trade name** (if any)	
9	**Address**	c/o Consumer Direct 607 SW Higgins Ave

Number Street Suite or room number

Missoula | MT | 59803

City State ZIP code

☑ Check here if the employer is a home care service recipient receiving home care services through a program administered by a federal, state, or local government agency.

Under penalties of perjury, I declare that I have examined this form and any attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

X Sign your name here

Date / /

Print your name here: Karen L. Wolf

Print your title here: Payroll/FEA Manager

Best daytime phone: 406 532-1900

00852

FORM **IBR-1**
EFO00147
01-07-14

Idaho Business Registration Form

Register online at: business.idaho.gov
Fax to: (208) 334-5364

Revised 2014

Return to: IDAHO BUSINESS REGISTRATION
PO BOX 36
BOISE, IDAHO 83722-0410

SHADED AREAS FOR STATE USE ONLY	
Account Number	Confirmation No.

1. Type of business (see instructions) ___ Corporation ___ Partnership ___ S Corporation X Sole Proprietorship ___ Nonprofit ___ Government ___ Fiduciary/Trust ___ Limited Liability Company

1a. If LLC, how have you chosen to be taxed for income tax purposes? ☐ Single Member ☐ Corporation ☐ Partnership ☐ S Corporation

2. Purpose of registration X New applicant ___ Change legal name ___ Change assumed business name (DBA) ___ Add new account type ___ Add/change location ___ Change in partners, shareholders or managing members ____%

3. Apply for permits/accounts ___ Boise Auditorium ___ City of Ketchum Local Option ___ E911 Prepaid Wireless Fee ___ Travel & Convention ___ Sales ___ Use X Unemployment X Withholding ___ Withholding only, no employees working in Idaho

Request more information ___ Amusement Device ___ Beer/Wine ___ Cigarette/Tobacco

4. Federal Employer Identification Number (EIN)	5. Social Security number (SSN)	6. Legal business name (see instructions)
	123 - 45 - 6789	John B. Smith

7. Assumed business name (DBA)	8. Date incorporated	9. State incorporated in	10. Month tax year ends
John B. Smith			December

11. Date business began in Idaho	12. Date sales or use will begin in Idaho ____ month ____ year	13. Estimated monthly taxable sales

14. Physical location of business (no PO Box or mail drop addresses)	Street address	City	State	Zip Code
	123 Apple St.	Boise	Idaho	83645

15. Mailing address	Street address or PO Box	City	State	Zip Code
c/o Consumer Direct	607 SW Higgins Ave Ste 104	Missoula	MT	59803

16. Mailing address for report forms	Street address or PO Box	City	State	Zip Code
c/o Consumer Direct	607 SW Higgins Ave Ste 104	Missoula	MT	59803

17. Business telephone number	18. Authorized contact person (name and title) See instructions for definition.
(406) 532-1900	Consumer Direct - Karen L. Wolf, Payroll/FEA Manager

19. Telephone number & extension of contact person	20. Email address of contact person	21. Fax number of contact person
(406) 532-1900 ext. 1931	taxdept@consumerdirectonline.net	406 532-1921

22. Primary nature of business: (Specify the product manufactured and/or sold or the type of service performed.)

Home Health Care - My Voice / My Choice Program for a disabled and/or aging employer.

23. Have you ever had a withholding, sales, use, workers' compensation or unemployment insurance number in Idaho? If yes, list all permit, account or policy numbers. (It is your responsibility to cancel any existing accounts you no longer need.)

No

24. List **(a)** owner and spouse of sole proprietorship, **(b)** all partners of partnership, **(c)** all corporate officers of corporation, **(d)** trustee or responsible party of fiduciary or trust, or **(e)** all members of limited liability companies. Social Security number required for every individual listed. **(Use additional sheet if necessary.)**

Name	Address of Residence	SSN/EIN and Phone Number	Corp Title	% Owned	Director? Yes/No	Compensated? Yes/No
John B. Smith	123 Apple St. Boise Idaho 83645	123 - 45 - 6789 208 - 898 - 0000				

CERTIFICATION: I certify that I am authorized as an owner, partner, corporate officer, member or representative to sign this document and that the statements made are correct and true to the best of my knowledge. (This form must also be signed by the spouse of a sole proprietor.)

Print name John B. Smith Signature John B. Smith Date 01/25/2014

Print name _____ Signature _____ Date _____

00857

Example

EFO00147-2
01-07-14

Revised 2014

25. Date employees first hired to work in Idaho	26. Date of employees' first paycheck in Idaho	27. Expected number of Idaho employees

28. Enter the amount of wages you have paid or plan to pay in Idaho. If you haven't paid or don't plan to pay wages during one of the periods listed, enter "NONE."

	Jan. 1 to March 31	April 1 to June 30	July 1 to Sept. 30	Oct. 1 to Dec. 31
Current Year				
Preceding Year				

29. If you estimated wages in #28, enter the date you plan to begin paying wages. _____

30. Will corporate officers receive compensation, salary or distribution of profits? ___ Yes _X_ No

31. Were you subject to the Federal Unemployment Tax Act during the current or preceding year? ___ Yes ___ No

32. Is this an organization exempt from income tax under Internal Revenue Service Code 501(c)(3)? ___ Yes _X_ No

33. Do you want more information about unemployment insurance for nonprofit corporations? **(see instructions)** ___ Yes _X_ No

34. Is workers' compensation insurance needed? **(see instructions)** ___Yes _X_ No, explain why: **Domestic Household Employer**
CAUTION: This is **not** an application for workers' compensation insurance

35. Do you have a workers' compensation insurance policy?	36. Have you notified your insurance company that you have or expect to have Idaho payroll?	37. Insurance agent's name and telephone number
___ Yes ___ No ___ In process	___ Yes ___ No	( )

38. Insurance company name	39. Policy number	40. Effective date	41. If applying for insurance with the Idaho State Insurance Fund, list application number:

42. Do you plan to perform work in other states using your existing Idaho employees? ___ Yes _X_ No If yes, which states? _____

WAGE THRESHOLDS LISTED BELOW DO NOT AFFECT AN EMPLOYER'S OBLIGATION TO CARRY WORKERS' COMPENSATION INSURANCE.

43. **For most employers:**
a) Have you had or will you have 1 or more workers (for any day or portion of a day) in 20 weeks or more in any calendar year? ____ Yes ____ No
b) Have you paid or will you pay $1,500 or more in wages during any calendar quarter? ____ Yes ____ No
c) If yes, indicate the earliest quarter and calendar year. _____ quarter _____ year

Example

44. **For agricultural employers only:**
a) Have you had or will you have 10 or more workers (for any day or portion of a day) in 20 weeks or more in any calendar year? ____ Yes ____ No
b) Have you paid or will you pay $20,000 or more in cash wages during any calendar quarter? ____ Yes ____ No
c) If yes, indicate the earliest quarter and calendar year. _____ quarter _____ year

45. **For domestic help employers only:**
a) If you are an individual, local college club, or chapter of a college fraternity or sorority, have you paid or will you pay $1,000 or more in cash wages in the state of Idaho during any calendar quarter? _X_ Yes ____ No
b) If yes, indicate the earliest quarter and calendar year. _____ quarter _____ year

ACQUIRING AN EXISTING BUSINESS OR CHANGING TYPE OF LEGAL BUSINESS ENTITY

If you buy an existing business, or change your business entity, Idaho law requires you to withhold enough of the purchase money to pay any sales tax and, in most cases, unemployment insurance due or unpaid by the previous owner/entity until the previous owner/entity produces a receipt from the Idaho Department of Labor and the Idaho State Tax Commission showing the taxes have been paid. If you fail to withhold the required purchase money and the taxes remain due and unpaid after the business is sold or converted to another entity type, you may be liable for the payment of the taxes collected or unpaid by the former owner/entity. When there is a change in the legal entity, you must notify your workers' compensation insurance company.

46. Did you acquire all or part of an existing business? ___ All ___ Part _X_ None	47. Did you change your legal business entity? ___ Yes _X_ No
48. Previous owner's name	49. Business name at time of purchase

50. Date acquired/changed	51. Account/permit numbers of the business acquired/changed	52. Do you want to receive a form to apply for the unemployment insurance experience rating of your predecessor? ____ Yes ____ No

PUBLICATION CONSENT

53. Yes, I agree to publish my business by category both in print and on the Internet in the Business Directory of Idaho at **lmi.idaho.gov** and any publication produced by the Idaho Department of Labor. This will increase visibility of my business to a larger pool of job applicants, will allow my business to be included when the Department of Labor responds to questions about the availability of products and services in the community, and expand the opportunity for additional sales. I acknowledge the Idaho Department of Labor's files will be accessed to obtain my company name, address, phone number, NAICS (industry) code and range of employment.

Signature_____

00858

FORM **IBR-1**
EFO00147
01-07-14

Idaho Business Registration Form

Register online at: business.idaho.gov
Fax to: (208) 334-5364

Revised 2014

Return to: IDAHO BUSINESS REGISTRATION

Form IBR-1 - Idaho Business Registration - allows Consumer Direct to obtain your Withholding account and Unemployment account for reporting/tax filing, and /or to receive your previously assigned accounts if not known.

Every gray box must be completed by you unless noted that Consumer Direct will complete the box.

1. Type of business **(see instructions)** ___ Corporation ___ Partnership ___ S Corporation _X_ Sole Proprietorship
___ Nonprofit ___ Government ___ Fiduciary/Trust ___ Limited Liability Compar

2. Purpose of registration _X_ New applicant ___ Change legal name ___ Change assumed bu
___ Add new account type ___ Add/change location ___ Change in partners, shareholders or managing members ____%

3. Apply for permits/accounts ___ Boise Auditorium ___ City of Ketchum Local Option __ E911 Prepaid Wireless Fee ___ Travel & Convention
___ Sales ___ Use _X_ Unemployment _X_ Withholding ___ Withholding only, no employees working in Idaho
Request more information ___ Amusement Device ___ Beer/Wine ___ Cigarette/Tobacco

4. Federal Employer Identification Number (FEIN)	5. Social Security number (SSN)	6. Legal business name **(see instructions)**
Consumer Direct will enter your FEIN	Enter FEIN Holder's SSN	Enter FEIN Holder's Name - **FIRST NAME, MIDDLE INITIAL, LAST NAME**

Enter FEIN Holder's name - **FIRST NAME, MIDDLE INITIAL, LAST NAME**

8. Date incorporated: **December**

11. Date business began in Idaho

Leave blank - First date employee worked will be entered as business start date.

12. Date sales or use

13. Estimated monthly taxable sales: **LEAVE BLANK - DOES NOT APPLY**

State Zip Code

business **(no PO Box or mail drop addresses)**

Enter Physical Business Location - Street, City, State, & Zip Code **(NO PO BOX)**

	Street address or PO Box	City	State	Zip Code
15. Mailing address				
c/o Consumer Direct	**607 SW Higgins Ave Ste 104**	**Missoula**	**MT**	**59803**
16. Mailing address for report forms				
c/o Consumer Direct	**607 SW Higgins Ave Ste 104**	**Missoula**	**MT**	**59803**

17. Business telephone number: **(406) 532-1900**

18. Authorized contact person (name and title) **See instructions for definition.**: **Consumer Direct - Karen L. Wolf, Payroll/FEA Manager**

19. Telephone number & extension of contact person: **(406) 532-1900 ext. 1931**

20. Email address of contact person: **taxdept@consumerdirectonline.net**

21. Fax number of contact person: **406 532-1921**

22. Primary nature of business: (Specify the product manufactured and/or sold or the type of service performed.)

Home Health Care - Family-Directed Services for a disabled child

23. Have you ever had a withholding, sales, use, workers' compensation or unemployment insurance number in Idaho? If yes, list all permit, account or policy numbers. (It is your responsibility to cancel any existing accounts you no longer need.)

If the FEIN Holder has had previous Withholding or Unemployment Insurance Account(s), enter the number(s).

24. List **(a)** owner and spouse of sole proprietorship, **(b)** all partners of partnership, **(c)** all corporate officers of corporation, **(d)** trustee or responsible party of fiduciary or trust, or **(e)** all members of limited liability companies. Social Security number required for every individual listed. **(Use additional sheet If necessary.)**

Name	Address of Residence	SSN/EIN and Phone Number	Corp Title	% Owned	Director? Yes/No	Compensated? Yes/No
Enter FEIN Holder's Name - **FIRST NAME, MIDDLE INITIAL, LAST NAME**	Enter Physical Business Location - Street, City, State, & Zip Code **(NO P.O. BOX)**	Enter FEIN Holder's SSN Enter Physical Business Location Telephone Number	**LEAVE BLANK - DOES NOT APPLY**			

CERTIFICATION: I certify that I am authorized as an owner, partner, corporate
made are c ust also

Print FEIN Holder's Name - **FIRST NAME, MIDDLE INITIAL, LAST NAME**

Have FEIN Holder sign here - **SIGNATURE MUST BE FIRST NAME, MIDDLE INITIAL, LAST NAME.**

Have FEIN Holder date

Print name gnature Date

SIGN NAME SHOWN AS FIRST NAME, MIDDLE INITIAL, LAST NAME - **Use SAME name & SAME address on all Federal & State Tax Forms.**

Print name Date

00857

EFO00147-2
01-07-14

Revised 2014

25. Date employees first hired to work in Idaho — Consumer Direct will enter date employees first worked

26. Date of employees' first paycheck in Idaho — Consumer Direct will enter date employees first paid

27. Expected number of Idaho employees — Consumer Direct will enter number of employee(s) after hired

28. Enter the amount of wages you have paid or plan to pay in Idaho. If you haven't paid or don't plan to pay wages enter "NONE."

	Jan. 1 to March 31	April 1 to June 30	July 1 to Sept. 30	Oct. 1 to Dec. 31
Current Year	**LEAVE BLANK - Consumer Direct will enter estimated wages based on wages paid out.**			
Preceding Year				

29. If you estimated wages in #28, enter wages — Consumer Direct will enter date employees first paid

30. Will corporate officers receive compe ofits? ___ Yes X No

31. Were you subject to the Federal Une ent or preceding year? ___ Yes ___ No

32. Is this an organization exempt from in Service Code 501(c)(3)? ___ Yes X No

33. Do you want more information about profit corporations? **(see instructions)** ___ Yes X No

34. Is workers' compensation insurance r es X No, explain why: **Domestic Household Employer**

CAUTION: This is **not** an applicatio rance

Check "Yes" on Line 31 unless the FEIN Holder is only employing a family member(s) (child(ren) under age 21, spouse, or parent(s)); if a family member(s) is employed, leave blank - Consumer Direct will answer.

35. **LEAVE BLANK - DOES NOT APPLY**
Line 35 - Line 41
Worker's Compensation is not applicable for Household Employers

38

42. Do you plan to perform work in other states using your existing Idaho employees? ___ Yes X No If yes, which states? _____

WAGE THRESHOLDS LISTED BELOW DO NOT AFFECT AN EMPLOYER'S OBLIGATION TO CARRY WORKERS' COMPENSATION INSURANCE.

43. **For most employers:**

Only complete Line 43 if all employees are exempt from SUTA

44. **For agricultural employers only:**

LEAVE BLANK - DOES NOT APPLY

45. **For domestic help employers only:**

a) If you are an individual, local college club, or chapter of a college fraternity or sorority, have you paid or will you pay $1,000 or more in cash wages in the state of Idaho during any calendar quarter? X Yes ___ No

b) If yes, indicate the earliest quarter and calendar year. **Leave Blank** - Consumer Direct will answer which quarter and year you become subject to Unemployment Insurance if applicable.

ACQUIRING AN EXISTING BUSINESS OR CHANGING TYP

If y mo of du ow

LEAVE BLANK - DOES NOT APPLY

46.

48.

50

PUBLICATION CONSENT

53.

LEAVE BLANK - DOES NOT APPLY
DO NOT SIGN - THIS QUESTION WILL NOT BE ANSWERED YES TO AT ANY TIME

00858

FORM **IBR-1**
EFO00147
01-07-14

Idaho Business Registration Form

Register online at: business.idaho.gov
Fax to: (208) 334-5364

Revised 2014

Return to: **IDAHO BUSINESS REGISTRATION**
PO BOX 36
BOISE, IDAHO 83722-0410

SHADED AREAS FOR STATE USE ONLY	
Account Number	Confirmation No.

1. Type of business **(see instructions)** ___ Corporation ___ Partnership ___ S Corporation X Sole Proprietorship ___ Nonprofit ___ Government ___ Fiduciary/Trust ___ Limited Liability Company

1a. If LLC, how have you chosen to be taxed for income tax purposes?
☐ Single Member ☐ Corporation ☐ Partnership ☐ S Corporation

2. Purpose of registration X New applicant ___ Change legal name ___ Change assumed business name (DBA) ___ Add new account type ___ Add/change location ___ Change in partners, shareholders or managing members ____%

3. Apply for permits/accounts ___ Boise Auditorium ___ City of Ketchum Local Option __ E911 Prepaid Wireless Fee ___ Travel & Convention ___ Sales ___ Use X Unemployment X Withholding ___ Withholding only, no employees working in Idaho

Request more information ___ Amusement Device ___ Beer/Wine ___ Cigarette/Tobacco

4. Federal Employer Identification Number (EIN)	5. Social Security number (SSN)	6. Legal business name **(see instructions)**	
	- -		
7. Assumed business name (DBA)	8. Date incorporated	9. State incorporated in	10. Month tax year ends
			December
11. Date business began in Idaho	12. Date sales or use will begin in Idaho ____ month ____ year	13. Estimated monthly taxable sales	

	Street address	City	State	Zip Code
14. Physical location of business **(no PO Box or mail drop addresses)**				
15. Mailing address	Street address or PO Box	City	State	Zip Code
c/o Consumer Direct	**607 SW Higgins Ave Ste 104**	**Missoula**	**MT**	**59803**
16. Mailing address for report forms	Street address or PO Box	City	State	Zip Code
c/o Consumer Direct	**607 SW Higgins Ave Ste 104**	**Missoula**	**MT**	**59803**

17. Business telephone number	18. Authorized contact person (name and title) **See instructions for definition.**		
(406) 532-1900	**Consumer Direct - Karen L. Wolf, Payroll/FEA Manager**		
19. Telephone number & extension of contact person	20. Email address of contact person	21. Fax number of contact person	
(406) 532-1900 ext. 1931	**taxdept@consumerdirectonline.net**	**406 532-1921**	

22. Primary nature of business: (Specify the product manufactured and/or sold or the type of service performed.)

Home Health Care - My Voice / My Choice Program for a disabled and/or aging employer.

23. Have you ever had a withholding, sales, use, workers' compensation or unemployment insurance number in Idaho? If yes, list all permit, account or policy numbers. (It is your responsibility to cancel any existing accounts you no longer need.)

No

24. List **(a)** owner and spouse of sole proprietorship, **(b)** all partners of partnership, **(c)** all corporate officers of corporation, **(d)** trustee or responsible party of fiduciary or trust, or **(e)** all members of limited liability companies. Social Security number required for every individual listed. **(Use additional sheet If necessary.)**

Name	Address of Residence	SSN/EIN and Phone Number	Corp Title	% Owned	Director? Yes/No	Compensated? Yes/No
		- -				

CERTIFICATION: I certify that I am authorized as an owner, partner, corporate officer, member or representative to sign this document and that the statements made are correct and true to the best of my knowledge. (This form must also be signed by the spouse of a sole proprietor.)

Print name_____ Signature_____ Date_____

Print name_____ Signature_____ Date_____

00857

25. Date employees first hired to work in Idaho	26. Date of employees' first paycheck in Idaho	27. Expected number of Idaho employees

28. Enter the amount of wages you have paid or plan to pay in Idaho. If you haven't paid or don't plan to pay wages during one of the periods listed, enter "NONE."

	Jan. 1 to March 31	April 1 to June 30	July 1 to Sept. 30	Oct. 1 to Dec. 31
Current Year				
Preceding Year				

29. If you estimated wages in #28, enter the date you plan to begin paying wages. _____

30. Will corporate officers receive compensation, salary or distribution of profits? ___ Yes _X_ No

31. Were you subject to the Federal Unemployment Tax Act during the current or preceding year? ___ Yes ___ No

32. Is this an organization exempt from income tax under Internal Revenue Service Code 501(c)(3)? ___ Yes _X_ No

33. Do you want more information about unemployment insurance for nonprofit corporations? **(see instructions)** ___ Yes _X_ No

34. Is workers' compensation insurance needed? **(see instructions)** ___Yes _X_ No, explain why: **Domestic Household Employer**

CAUTION: This is **not** an application for workers' compensation insurance

35. Do you have a workers' compensation insurance policy?	36. Have you notified your insurance company that you have or expect to have Idaho payroll?	37. Insurance agent's name and telephone number
___ Yes ___ No ___ In process	___ Yes ___ No	( )

38. Insurance company name	39. Policy number	40. Effective date	41. If applying for insurance with the Idaho State Insurance Fund, list application number:

42. Do you plan to perform work in other states using your existing Idaho employees? ___ Yes _X_ No If yes, which states? _____

WAGE THRESHOLDS LISTED BELOW DO NOT AFFECT AN EMPLOYER'S OBLIGATION TO CARRY WORKERS' COMPENSATION INSURANCE.

43. **For most employers:**
   a) Have you had or will you have 1 or more workers (for any day or portion of a day) in 20 weeks or more in any calendar year? ____ Yes ____ No
   b) Have you paid or will you pay $1,500 or more in wages during any calendar quarter? ____ Yes ____ No
   c) If yes, indicate the earliest quarter and calendar year. _____ (quarter) (year)

44. **For agricultural employers only:**
   a) Have you had or will you have 10 or more workers (for any day or portion of a day) in 20 weeks or more in any calendar year? ____ Yes ____ No
   b) Have you paid or will you pay $20,000 or more in cash wages during any calendar quarter? ____ Yes ____ No
   c) If yes, indicate the earliest quarter and calendar year. _____ (quarter) (year)

45. **For domestic help employers only:**
   a) If you are an individual, local college club, or chapter of a college fraternity or sorority, have you paid or will you pay $1,000 or more in cash wages in the state of Idaho during any calendar quarter? _X_ Yes ____ No
   b) If yes, indicate the earliest quarter and calendar year. _____ (quarter) (year)

ACQUIRING AN EXISTING BUSINESS OR CHANGING TYPE OF LEGAL BUSINESS ENTITY

If you buy an existing business, or change your business entity, Idaho law requires you to withhold enough of the purchase money to pay any sales tax and, in most cases, unemployment insurance due or unpaid by the previous owner/entity until the previous owner/entity produces a receipt from the Idaho Department of Labor and the Idaho State Tax Commission showing the taxes have been paid. If you fail to withhold the required purchase money and the taxes remain due and unpaid after the business is sold or converted to another entity type, you may be liable for the payment of the taxes collected or unpaid by the former owner/entity. When there is a change in the legal entity, you must notify your workers' compensation insurance company.

46. Did you acquire all or part of an existing business? ___ All ___ Part _X_ None	47. Did you change your legal business entity? ___ Yes _X_ No

48. Previous owner's name	49. Business name at time of purchase

50. Date acquired/changed	51. Account/permit numbers of the business acquired/changed	52. Do you want to receive a form to apply for the unemployment insurance experience rating of your predecessor? ____ Yes ____ No

PUBLICATION CONSENT

53. Yes, I agree to publish my business by category both in print and on the Internet in the Business Directory of Idaho at **lmi.idaho.gov** and any publication produced by the Idaho Department of Labor. This will increase visibility of my business to a larger pool of job applicants, will allow my business to be included when the Department of Labor responds to questions about the availability of products and services in the community, and expand the opportunity for additional sales. I acknowledge the Idaho Department of Labor's files will be accessed to obtain my company name, address, phone number, NAICS (industry) code and range of employment.

Signature_____

00858

EFO00104 12-26-13

Idaho State Tax Commission
Power of Attorney

1. TAXPAYER/GRANTOR INFORMATION

*Taxpayer/Grantor's last name	* Taxpayer/Grantor's first name/middle initial	* Taxpayer/Grantor's SSN or EIN
Smith	John B.	
*Spouse's last name	*Spouse's first name/middle initial	*Spouse's SSN
*Address		Daytime telephone number
123 Apple St.		406 532-1900
*City, State, Zip		Email address
Boise Idaho 83645		

2. REPRESENTATIVE(S) - For multiple representatives, attach additional sheets.

*Name	PTIN, EIN or SSN
Cindy Kelly	MT1286
*Firm or company's legal name	Telephone number
Consumer Direct Fiscl Vendor Agent for ID	406 532-1900
*Address	Fax number
607 SW Higgins Ave Ste 104	406 532-1921
*City, State, Zip	Email address
Missoula, MT 59803	taxdept@consumerdirectonline.net

Check here if you **don't** want the representative to receive copies of notices and communications: ☐

3. TAX MATTERS APPROVED FOR REPRESENTATION

The above representative is hereby appointed as attorney-in-fact to represent the taxpayer/grantor(s) before the Idaho Tax Commission for the following tax or fee matter(s). You must identify the tax or fee type, permit number (if applicable), and specific periods/years.

*Tax or Fee Types	*State Tax/Fee Permit Number (Required if applicable)	*Periods/Years (Must include beginning and ending date)
☐ Individual income tax ☐ Business income tax		
☐ Sales & use tax		
☑ Income tax withholding		2014 - 2017
☑ Other tax/fee (specify) Unemployment		/2014 - /2017

Example

4. ACTIONS AUTHORIZED

The representative(s) are generally authorized to receive and inspect confidential tax or fee information and records, perform any and all actions that the taxpayer/grantor(s) named above can perform with respect to the specified tax or fee matters listed. The authority **doesn't** include the power to receive refund checks.

Added or deleted actions - List any specific additions or deletions to the actions otherwise authorized in this Power of Attorney:

_____

_____

_____

_____

5. REVOCATION/EXPIRATION

The filing of this Power of Attorney (POA) automatically revokes all prior POAs on file with the Tax Commission for the same matters and years authorized in this document.

Check here if you **don't** want to revoke prior POA(s): ☐ Expiration date (optional): _____

6. SIGNATURE OF TAXPAYER/GRANTOR(S)

All parties identified in Section 1 **MUST** sign.

If signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, or trustee on behalf of the taxpayer/grantor: I certify that I have the authority to execute this form.

*Name	Title (If applicable)	Date
John B. Smith	Household Employer	1/7/2014
*Name	Title (If applicable)	Date

** Required Information* ***This form is valid only if all information is complete. An incomplete form will be returned to you.***

01869

EFO00104

Form EFO00104, ID Power of Attorney, allows you to authorize Consumer Direct to act as your representative with the Idaho Tax Commission and Idaho Department of Labor.

Power of Attorney

Every gray box must be completed by you unless noted that Consumer Direct will complete the box.

1. TAXPAYER/GRANTOR INFORMATION

*Taxpayer/Grantor's last name	* Taxpayer/Grantor's first name/middle initial	Consumer Direct will enter your FEIN
Enter FEIN Holder's **LAST NAME**	Enter FEIN Holder's **FIRST NAME, MIDDLE INTIAL**	
*Spouse's last name	*Spouse's first name/middle initial	*Spouse's SSN
*Address Enter Physical Business Location - Street **(NO P.O. BOX)**		Enter Physical Business Location Telephone Number
*City, State, Zip Enter Physical Business Location - City, State, & Zip Code		Email address

2. REPRESENTATIVE(S) - For multiple representatives, attach additional sheets.

*Name **Cindy Kelly**	PTIN, EIN or SSN **MT1286**
*Firm or company's legal name **Consumer Direct Fiscal Vendor Agent for ID**	Telephone number **(406) 532-1900**
*Address **607 SW Higgins Ave Ste 104**	Fax number **(406) 532-1921**
*City, State, Zip **Missoula, MT 59803**	Email address **taxdept@consumerdirectonline.net**

Do not check - all notices and correspondence will be sent to Consumer Direct.

3. TAX MATTERS APPROVED FOR REPRESENTATION

The above representative is hereby appointed as attorney-in-fact to represent the taxpayer/grantor(s) before the Idaho Tax Commission for the following tax or fee matter(s). You must identify the tax or fee type, permit number (if applicable), and specific periods/years.

*Tax or Fee Types	*State Tax/Fee Permit Number (Required if applicable)	*Periods/Years (Must include beginning and ending date)
☐ Individual income tax ☐ Business income tax		
☐ Sales & use tax		Consumer Direct will enter tax periods dependant upon start date of your services
☑ Income tax withholding	Consumer Direct will enter your Withholding number	
☑ Other tax/fee (specify) **Unemployment**	Consumer Direct will enter your Unemployment number	**/2014 - /2017**

4. ACTIONS AUTHORIZED

The representative(s) are generally authorized to receive and inspect confidential tax or fee information and records, perform any and all actions that the taxpayer/grantor(s) named above can perform with respect to the specified tax or fee matters listed. The authority **doesn't** include the power to receive refund checks.

Added or deleted actions - List any specific additions or deletions to the actions otherwise authorized in this Power of Attorney:

_____

_____

_____

_____

5. REVOCATION/EXPIRATION

The filing of this Power of Attorney (POA) automatically revokes all prior POAs on file with the Tax Commission for the same matters and years authorized in this document.

Check here if you **don't** want to revoke prior POA(s): ☐ Expiration date (optional): _____

6. SIGNATURE OF TAXPAYER/GRANTOR(S)

All parties identified in Section 1 **MUST** sign.

If signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, or trustee on behalf of the taxpayer/grantor: I certify that I have the authority to execute this form.

Have FEIN Holder sign - **SIGNATURE MUST BE FIRST NAME, MIDDLE INITAL, LAST NAME.**

Household Employer

Have FEIN Holder or Guardian date

*Name Title (If applicable) Date

SIGN NAME SHOWN AS FIRST NAME, MIDDLE INITIAL, LAST NAME - **Use SAME name & SAME address on all Federal & State Tax Forms.**

01869

***** ***Required Information*** ***This form is valid only if all information is complete. An incomplete form will be returned to you.***

EFO00104 12-26-13

Idaho State Tax Commission
Power of Attorney

1. TAXPAYER/GRANTOR INFORMATION

*Taxpayer/Grantor's last name	* Taxpayer/Grantor's first name/middle initial	* Taxpayer/Grantor's SSN or EIN
*Spouse's last name	*Spouse's first name/middle initial	*Spouse's SSN
*Address		Daytime telephone number 406 532-1900
*City, State, Zip		Email address

2. REPRESENTATIVE(S) - For multiple representatives, attach additional sheets.

*Name **Cindy Kelly**	PTIN, EIN or SSN **MT1286**
*Firm or company's legal name **Consumer Direct Fiscl Vendor Agent for ID**	Telephone number **406 532-1900**
*Address **607 SW Higgins Ave Ste 104**	Fax number **406 532-1921**
*City, State, Zip **Missoula, MT 59803**	Email address **taxdept@consumerdirectonline.net**

Check here if you **don't** want the representative to receive copies of notices and communications: ☐

3. TAX MATTERS APPROVED FOR REPRESENTATION

The above representative is hereby appointed as attorney-in-fact to represent the taxpayer/grantor(s) before the Idaho Tax Commission for the following tax or fee matter(s). You must identify the tax or fee type, permit number (if applicable), and specific periods/years.

*Tax or Fee Types	*State Tax/Fee Permit Number (Required if applicable)	*Periods/Years (Must include beginning and ending date)
☐ Individual income tax ☐ Business income tax		
☐ Sales & use tax		
☑ Income tax withholding		**2014 - 2017**
☑ Other tax/fee (specify) **Unemployment**		**/2014 - /2017**

4. ACTIONS AUTHORIZED

The representative(s) are generally authorized to receive and inspect confidential tax or fee information and records, perform any and all actions that the taxpayer/grantor(s) named above can perform with respect to the specified tax or fee matters listed. The authority **doesn't** include the power to receive refund checks.

Added or deleted actions - List any specific additions or deletions to the actions otherwise authorized in this Power of Attorney:

_____

_____

_____

_____

5. REVOCATION/EXPIRATION

The filing of this Power of Attorney (POA) automatically revokes all prior POAs on file with the Tax Commission for the same matters and years authorized in this document.

Check here if you **don't** want to revoke prior POA(s): ☐ Expiration date (optional): _____

6. SIGNATURE OF TAXPAYER/GRANTOR(S)

All parties identified in Section 1 **MUST** sign.

If signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, or trustee on behalf of the taxpayer/grantor: I certify that I have the authority to execute this form.

Household Employer

*Name	Title (If applicable)	Date
*Name	Title (If applicable)	Date

Required Information** ***This form is valid only if all information is complete. An incomplete form will be returned to you.

01869

Family-Directed Services Option
FISCAL EMPLOYER AGENT SERVICES

COMMUNITY SUPPORT WORKER EMPLOYEE PACKET

Welcome to Idaho's Family-Directed Services Option! We are pleased that you will be working with and providing services to a family in this program. You will be helping Idaho meet its goal of giving people with disabilities more choice and control over their services.

Introduction: Consumer Direct is a Fiscal Employer Agent for the Family-Directed Services Option. We are like a personal banker or payroll service company. We process payroll, file taxes, pay for services provided by other businesses or agencies and bill the state for services. Consumer Direct provides the family with the necessary paperwork to get set up as an employer. We also provide the paperwork for individuals to become enrolled as a family's employee. Once employees are enrolled, we process all of the forms and pay employees as directed by the family (employer). Consumer Direct has more than fifteen years of experience in many different states assisting people to self-direct their supports and services.

As your employer, the parent's (or legal guardian's) role is to:

- Take on the responsibilities of being an employer.
- Recruit, hire, train, manage (supervise) and dismiss all employees.
- Complete Employment Agreements with all employees. These describe the services the employee will provide and the rate of pay.
- Determine a schedule and schedule employees.
- Submit time sheets only for the services approved on the Participant's Support and Spending Plan.
- Pay the employee directly (the Participant pays…the Idaho Self Direction Program does not pay) for any work performed that is not approved in the Participant's Support and Spending Plan.
- Approve and sign all time sheets.
- Make sure all signed time sheets are submitted to Consumer Direct on time.
- Treat employees consistently and fairly.
- Keep required records and receipts.

Completing the forms: The purpose of this Packet is to provide all the paperwork for an individual to become an employee of the Participant's family. The Employee Packet includes some forms that you fill out by yourself, and some you and the Participant's representative fill out together. If you have questions about filling out any forms, please call Consumer Direct right away so we can help. Our toll free number is 1-888-898-0470.

If you want more help, you also can stop by the Consumer Direct office in Meridian (address below) during business hours, Monday - Friday, 8:00 am - 5:00 pm.

Upon completion of the forms, please mail or fax them to Consumer Direct at:

Consumer Direct
280 E. Corporate Dr., Suite 210
Meridian, Idaho 83642-2953

Toll Free Fax: 1-877-898-0417
Fax: (208) 898-0417

It is very important that you complete these forms and return them to Consumer Direct as quickly as possible. You cannot start work for a Participant until you have been enrolled as an employee. When all enrollment forms are correctly completed and submitted, each employee/worker will receive an employee identification number. Consumer Direct will send you your number when it is assigned.

The forms in this Community Support Worker Employee Packet include:

1. New Employee Checklist: The New Employee Checklist lists all of the forms in the Employee Packet that you need to complete. Please use this checklist to keep track of which forms you have finished. As they are completed, the Participant's representative dates and initials each item in the list. They also sign the bottom of the form, when all paperwork has been completed. At the very bottom of the form, write the date the packet of forms was submitted to Consumer Direct.

2. Employee Data Form: The Employee Data Form is designed to gather basic information about you so we can enroll you as an employee and set your file up in Consumer Direct's payroll system. When filling in this form, please:

- Complete all of the blanks on the form as labeled (for example, name, physical address, mailing address, phone and so on).
- Check how you plan to turn in your time sheets (in the lower left hand corner).
- Let us know how you prefer for Consumer Direct to contact you. Place a check(s) in the box in the lower right to show how you want us to contact you.
- Sign and date the bottom of the form to indicate that all the information is correct.

The last part of the Employee Data Form is the bolded print at the bottom of the page. It reads: **"If you complete an Employee Agreement you become an employee of the family. You will not be an employee of Consumer Direct."** This is an important point. You are not an employee of Consumer Direct or the State of Idaho.

3. USCIS I-9 Employment Eligibility Verification: The purpose of this form is to document that you are authorized to work in the United States. Section 1 of the form is filled out by you, the employee. Section 2 of the form is completed by your employer, the Participant's representative. The directions for completing the I-9 are included with the form in the packet.

4. IRS W-4 Form: The W-4 form needs to be completed so that the correct amount of federal income tax can be withheld from your pay check. The directions are at the top of the form. The "Personal Allowances Worksheet" in the middle of the page is a way to figure out how many allowances you claim in box 5 on the W-4 form. There are rules to follow in deciding how many allowances you can claim. The smaller the number of allowances you claim, the more taxes will be withheld from your pay check. This means you receive less take home pay. For example, if you claim "0" or "1", more will be withheld.

5. Pay Selection Form: The purpose of this form is for you to choose how you receive payment for the time you work. Consumer Direct offers three pay options: (1) direct deposit to your bank or credit union account, (2) direct deposit to a Visa pay card, or (3) paper check. Please read the descriptions of each before placing a checkmark in the box next to your selection. If you choose direct deposit to a bank or credit union account, please provide your account information as requested, and attached a voided check or other documentation from your bank/credit union confirming your account and routing numbers (please note, a deposit slip is not acceptable for this purpose). Don't forget to sign and date the form.

6. Employment Relationship Disclosure Form: Most employees must pay taxes (Social Security, Medicare, State and Federal Income). The purpose of this form is to determine whether your relationship with the Participant makes you an employee who is exempt from paying certain taxes. Please check the box in item 1 to indicate your relationship to the Participant/FEIN holder, review the explanations in item 2, and sign and date the bottom of the form.

7. Medicaid-Community Support Worker Agreement: This Agreement is a State form which a person must review and sign to enroll as a Participant's employee. You agree that the Participant will pay you only for work done in accordance with program rules and the Participant-Community Support Worker Employment Agreement (described below). To complete the Agreement: print your name on page 1. Check the correct box to indicate if you are connected with an agency. Review the form carefully, and sign and date on page two. The employee's signature indicates that he/she agrees with the conditions outlined in the Agreement.

8. Participant-Community Support Worker Employment Agreement: This is the State 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.

9. Criminal History Check – Waiver of Liability – Assumption of Risk: This State form is **ONLY REQUIRED IF** the Participant's representative wishes to waive the employee from being subject to a criminal history check prior to providing service. On the form, the Participant's representative will need to document the reason for the waiver as well as how they will maintain their health and safety.

10. Criminal History Check – Waiver of Liability – Assumption of Risk – Failed Criminal History Check: This State form is **ONLY REQUIRED IF** an employee has failed a criminal history check, yet the Participant's representative still wishes for this person to be their employee. On the form, the Participant's representative will need to document the reason for the waiver as well as how they will maintain their health and safety.

ADDITIONAL FORMS AND INSRUCTIONS: provided during enrollment, available upon request and available online at http://consumerdirectid.com/forms.

1. Status Change Form: This form is used to tell Consumer Direct if there is new information about a program participant, a participant's representative or an employee. It is important that employees notify Consumer Direct of any change in name, address or phone number to ensure there are no interruptions in pay. This is done by completing and submitting the Status Change Form to Consumer Direct's office by fax or mail. Don't forget to sign and date the form.

2. Termination Form: The Termination Form serves two purposes. It notifies Consumer Direct when the Participant has terminated an employee or when the employee has decided to stop working for the Participant. It also provides information about where the employee's last check should be sent and any special instructions about the last check. It will be completed as necessary for an employee. The label in each box clearly indicates what information that should be included. The Employer and employee together complete this form, sign and date it at the bottom. Then the Employer submits the form to Consumer Direct.

3. Feedback Form: Consumer Direct always is interested in feedback from you. Your feedback helps us improve our services. We want to hear about things that worked well for you (compliments or comments), ideas you have for doing things better and any concerns you have with our services. To give us feedback you can:

- Call a Program Coordinator in Idaho (toll-free 1-888-898-0470).
- Fill out the Feedback Form and mail it or fax it to the Consumer Direct office.
- Contact the Idaho Consumer Direct Program Manager (toll-free 1-888-898-0470), if your feedback is about the Program Coordinator or if you talked with the Program Coordinator first, but you would like to talk with someone else.

PLEASE, if you are unhappy (dissatisfied) about something involving Consumer Direct, let us know right away. Don't let the problem become bigger. We will try to work out the problem with you.

TIMESHEETS. A timesheet must be completed to report the hours an employee works. Employees have two options for submitting timesheets, paper or electronic.

4. Online Timesheet Instructions: Follow the instructions for submitting time online. Consumer Direct strongly recommends the use of our online time cards available through a secure website, MyDirectCare.com (this site is also referred to as a "web portal"). Online time entry and approval provides an efficient and error-minimizing way to enter time into the Consumer Direct payroll system. Through this process, the employee enters work shift information onto an electronic time card. At the end of the payroll cycle when timesheets would normally be due, the Employer will log into the system and approve the employee's time. Once time has been approved by the Employer, it can be processed and paid by Consumer Direct.

Online time submittal means no more mailing or faxing paper timesheets to the Consumer Direct office.

5. Paper Timesheets: For employees who choose to use paper timesheets, timesheets (and instructions) are available upon request and can be downloaded from the Consumer Direct website at: http://consumerdirectid.com/forms

6. Paper Timesheet Instructions: Please follow the instructions when filling out a timesheet. Remember, an employee can only be paid through this program for services that are approved in the Participant's Support and Spending Plan. The hours worked must be for services that are outlined on the Participant-Community Support Worker Employment Agreement or Participant-Support Broker Employment Agreement.

You and the Participant both sign the timesheet to show that it is correct. After the timesheet is finished, it should be submitted to Consumer Direct by mail or fax by the deadline indicated on the form. Our address and toll-free fax number is provided on the bottom of the timesheet.

If you prefer, you can drop off time sheets at the Consumer Direct office. A drop box (mail slot) is available for after-hours use.

7. Payroll Schedule: The Payroll Schedule shows when time sheets are due. This is the date paper time sheets must be mailed, faxed or dropped off at Consumer Direct and when electronic time sheets must be approved by the employer. Time sheets must be submitted by midnight on the Monday following the pay period. The Payroll Schedule also shows the date and day for pay day. Pay days occur every two weeks and are always on a Friday. Employees are paid by check, direct deposit or pay card.

Remember, any time sheet received by Consumer Direct after the Payroll Schedule due date (Monday by midnight) will be paid on the following pay date.

NEW EMPLOYEE PACKET FLOWSHEET

<u>Legal names</u> must be used on all documents – your legal name is how it is written on your social security card.

- Complete all information on each form found in the employee packet.
- This checklist is for your use only. It does not need to be sent to Consumer Direct.
- Sent new employee packet to Consumer Direct BEFORE the employee starts working.

<u>Employee Data Form (1 page)</u>

- ☐ Employee's legal name, address, phone number, and email address if they have one
- ☐ Date of birth
- ☐ Social Security number
- ☐ Participant's Legal Name
- ☐ Employee signature and date

<u>I-9 (2 pages)</u> - use the example I-9 when completing

Page 1 – *Filled out by **employee***

Section 1:

- ☐ Write N/A if box does not apply. Do not leave any boxes empty.
- ☐ Other names: employee lists all other names they have used such as a maiden name.
- ☐ Must use physical address, no P.O. boxes.

Section 2:

- ☐ One of the check boxes must be checked
- ☐ Employee signature and date – not birthdate

Section 3:

- ☐ Only complete if someone other than the employee filled in or help fill in the information

Page 2 – *Filled out by **employer***

- ☐ In section above List A or List B and List C write in the employee's name as found on page 1. (last name, first name and middle initial)

List A or List B and List C section:

- ☐ Only accept documents found on the list of acceptable documents page
- ☐ Write the document's information in the correct spot.
  - Example: a social security care is a List C document. Write the social security card information under List C – not List A or List B.
- ☐ Check expiration dates. Cannot accept an expired document.
- ☐ Social Security cards and birth certificates do not have expiration dates – write N/A

Certification Section:

- ☐ Write in first day of employment – If first day is unknown, estimate or write in the date the paperwork was filled out.
- ☐ Participant/Legal Guardian signature and date
- ☐ Printed last name and first name of signer
- ☐ Employer name = Participant's First and Last name
- ☐ Employer's address, city, zip code

Section 3:

- ☐ Only used for rehiring purposes.

W-4 (1 page) – provide copy of social security card so Consumer Direct can verify legal name was used

- ☐ Employee's legal name
- ☐ Social Security number
- ☐ Physical address information
- ☐ Box marked in section 3
- ☐ Withholding information – can only have something written in box 5 and 6 OR box 7. Cannot have information written in box 5, 6, and 7.
    - box 5 - withholding amount
    - box 6 - used for extra amount to be taken out for federal and state taxes.
    - Box 7 – used to claim exemption from federal and state taxes.
- ☐ Employee signature and date

Pay Selection Form (1 page)

- ☐ Employee name written at top
- ☐ 1 pay option selected
- ☐ For direct deposit a voided check or letter from bank with routing and account numbers included. No deposit slips
- ☐ Employee signature and date

Employment Relationship Disclosure Form (1 page)

- ☐ Employee's legal name
- ☐ FEIN Holder's legal name (parent/guardian who was set up as the business holder)
- ☐ Participant's legal name
- ☐ 1 relationship box checked
- ☐ If Other is checked must write in relationship
- ☐ Employee signature and date

Medicaid – Community Support Worker Agreement (2 pages)

Page 1:

- ☐ Write in Employee's legal name
- ☐ Check Yes or No

Page 2:

- ☐ Print employee's legal name
- ☐ Employee signature and date

Participant – Community Support Worker Employment Agreement (5 pages)

Page 1

- ☐ Participant's legal name
- ☐ Employee's legal name

Page 2

- ☐ Nothing to fill out

Page 3 – Refer to SSP if needed

- ☐ Column A – provide job description
- ☐ Column B – which service code will employee be using. **Check only one box per row.**
- ☐ Column C – Number of hours or miles used for the year.
- ☐ Column D – **Employee's actual rate of pay**. Do not include rate with taxes.
  - Example: list $13.00/hr not $13.36/hr which includes payroll taxes
- ☐ Column E –multiply amounts from column C by column D.
- ☐ If this is an updated agreement, write in the effective date for when this new agreement should go into effect. Upper right hand corner.

Page 4

- ☐ Section 14 is not required. Use this area if there are additional terms or certificates required for the position.
  - Examples: valid driver's license, automobile insurance, CPR certification, registered nursing degree, must have a cell phone at all times to maintain contact, etc.
- ☐ Participant or Legal Guardian signature and date
- ☐ Employee (CSW) signature and date

Page 5

- ☐ Employee initials if they are getting the criminal history background check
  or
- ☐ Check the box if you are waiving the criminal history background check requirement

Criminal History Background Check

- ☐ Provide background check clearance letter
  or
- ☐ Waive the requirement with the Criminal History Check Waiver of Liability Form.

Criminal History Check Waiver of Liability – Assumption of Risk (1 page)

- ☐ Participant's legal name
- ☐ Medicaid ID #
- ☐ Date
- ☐ Employee's legal name
- ☐ Employee's relationship to the participant
- ☐ Description of service being provided to participant
- ☐ Reason – why are you waiving the background check requirement
- ☐ Healthy and Safety section – by waiving the background check requirement how will you make sure you are healthy and safe
- ☐ Participant or Legal Guardian's signature and date
- ☐ **Support broker signature and date**

IDAHO Fiscal Employer Agent
FAMILY-DIRECTED SERVICES
NEW EMPLOYEE (CSW) CHECKLIST

	/ /	
Employee Name	Estimated Start Date	Child's Name

Welcome to Consumer Direct!

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

The Family Representative should date and initial each item in the lists below as they are completed.

Mandatory Forms - all new Employees

	Date	Initial	
1.	_____	_____	New Employee Checklist (this form)
2.	_____	_____	Employee Data Form
3.	_____	_____	I-9 Form
4.	_____	_____	W-4 Federal Form
5.	_____	_____	Pay Selection Form (attachment may be required)
6.	_____	_____	Employment Relationship Disclosure Form
7.	_____	_____	Medicaid-Community Support Worker Agreement
8.	_____	_____	Participant-Community Support Worker Employment Agreement

Mandatory Documentation - all new Employees

1.	_____	_____	Social Security Card (provide photocopy)

Forms Required only if Employer waives certain Criminal History Check requirements

1.	_____	_____	Criminal History Check – Waiver of Liability – Assumption of Risk
2.	_____	_____	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 Consumer Direct: ____/____/_____

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CONSUMER DIRECT

IDAHO Fiscal Employer Agent
FAMILY-DIRECTED SERVICES
EMPLOYEE DATA FORM

Employee Data Form

Name: _____ _____ _____
First Middle Last

Physical Address: _____

_____
City State Zip Code

County: _____ Region: _____

Mailing Address (if different): _____

_____
City State Zip Code

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

Email: _____

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

Name of Child Receiving Service: _____

Name of Employer (Parent/Legal Guardian): _____

☐ I am enrolling as a Support Broker
☐ I am currently employed by another Participant in the Idaho Self Direction Program

I will primarily turn in my time sheets by:
☐ Online
☐ Fax
☐ US Postal Service
☐ In Person

How do you want to be contacted?
☐ Phone
☐ Email
☐ Mail

***Please Read Carefully*: If you complete an employment agreement you become an employee of the family. You will not be an employee of Consumer Direct.**

_____ _____
Employee Signature Date

00840

Instructions for Completing Form I-9 Section 1

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

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

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

Employee (steps 1-9)

① Print your full legal name: Last, First and Middle Initial. Provide any other names used, such as maiden name. Enter "N/A" if you have never had another name.

② Print your physical address. Entering a PO Box is not allowed. Enter "N/A" if you have no apartment number.

③ Print your date of birth (mm/dd/yyyy).

④ Print your Social Security Number.

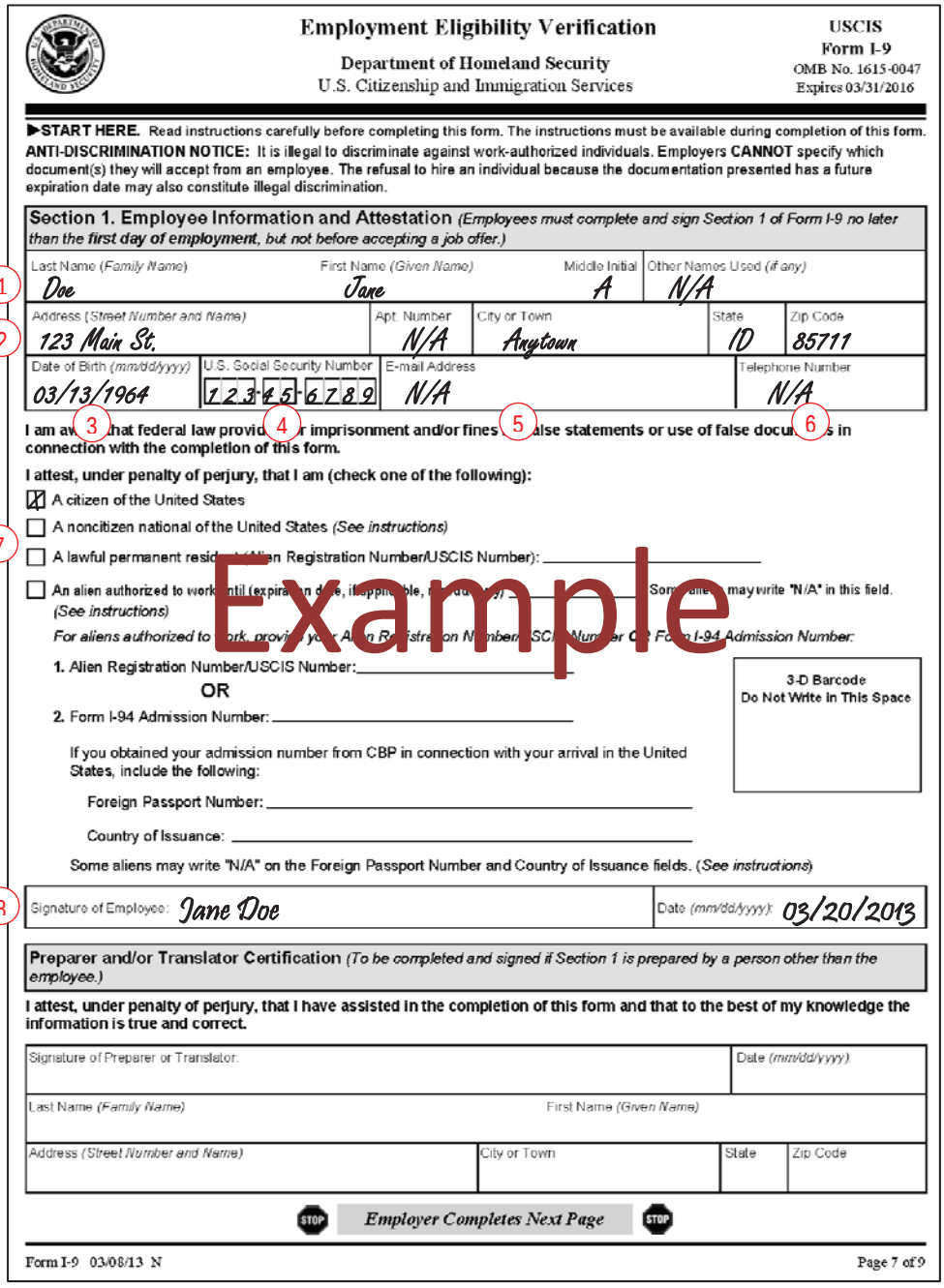
⑤ Print your email address or print "N/A" if you choose not to provide it.

⑥ Print your telephone number or print "N/A" if you choose not to provide it.

⑦ Check the one box that best describes your citizenship or immigration status in the United States.

⑧ Sign and print the date you completed the form. **No later than first day of work for pay.**

⑨ Provide documents to your employer to complete Section 2.



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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

▶START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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

Last Name (Family Name)	First Name (Given Name)	Middle Initial	Other Names Used (if any)
Doe	Jane	A	N/A

Address (Street Number and Name)	Apt. Number	City or Town	State	Zip Code
123 Main St.	N/A	Anytown	ID	85711

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	E-mail Address	Telephone Number
03/13/1964	1 2 3 4 5 6 7 8 9	N/A	N/A

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):

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

For aliens authorized to work, provide your Alien Registration Number/USCIS Number OR Form I-94 Admission Number:

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. *(See instructions)*

3-D Barcode
Do Not Write In This Space

Signature of Employee:	Date (mm/dd/yyyy):
Jane Doe	03/20/2013

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

I attest, under penalty of perjury, that I have assisted in the completion 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)

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

STOP *Employer Completes Next Page* STOP

Form I-9 03/08/13 N Page 7 of 9

Example

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

Instructions for Completing Form I-9 Section 2

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

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

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

Employer (steps 1-10)

① Print employee's name from Section 1: Last, First and Middle Initial.

② Print each document's details in the appropriate List column.

Examine <u>one document from List A</u>

OR

<u>one from List B and one from List C</u>.

Only accept unexpired, original documents (no photocopies).

③ Print the date of the employee's first day of work.

④ Sign the form.

⑤ Print the date you signed the form. **Must be completed and signed within 3 days of employee's first day of work.**

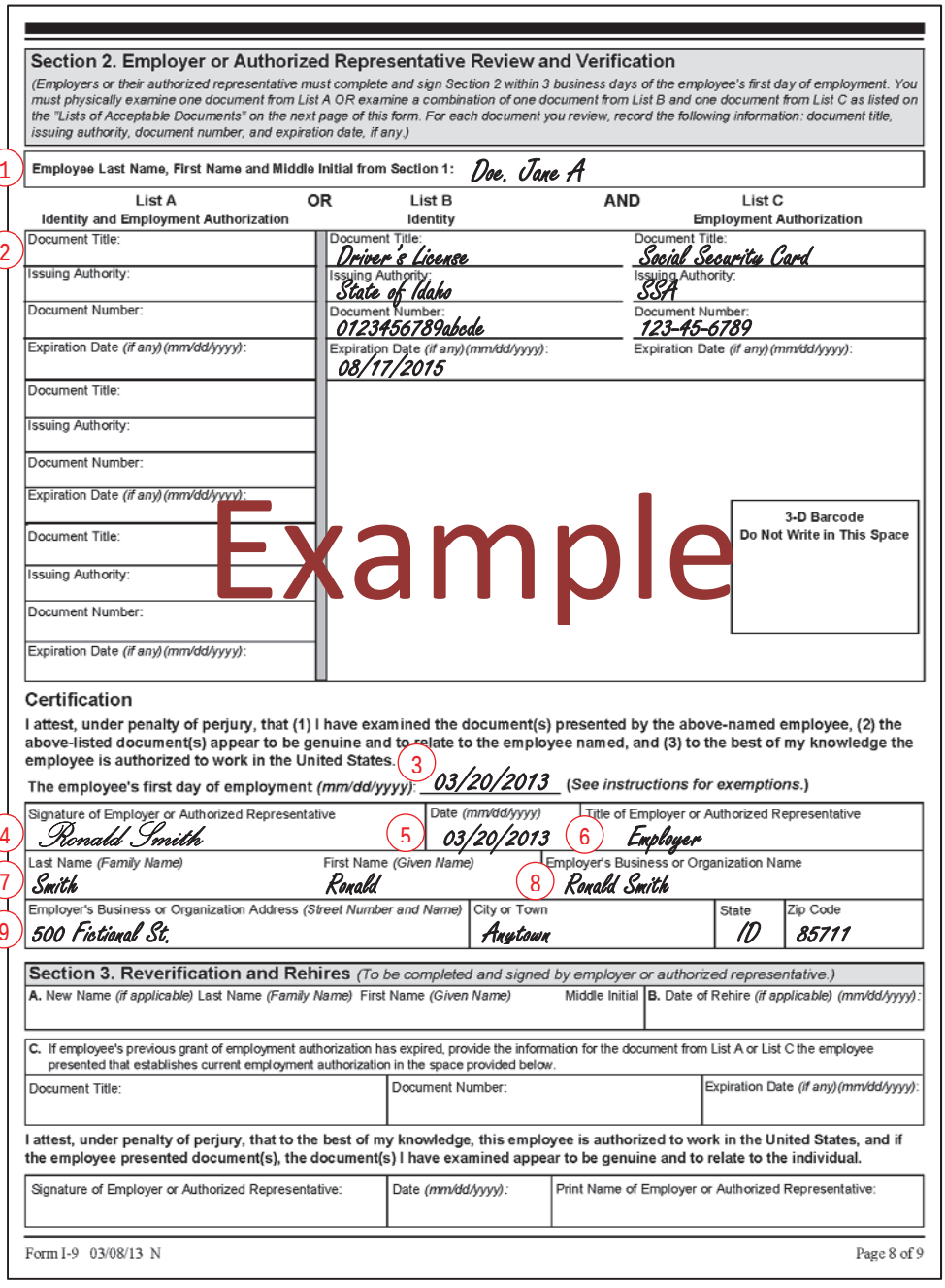
⑥ If not pre-populated, print your title as "Employer."

⑦ Print your last and first name.

⑧ Print your first and last name.

⑨ Print your physical address, city, state and zip code.

⑩ Submit form I-9 to Consumer Direct with the Employee Packet.



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 examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

1 Employee Last Name, First Name and Middle Initial from Section 1: Doe, Jane A

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
2 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: 0123456789abcde		Document Number: 123-45-6789
Expiration Date (if any) (mm/dd/yyyy):		Expiration Date (if any) (mm/dd/yyyy): 08/17/2015		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):				

Example

3-D Barcode 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.

3 **The employee's first day of employment (mm/dd/yyyy):** 03/20/2013 **(See instructions for exemptions.)**

4 Signature of Employer or Authorized Representative	5 Date (mm/dd/yyyy)	6 Title of Employer or Authorized Representative
Ronald Smith	03/20/2013	Employer

7 Last Name (Family Name)	First Name (Given Name)	8 Employer's Business or Organization Name
Smith	Ronald	Ronald Smith

9 Employer's Business or Organization Address (Street Number and Name)	City or Town	State	Zip Code
500 Fictional St.	Anytown	ID	85711

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

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

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current 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:	Date (mm/dd/yyyy):	Print Name of Employer or Authorized Representative:

Form I-9 03/08/13 N Page 8 of 9

Note: These instructions are for informational purposes only. Refer to pages 3 and 4 of Form I-9 Instructions for detailed information.

Instructions for Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

Read all instructions carefully before completing this form.

Anti-Discrimination Notice. It is illegal to discriminate against any work-authorized individual in hiring, discharge, recruitment or referral for a fee, or in the employment eligibility verification (Form I-9 and E-Verify) process based on that individual's citizenship status, immigration status or national origin. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination. For more information, call the Office of Special Counsel for Immigration-Related Unfair Employment Practices (OSC) at 1-800-255-7688 (employees), 1-800-255-8155 (employers), or 1-800-237-2515 (TDD), or visit **www.justice.gov/crt/about/osc**.

What Is the Purpose of This Form?

Employers must complete Form I-9 to document verification of the identity and employment authorization of each new employee (both citizen and noncitizen) hired after November 6, 1986, to work in the United States. In the Commonwealth of the Northern Mariana Islands (CNMI), employers must complete Form I-9 to document verification of the identity and employment authorization of each new employee (both citizen and noncitizen) hired after November 27, 2011. Employers should have used Form I-9 CNMI between November 28, 2009 and November 27, 2011.

General Instructions

Employers are responsible for completing and retaining Form I-9. For the purpose of completing this form, the term "employer" means all employers, including those recruiters and referrers for a fee who are agricultural associations, agricultural employers, or farm labor contractors.

Form I-9 is made up of three sections. Employers may be fined if the form is not complete. Employers are responsible for retaining completed forms. Do not mail completed forms to U.S. Citizenship and Immigration Services (USCIS) or Immigration and Customs Enforcement (ICE).

Section 1. Employee Information and Attestation

Newly hired employees must complete and sign Section 1 of Form I-9 **no later than the first day of employment**. Section 1 should never be completed before the employee has accepted a job offer.

Provide the following information to complete Section 1:

Name: Provide your full legal last name, first name, and middle initial. Your last name is your family name or surname. If you have two last names or a hyphenated last name, include both names in the last name field. Your first name is your given name. Your middle initial is the first letter of your second given name, or the first letter of your middle name, if any.

Other names used: Provide all other names used, if any (including maiden name). If you have had no other legal names, write "N/A."

Address: Provide the address where you currently live, including Street Number and Name, Apartment Number (if applicable), City, State, and Zip Code. Do not provide a post office box address (P.O. Box). Only border commuters from Canada or Mexico may use an international address in this field.

Date of Birth: Provide your date of birth in the mm/dd/yyyy format. For example, January 23, 1950, should be written as 01/23/1950.

U.S. Social Security Number: Provide your 9-digit Social Security number. Providing your Social Security number is voluntary. However, if your employer participates in E-Verify, you must provide your Social Security number.

E-mail Address and Telephone Number (Optional): You may provide your e-mail address and telephone number. Department of Homeland Security **(**DHS) may contact you if DHS learns of a potential mismatch between the information provided and the information in DHS or Social Security Administration (SSA) records. You may write "N/A" if you choose not to provide this information.

All employees must attest in Section 1, under penalty of perjury, to their citizenship or immigration status by checking one of the following four boxes provided on the form:

1. **A citizen of the United States**
2. **A noncitizen national of the United States:** Noncitizen nationals of the United States are persons born in American Samoa, certain former citizens of the former Trust Territory of the Pacific Islands, and certain children of noncitizen nationals born abroad.
3. **A lawful permanent resident:** A lawful permanent resident is any person who is not a U.S. citizen and who resides in the United States under legally recognized and lawfully recorded permanent residence as an immigrant. The term "lawful permanent resident" includes conditional residents. If you check this box, write either your Alien Registration Number (A-Number) or USCIS Number in the field next to your selection. At this time, the USCIS Number is the same as the A-Number without the "A" prefix.
4. **An alien authorized to work:** If you are not a citizen or national of the United States or a lawful permanent resident, but are authorized to work in the United States, check this box.

   If you check this box:

   a. Record the date that your employment authorization expires, if any. Aliens whose employment authorization does not expire, such as refugees, asylees, and certain citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or Palau, may write "N/A" on this line.

   b. Next, enter your Alien Registration Number (A-Number)/USCIS Number. At this time, the USCIS Number is the same as your A-Number without the "A" prefix. If you have not received an A-Number/USCIS Number, record your Admission Number. You can find your Admission Number on Form I-94, "Arrival-Departure Record," or as directed by USCIS or U.S. Customs and Border Protection (CPB).

   (1) If you obtained your admission number from CBP in connection with your arrival in the United States, then also record information about the foreign passport you used to enter the United States (number and country of issuance).

   (2) If you obtained your admission number from USCIS *within the United States*, or you entered the United States without a foreign passport, you must write "N/A" in the Foreign Passport Number and Country of Issuance fields.

Sign your name in the "Signature of Employee" block and record the date you completed and signed Section 1. By signing and dating this form, you attest that the citizenship or immigration status you selected is correct and that you are aware that you may be imprisoned and/or fined for making false statements or using false documentation when completing this form. To fully complete this form, you must present to your employer documentation that establishes your identity and employment authorization. Choose which documents to present from the Lists of Acceptable Documents, found on the last page of this form. You must present this documentation no later than the third day after beginning employment, although you may present the required documentation before this date.

Preparer and/or Translator Certification

The Preparer and/or Translator Certification must be completed if the employee requires assistance to complete Section 1 (e.g., the employee needs the instructions or responses translated, someone other than the employee fills out the information blocks, or someone with disabilities needs additional assistance). The employee must still sign Section 1.

Minors and Certain Employees with Disabilities (Special Placement)

Parents or legal guardians assisting minors (individuals under 18) and certain employees with disabilities should review the guidelines in the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)* on **www.uscis.gov/I-9Central** before completing Section 1. These individuals have special procedures for establishing identity if they cannot present an identity document for Form I-9. The special procedures include **(1)** the parent or legal guardian filling out Section 1 and writing "minor under age 18" or "special placement," whichever applies, in the employee signature block; and **(2)** the employer writing "minor under age 18" or "special placement" under List B in Section 2.

Section 2. Employer or Authorized Representative Review and Verification

Before completing Section 2, employers must ensure that Section 1 is completed properly and on time. Employers may not ask an individual to complete Section 1 before he or she has accepted a job offer.

Employers or their authorized representative must complete Section 2 by examining evidence of identity and employment authorization within 3 business days of the employee's first day of employment. For example, if an employee begins employment on Monday, the employer must complete Section 2 by Thursday of that week. However, if an employer hires an individual for less than 3 business days, Section 2 must be completed no later than the first day of employment. An employer may complete Form I-9 before the first day of employment if the employer has offered the individual a job and the individual has accepted.

Employers cannot specify which document(s) employees may present from the Lists of Acceptable Documents, found on the last page of Form I-9, to establish identity and employment authorization. Employees must present one selection from List A **OR** a combination of one selection from List B and one selection from List C. List A contains documents that show both identity and employment authorization. Some List A documents are combination documents. The employee must present combination documents together to be considered a List A document. For example, a foreign passport and a Form I-94 containing an endorsement of the alien's nonimmigrant status must be presented together to be considered a List A document. List B contains documents that show identity only, and List C contains documents that show employment authorization only. If an employee presents a List A document, he or she should **not** present a List B and List C document, and vice versa. If an employer participates in E-Verify, the List B document must include a photograph.

In the field below the Section 2 introduction, employers must enter the last name, first name and middle initial, if any, that the employee entered in Section 1. This will help to identify the pages of the form should they get separated.

Employers or their authorized representative must:

1. Physically examine each original document the employee presents to determine if it reasonably appears to be genuine and to relate to the person presenting it. The person who examines the documents must be the same person who signs Section 2. The examiner of the documents and the employee must both be physically present during the examination of the employee's documents.
2. Record the document title shown on the Lists of Acceptable Documents, issuing authority, document number and expiration date (if any) from the original document(s) the employee presents. You may write "N/A" in any unused fields.

   If the employee is a student or exchange visitor who presented a foreign passport with a Form I-94, the employer should also enter in Section 2:

   a. The student's Form I-20 or DS-2019 number (Student and Exchange Visitor Information System-SEVIS Number); **and** the program end date from Form I-20 or DS-2019.
3. Under Certification, enter the employee's first day of employment. Temporary staffing agencies may enter the first day the employee was placed in a job pool. Recruiters and recruiters for a fee do not enter the employee's first day of employment.
4. Provide the name and title of the person completing Section 2 in the Signature of Employer or Authorized Representative field.
5. Sign and date the attestation on the date Section 2 is completed.
6. Record the employer's business name and address.
7. Return the employee's documentation.

Employers may, but are not required to, photocopy the document(s) presented. If photocopies are made, they should be made for **ALL** new hires or reverifications. Photocopies must be retained and presented with Form I-9 in case of an inspection by DHS or other federal government agency. Employers must always complete Section 2 even if they photocopy an employee's document(s). Making photocopies of an employee's document(s) cannot take the place of completing Form I-9. Employers are still responsible for completing and retaining Form I-9.

Unexpired Documents

Generally, only unexpired, original documentation is acceptable. The only exception is that an employee may present a certified copy of a birth certificate. Additionally, in some instances, a document that appears to be expired may be acceptable if the expiration date shown on the face of the document has been extended, such as for individuals with temporary protected status. Refer to the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)* or I-9 Central (www.uscis.gov/I-9Central) for examples.

Receipts

If an employee is unable to present a required document (or documents), the employee can present an acceptable receipt in lieu of a document from the Lists of Acceptable Documents on the last page of this form. Receipts showing that a person has applied for an initial grant of employment authorization, or for renewal of employment authorization, are not acceptable. Employers cannot accept receipts if employment will last less than 3 days. Receipts are acceptable when completing Form I-9 for a new hire or when reverification is required.

Employees must present receipts within 3 business days of their first day of employment, or in the case of reverification, by the date that reverification is required, and must present valid replacement documents within the time frames described below.

There are three types of acceptable receipts:

1. A receipt showing that the employee has applied to replace a document that was lost, stolen or damaged. The employee must present the actual document within 90 days from the date of hire.
2. The arrival portion of Form I-94/I-94A with a temporary I-551 stamp and a photograph of the individual. The employee must present the actual Permanent Resident Card (Form I-551) by the expiration date of the temporary I-551 stamp, or, if there is no expiration date, within 1 year from the date of issue.
3. The departure portion of Form I-94/I-94A with a refugee admission stamp. The employee must present an unexpired Employment Authorization Document (Form I-766) or a combination of a List B document and an unrestricted Social Security card within 90 days.

When the employee provides an acceptable receipt, the employer should:

1. Record the document title in Section 2 under the sections titled List A, List B, or List C, as applicable.
2. Write the word "receipt" and its document number in the "Document Number" field. Record the last day that the receipt is valid in the "Expiration Date" field.

By the end of the receipt validity period, the employer should:

1. Cross out the word "receipt" and any accompanying document number and expiration date.
2. Record the number and other required document information from the actual document presented.
3. Initial and date the change.

See the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)* at **www.uscis.gov/I-9Central** for more information on receipts.

Section 3. Reverification and Rehires

Employers or their authorized representatives should complete Section 3 when reverifying that an employee is authorized to work. When rehiring an employee within 3 years of the date Form I-9 was originally completed, employers have the option to complete a new Form I-9 or complete Section 3. When completing Section 3 in either a reverification or rehire situation, if the employee's name has changed, record the name change in Block A.

For employees who provide an employment authorization expiration date in Section 1, employers must reverify employment authorization on or before the date provided.

Some employees may write "N/A" in the space provided for the expiration date in Section 1 if they are aliens whose employment authorization does not expire (e.g., asylees, refugees, certain citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or Palau). Reverification does not apply for such employees unless they chose to present evidence of employment authorization in Section 2 that contains an expiration date and requires reverification, such as Form I-766, Employment Authorization Document.

Reverification applies if evidence of employment authorization (List A or List C document) presented in Section 2 expires. However, employers should not reverify:

1. U.S. citizens and noncitizen nationals; or

2. Lawful permanent residents who presented a Permanent Resident Card (Form I-551) for Section 2.

Reverification does not apply to List B documents.

If both Section 1 and Section 2 indicate expiration dates triggering the reverification requirement, the employer should reverify by the earlier date.

For reverification, an employee must present unexpired documentation from either List A or List C showing he or she is still authorized to work. Employers CANNOT require the employee to present a particular document from List A or List C. The employee may choose which document to present.

To complete Section 3, employers should follow these instructions:

1. Complete Block A if an employee's name has changed at the time you complete Section 3.

2. Complete Block B with the date of rehire if you rehire an employee within 3 years of the date this form was originally completed, and the employee is still authorized to be employed on the same basis as previously indicated on this form. Also complete the "Signature of Employer or Authorized Representative" block.

3. Complete Block C if:

   a. The employment authorization or employment authorization document of a current employee is about to expire and requires reverification; or

   b. You rehire an employee within 3 years of the date this form was originally completed and his or her employment authorization or employment authorization document has expired. (Complete Block B for this employee as well.)

   To complete Block C:

   a. Examine either a List A or List C document the employee presents that shows that the employee is currently authorized to work in the United States; and

   b. Record the document title, document number, and expiration date (if any).

4. After completing block A, B or C, complete the "Signature of Employer or Authorized Representative" block, including the date.

   For reverification purposes, employers may either complete Section 3 of a new Form I-9 or Section 3 of the previously completed Form I-9. Any new pages of Form I-9 completed during reverification must be attached to the employee's original Form I-9. If you choose to complete Section 3 of a new Form I-9, you may attach just the page containing Section 3, with the employee's name entered at the top of the page, to the employee's original Form I-9. If there is a more current version of Form I-9 at the time of reverification, you must complete Section 3 of that version of the form.

What Is the Filing Fee?

There is no fee for completing Form I-9. This form is not filed with USCIS or any government agency. Form I-9 must be retained by the employer and made available for inspection by U.S. Government officials as specified in the **"USCIS Privacy Act Statement"** below.

USCIS Forms and Information

For more detailed information about completing Form I-9, employers and employees should refer to the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)*.

You can also obtain information about Form I-9 from the USCIS Web site at www.uscis.gov/I-9Central, by e-mailing USCIS at **I-9Central@dhs.gov**, or by calling **1-888-464-4218**. For TDD (hearing impaired), call **1-877-875-6028**.

To obtain USCIS forms or the *Handbook for Employers*, you can download them from the USCIS Web site at www.uscis.gov/forms. You may order USCIS forms by calling our toll-free number at **1-800-870-3676**. You may also obtain forms and information by contacting the USCIS National Customer Service Center at **1-800-375-5283**. For TDD (hearing impaired), call **1-800-767-1833**.

Information about E-Verify, a free and voluntary program that allows participating employers to electronically verify the employment eligibility of their newly hired employees, can be obtained from the USCIS Web site at www.dhs.gov/E-Verify, by e-mailing USCIS at **E-Verify@dhs.gov** or by calling **1-888-464-4218**. For TDD (hearing impaired), call **1-877-875-6028.**

Employees with questions about Form I-9 and/or E-Verify can reach the USCIS employee hotline by calling **1-888-897-7781**. For TDD (hearing impaired), call **1-877-875-6028.**

Photocopying and Retaining Form I-9

A blank Form I-9 may be reproduced, provided all sides are copied. The instructions and Lists of Acceptable Documents must be available to all employees completing this form. Employers must retain each employee's completed Form I-9 for as long as the individual works for the employer. Employers are required to retain the pages of the form on which the employee and employer enter data. If copies of documentation presented by the employee are made, those copies must also be kept with the form. Once the individual's employment ends, the employer must retain this form for either 3 years after the date of hire or 1 year after the date employment ended, whichever is later.

Form I-9 may be signed and retained electronically, in compliance with Department of Homeland Security regulations at 8 CFR 274a.2.

USCIS Privacy Act Statement

AUTHORITIES: The authority for collecting this information is the Immigration Reform and Control Act of 1986, Public Law 99-603 (8 USC 1324a).

PURPOSE: This information is collected by employers to comply with the requirements of the Immigration Reform and Control Act of 1986. This law requires that employers verify the identity and employment authorization of individuals they hire for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

DISCLOSURE: Submission of the information required in this form is voluntary. However, failure of the employer to ensure proper completion of this form for each employee may result in the imposition of civil or criminal penalties. In addition, employing individuals knowing that they are unauthorized to work in the United States may subject the employer to civil and/or criminal penalties.

ROUTINE USES: This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The employer will keep this form and make it available for inspection by authorized officials of the Department of Homeland Security, Department of Labor, and Office of Special Counsel for Immigration-Related Unfair Employment Practices.

Paperwork Reduction Act

An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The public reporting burden for this collection of information is estimated at 35 minutes per response, including the time for reviewing instructions and completing and retaining the form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: U.S. Citizenship and Immigration Services, Regulatory Coordination Division, Office of Policy and Strategy, 20 Massachusetts Avenue NW, Washington, DC 20529-2140; OMB No. 1615-0047. **Do not mail your completed Form I-9 to this address.**

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

►START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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

Last Name (*Family Name*)	First Name *(Given Name)*	Middle Initial	Other Names Used *(if any)*

Address (*Street Number and Name)*	Apt. Number	City or Town	State	Zip Code
			Idaho	

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	E-mail Address	Telephone Number
/ /	☐☐☐-☐☐-☐☐☐☐		

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

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

☐ A citizen of the United States

☐ A noncitizen national of the United States *(See instructions)*

☐ A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____ . Some aliens may write "N/A" in this field. *(See instructions)*

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date *(mm/dd/yyyy):*

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

I attest, under penalty of perjury, that I have assisted in the completion 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)*		
Address *(Street Number and Name)*	City or Town	State	Zip Code

STOP ***Employer Completes Next Page*** STOP

03149

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 examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title:		Document Title:		Document Title:
Issuing Authority:		Issuing Authority:		Issuing Authority:
Document Number:		Document Number:		Document Number:
Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				

3-D Barcode
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)*: _____ (*See instructions for exemptions*.)

Signature of Employer or Authorized Representative	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative Employer
Last Name *(Family Name)* First Name *(Given Name)*		Employer's Business or Organization Name
Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State / Zip Code

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

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

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current 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:	Date *(mm/dd/yyyy):*	Print Name of Employer or Authorized Representative:

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

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

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.

00540 - Delete

Form W-4 (2014)

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

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2014 expires February 17, 2015. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,000 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity iincome, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2014. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	**A**	
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less. . . .	**B**	
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	**C**	
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	**D**	
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . .	**E**	
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit . . . (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	**F**	
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $65,000 ($95,000 if married), enter "2" for each eligible child; then **less** "1" if you have three to six eligible children or **less** "2" if you have seven or more eligible children. • If your total income will be between $65,000 and $84,000 ($95,000 and $119,000 if married), enter "1" for each eligible child . . .	**G**	
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ►	**H**	

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Separate here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

► **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2014

1 Your first name and middle initial	Last name	**2 Your social security number**	
Home address (number and street or rural route)		**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code		**4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ► ☐	
5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)		**5**	
6 Additional amount, if any, you want withheld from each paycheck		**6**	$
7 I claim exemption from withholding for 2014, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here . . . . . ►		**7**	

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

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

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number (EIN)

For Privacy Act and Paperwork Reduction Act Notice, see page 2. Cat. No. 10220Q

00884

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2014 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1950) of your income, and miscellaneous deductions. For 2014, you may have to reduce your itemized deductions if your income is over $305,050 and you are married filing jointly or are a qualifying widow(er); $279,650 if you are head of household; $254,200 if you are single and not head of household or a qualifying widow(er); or $152,525 if you are married filing separately. See Pub. 505 for details	1	$
2	Enter: { $12,400 if married filing jointly or qualifying widow(er); $9,100 if head of household; $6,200 if single or married filing separately }	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2014 adjustments to income and any additional standard deduction (see Pub. 505)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2014 Form W-4* worksheet in Pub. 505.)	5	$
6	Enter an estimate of your 2014 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero or less, enter "-0-"	7	$
8	**Divide** the amount on line 7 by $3,950 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**)	1	
2	Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3"	2	
3	If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet	3	

Note. If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4	Enter the number from line 2 of this worksheet	4	
5	Enter the number from line 1 of this worksheet	5	
6	**Subtract** line 5 from line 4	6	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here	7	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	$
9	Divide line 8 by the number of pay periods remaining in 2014. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2014. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	$

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $6,000	0	$0 - $6,000	0
6,001 - 13,000	1	6,001 - 16,000	1
13,001 - 24,000	2	16,001 - 25,000	2
24,001 - 26,000	3	25,001 - 34,000	3
26,001 - 33,000	4	34,001 - 43,000	4
33,001 - 43,000	5	43,001 - 70,000	5
43,001 - 49,000	6	70,001 - 85,000	6
49,001 - 60,000	7	85,001 - 110,000	7
60,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 100,000	10	140,001 and over	10
100,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $74,000	$590	$0 - $37,000	$590
74,001 - 130,000	990	37,001 - 80,000	990
130,001 - 200,000	1,110	80,001 - 175,000	1,110
200,001 - 355,000	1,300	175,001 - 385,000	1,300
355,001 - 400,000	1,380	385,001 and over	1,560
400,001 and over	1,560		

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

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

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

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

00540

CONSUMER DIRECT

PAY SELECTION FORM

Name: _____

(please print)

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

Consumer Direct offers the following pay options. Please select <u>one</u> option below.

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

☐ **Bank or Credit Union Direct Deposit** – I authorize Consumer Direct to initiate payroll deposits to (name of bank or financial institution): _____

Account Type (check one): ☐ Checking ☐ Savings

For Checking Accounts:

Attach (tape) a voided check here

Do not attach a deposit slip.

For Savings Accounts: provide a document from your bank with exact numbers to process direct deposits to your account. If the document is larger than a standard-sized check, please provide a separate document. Do not attach a deposit slip because it does not have all the necessary numbers.

I authorize Consumer Direct to process my selected method of pay as indicated. In the event that funds are deposited mistakenly to my account, I authorize Consumer Direct to debit my account to correct the error. It is my responsibility to confirm that each deposit has occurred and to pay any fees caused by overdrafts on my account. Deposits will be made on each payday unless I notify my employer, in writing, of my request to stop direct deposits. I understand that Consumer Direct reserves the right to refuse any direct deposit request, that all direct deposits are made through an Automated Clearing House (ACH), and that the processing is subject to ACH terms and limitations, as well as those of my financial institution. I understand that I may still receive a paper check while my selected method of pay is being set up.

☐ **Opt-Out (decline or stop direct deposit)** – I decline direct deposit and authorize Consumer Direct to issue me pay checks and to mail them to my address on file. I accept that I may not receive my paycheck on paydays due to USPS First Class mail delays or operations.

_____ _____

Signature Date

00842

Rev. 10/05/2014

Your Pay

FASTER. SAFER. EASIER.

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

Immediately loaded to your card on payday | **Available to use** right away | **Protected** if lost or stolen[1]

About the Focus Card

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

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

Getting Started is Easy

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

Sign Up!

$0.00 No cost to sign up.

No credit check or bank account required.[2]

And Save!

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

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

Please select the US Bank Focus Card Direct Deposit option on your Consumer Direct Pay Selection Form to enroll.

Consumer Direct

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

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

focus

Getting Started

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

Follow the activation instructions that accompany your card.

Features

Cash Back Rewards

For purchases at certain retail and restaurant locations.

Savings Account

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

Cash Reload Networks[5]

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

Text and Email Alerts[4]

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

Mobile Banking App[4]

Quickly see your account balance and transaction history.

Track Spending

Online | Phone | Email | Text[4] | Mobile App

Fee Schedule

Activity		Cost		
Monthly Account Maintenance		Free		
Purchases at Point-of-Sale (Domestic)		Free		
Cash Back with Purchases (Domestic)		Free		
ATM Transactions		Cash Withdrawal	Declined Withdrawal	Balance Inquiry
The owner of any Non-U.S. Bank or Non-MoneyPass ATM may assess an additional surcharge fee for any ATM transaction that you complete.	U.S. Bank ATM	Free	Free	Free
	MoneyPass® ATM	Free	Free	Free
	Allpoint® ATM	Free	Free	Free
	Other ATM	$2.00	$0.50	$1.00
	International ATM	$3.00	$0.50	$1.00
Teller Cash Withdrawal		Free		
Teller Cash Withdrawal Decline		$0.00		
Customer Service Automated Phone Service, Online, Live Phone Representative		Free		
Text or Email Alerts[4]		Free		
Inactivity After 90 consecutive days. Not assessed if balance is $0.00.		$2.00 Per Month		
Monthly Paper Statement		If requested – $2.00		
Card Replacement				
Non-Personalized Issued by employer (If applicable to your program)		$5.00		
Personalized		Standard $5.00; Expedited $15.00; Overnight $25.00		
ChekToday Convenience Checks (If applicable to your program)	Check Authorization	Free		
	Check Order	Free; Expedited $35.00		
	Check Return	$25.00		
	Stop Payment	$25.00		
	Lost/Stolen Check	$25.00		
	Void Check	Free		
	Check Reversal	$25.00		
	Check Copy	$10.00		
Foreign Transaction		Up to 3% of transaction amount		

Transaction Limits	Count	Amount
Maximum Card Balance	N/A	$40,000
Purchases (includes cash back)	20 per day	$4,000 per day
Cash Loads (If applicable to your program)	3 per day	$950 per day
Teller Cash Withdrawal	5 per day	$2,525 per day
ATM Withdrawal	5 per day	$1,525 per day; $1,025 max transaction
Loads or Deposits	10 per day	$20,000 per day
Signature-based POS returns	4 per day	N/A
Pending ACH Credits	5 per day	$5,000 per day
ACH Loads	5 per day	$20,000 per day

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

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

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

Idaho Fiscal Employer Agent
Family-Directed Services
EMPLOYMENT RELATIONSHIP DISCLOSURE

Employee Name	FEIN Holder Name	Child Name

Instructions: Each Employee must provide the following information about their relationship with the employer (FEIN Holder) and the Family Directed Services recipient (child receiving services) before employment begins. You must review, complete all the sections below, and sign and date at the bottom of the form. This information is required to begin employment.

1) EMPLOYEE/FEIN HOLDER RELATIONSHIP DISCLOSURE:
Before employment, my existing relationship with the above-named **FEIN Holder (please check one):**

- ☐ Parent (Exempt)
- ☐ Spouse (Exempt)
- ☐ Sibling
- ☐ No relationship
- ☐ Step Parent (Exempt)
- ☐ Child, under age 21 (Exempt)
- ☐ Legal Representative/Power of Attorney
- ☐ Other, please describe: _____

2) EMPLOYEE/CHILD RECEIVING SERVICES RELATIONSHIP DISCLOSURE:
Before employment, my existing relationship with the above-named **Child (please check one)**:

- ☐ Parent (Not allowed to be a paid employee)
- ☐ No relationship
- ☐ Sibling
- ☐ Step Parent (Not allowed to be a paid employee)
- ☐ Guardian (Not allowed to be a paid employee)
- ☐ Other, please describe: _____

3) RELATIONSHIP AND EMPLOYMENT ACKNOWLEDGMENTS:

• **All Employees are Subject to Federal and State Tax Withholding -** I understand that regardless of my relationship with the FEIN Holder, I am subject to all employment requirements including criminal background checks (unless waived by the Participant) and Federal and State tax withholdings.

• **Federal and state taxation rules change frequently.** *Please consult with your tax advisor if you have any questions on completion of your W-4. If you discover that your tax situation has changed during the year, you may submit a revised W-4 for withholding adjustments on future pay.*

• **Exempt Employees -** If my relationship with the FEIN Holder indicates Exempt above, I understand I am entering into an employment relationship that is exempt from FICA (Social Security), Medicare, FUTA (Federal Unemployment) and SUTA (State Unemployment) and those taxes will not be withheld or applied on my paycheck.

• **By not paying into certain taxes it means I am not earning Social Security history work credits.** When you work and pay into FICA (Social Security), you earn work credits toward Social Security benefits. If my relationship with the FEIN Holder indicates Exempt above, I understand I will not earn Social Security Work Credits.

• **I understand that if I am the Parent, Step Parent, or Guardian of the Child named above, I cannot be a paid Employee in the Family Directed Services option.**

4) AMENDED PAYROLL TAX RETURNS: Consumer Direct will file all required amended payroll tax returns in instances where there have been overcollected Social Security and Medicare taxes from employees' compensation. The employee will receive refunds of overcollected social security and Medicare taxes directly from Consumer Direct. These refunds will be paid to the employee in January immediately following year-end. The employee agrees that they have not, or will not file a claim for refund of overcollected Medicare or Social Security with the IRS.

_____ _____

Employee Signature *Date*

00841

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

_____, 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

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

_____

Printed name of CSW

_____

Signature of CSW Date

Note: Each CSW must sign personally.

00861

IDAHO DEPARTMENT OF HEALTH & WELFARE

PARTICIPANT-COMMUNITY SUPPORT WORKER EMPLOYMENT AGREEMENT

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

and_____, a Community Support Worker (CSW).

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

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

1. CSW services are to be provided in accordance with the Participant's SDCS Support and Spending Plan, and the SDCS rules, outlined in IDAPA 16.03.13, "Consumer-Directed Services."

2. It is mutually understood that CSW is the employee of the Participant, and that the Participant directs, controls and approves the CSW's work.

3. The CSW is hired to assist the Participant and assumes no legal liability for the Participant's conduct.

4. The CSW promises that he/she meets the following minimum qualifications to be a CSW, as outlined in Section 136 of IDAPA 16.03.13, "Consumer-Directed Services."

5. The parties mutually agree that CSW is an employee of the Participant and is not an employee of the SDCS Option or the Fiscal Employer Agent (FEA), and agree that the CSW is not entitled to nor will make claim for any employee benefits from the SDCS Option or the FEA, including but not limited to, worker's compensation, disability, life or health insurance.

6. The CSW agrees to notify the Participant immediately in the event he/she is unable to provide the agreed services due to sickness, injury or personal emergency. The CSW must obtain the Participant's written approval in advance for any pre-planned absence.

7. The Participant shall train the CSW on the duties and responsibilities of the CSW and shall be responsible for approving the accuracy of CSW's time records.

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

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

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

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

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

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

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.

****Effective date** _____

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

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:

_____

_____

_____

_____

_____

15. The Community Support Worker (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 completed criminal history check, including clearance in accordance with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks";
    - **The CSW will list the Department as the agency/employer, using identification number 1710.**
- A copy of this agreement; and
- Time sheets approved by Participant recording hours worked.

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

- Unless the Criminal History Background Check is Waived, the Community Support Worker 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 the 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.

IDAHO DEPARTMENT OF
HEALTH & WELFARE

Criminal History Check
Waiver of Liability - Assumption of Risk

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

Waiver: I do not want (name of community support worker) _____ to be subject to

Criminal History Check requirements.

Relationship to the Participant: _____

Description of Service: _____

Reason:

_____

_____

_____

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

_____

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

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

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

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

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

Comments:

_____

_____
Signature of Support Broker Date

00867

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

00868

Dear Community Support Worker,

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

The annual Open Enrollment Period for the Health Insurance Marketplace is usually scheduled to begin on November 15th each year for coverage starting January 1st of each year. This is the ***one*** time of year where you can apply for private health insurance coverage through the marketplace. To confirm Open Enrollment Period dates for this year, please contact www.HealthCare.gov. ***NOTE****: You can apply for Medicaid or CHIP (Children's Health Insurance Program) any time of year.*

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

If you have any questions about healthcare reform or the online application process, please contact the Health Insurance Marketplace Call Center at 1-800-318-2596 or visit www.HealthCare.gov.

Thank you,
Human Resources Department
for Consumer Direct and the Consumer Direct Family of Companies

Health Care Marketplace

PART A: General Information

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please call 1-800-318-2596 or visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

In the Idaho self-directed care model, the Participant is the employer of record and the managing employer. **Health insurance is not being offered by your employer.** You and your family may be able to obtain health coverage through the Marketplace, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.

Medicaid Coverage

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

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

- Contact your state Medicaid agency online at www.healthandwelfare.idaho.gov or call their Customer Service Center at 1-877-456-1233.

- Fill out an application for coverage in the Health Insurance Marketplace at www.healthcare.gov/marketplace.

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

IDAHO Fiscal Employer Agent
FAMILY-DIRECTED SERVICES
NEW SUPPORT BROKER CHECKLIST

	/ /	
Support Broker Name	Estimated Start Date	Child's Name

Welcome to Consumer Direct!

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

The Family Representative should date and initial each item in the lists below as they are completed.

Mandatory Forms - all new Support Brokers

	Date	Initial	
1.	_____	_____	New Employee Checklist (this form)
2.	_____	_____	Employee Data Form
3.	_____	_____	Participant-Support Broker Employment Agreement
4.	_____	_____	I-9 Form
5.	_____	_____	W-4 Federal Form
6.	_____	_____	Pay Selection Form (Attachment may be required)
7.	_____	_____	Employment Relationship Disclosure Form
8.	_____	_____	Medicaid-Support Broker Agreement

Mandatory Documentation - all new Support Brokers

1.	_____	_____	Social Security Card (provide photocopy)
2.	_____	_____	Support Broker Qualifications Letter
3.	_____	_____	Notice of Clearance Letter – 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 Consumer Direct: ____/____/_____

CONSUMER DIRECT

IDAHO Fiscal Employer Agent
FAMILY-DIRECTED SERVICES
EMPLOYEE DATA FORM

Employee Data Form

Name: _____ _____ _____
First Middle Last

Physical Address: _____

_____
City State Zip Code

Idaho

County: _____ Region: _____

Mailing Address (if different): _____

_____
City State Zip Code

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

Email: _____

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

Name of Child Receiving Service: _____

Name of Employer (Parent/Legal Guardian): _____

☑ I am enrolling as a Support Broker
☐ I am currently employed by another Participant in the Idaho Self Direction Program

I will primarily turn in my time sheets by:
☐ Online
☐ Fax
☐ US Postal Service
☐ In Person

How do you want to be contacted?
☐ Phone
☐ Email
☐ Mail

***Please Read Carefully*: If you complete an employment agreement you become an employee of the family. You will not be an employee of Consumer Direct.**

_____ _____
Employee Signature Date

00840

IDAHO DEPARTMENT OF
HEALTH & WELFARE

PARTICIPANT-SUPPORT BROKER EMPLOYMENT AGREEMENT

This agreement is hereby made between _____a participant of the Self-Directed Community Supports (SDCS) Option, a Medicaid option administered by the Department of Health and Welfare (department), and _____, a Support Broker.

The participant wants to hire the support broker for services under the Self-Directed Community Supports Option. In exchange, the support broker wants to be paid for the 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 support broker and approved by the employer, who is the participant.

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

1. Support broker services are to be provided in accordance with "Participant-Support Broker Agreement", and the Self-Directed Community Supports rules, according to the Idaho Administrative Procedures Act (IDAPA) 16.03.13, "Consumer-Directed Services."

2. The support broker is hired to help the participant, and assumes no responsibility for the participant's conduct.

3. That the support broker is an employee of the participant and not an employee of the Self-Directed Community Support Option or the FEA, and agree that the support broker is not entitled to, nor will make claim for any employee benefits from the Self-Directed Community Support Option or the FEA, including but not limited to, worker's compensation, disability, life insurance, or health insurance.

4. The support broker will take all actions necessary to become the participant's employee, and to maintain the employment relationship by submitting necessary documents to the FEA, including:

   - A "Support Broker Letter of Approval" from the Department.
   - A Completed W-4, I-9, and other IRS required forms.
   - A completed criminal history check, including clearance in accordance with *IDAPA* 16.05.06, "Criminal History and Background Checks".
   - A copy of this agreement.
   - Participant approved time sheets that record the hours the support broker worked.

5. The support broker will provide all required support broker duties outlined in Subsection 136.02 of *IDAPA* 16.03.13, "Consumer-Directed Services" and, as mutually agreed upon with the participant, the optional support broker duties outlined in Subsection 136.03 of *IDAPA* 16.03.13, "Consumer-Directed Services."

6. The support broker's wage is not to exceed $18.72 per hour. It is mutually understood that any overtime hours or services not described in the participant's "Self-Directed Community Supports Support and Spending Plan", or described elsewhere in this agreement, are not covered by or paid through this agreement.

7. Terms and conditions of work (job duties):

Service or Task	Service Code	Number of hours per year needed to perform this task		Wage per hour		Annual Cost
Person centered planning participation includes:	☐ SBS ☐ SB2 ☐ SB3		X		=	$ Sub Total
Developing the written Support and Spending Plan includes:	☐ SBS ☐ SB2 ☐ SB3		X		=	$ Sub Total
Helping the employer to review and monitor the budget includes:	☐ SBS ☐ SB2 ☐ SB3		X		=	$ Sub Total
Submitting the employer satisfaction documentation to the department as requested includes:	☐ SBS ☐ SB2 ☐ SB3		X		=	$ Sub Total
Participating in the quality assurance process with the department includes:	☐ SBS ☐ SB2 ☐ SB3		X		=	$ Sub Total
Helping the employer with the annual re-determination process includes:	☐ SBS ☐ SB2 ☐ SB3		X		=	$ Sub Total
Helping the employer to meet participant responsibilities includes:	☐ SBS ☐ SB2 ☐ SB3		X		=	$ Sub Total
Criminal History Check Waiver Process (example: complete waiver form, education and counseling to participant and circle of support, assist with detailing rationale for waiver and identifying how health and safety will be protected).	☐ SBS ☐ SB2 ☐ SB3		X		=	$ Sub Total
Other: Give details of job duties:	☐ SBS ☐ SB2 ☐ SB3		X		=	$ Sub Total
Total Cost of Annual Support					=	$ Total

The support broker agrees not to 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-Support Broker Agreement" has been submitted to the FEA.

Medicaid funding can only pay for services that are provided. Under the provision of this agreement, the employee cannot bill for holiday, vacation, or sick time taken. Overtime hours are not allowed.

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 with their signatures. It is mutually understood that this is employment at will. Either party can terminate the relationship without cause with 30 days notice. This agreement can be terminated immediately at any time by the participant due to unsatisfactory support broker performance.

Participant	Date
Legal Guardian (if applicable)	Date
Support Broker	Date

Instructions for Completing Form I-9 Section 1

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

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

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

Employee (steps 1-9)

① Print your full legal name: Last, First and Middle Initial. Provide any other names used, such as maiden name. Enter "N/A" if you have never had another name.

② Print your physical address. Entering a PO Box is not allowed. Enter "N/A" if you have no apartment number.

③ Print your date of birth (mm/dd/yyyy).

④ Print your Social Security Number.

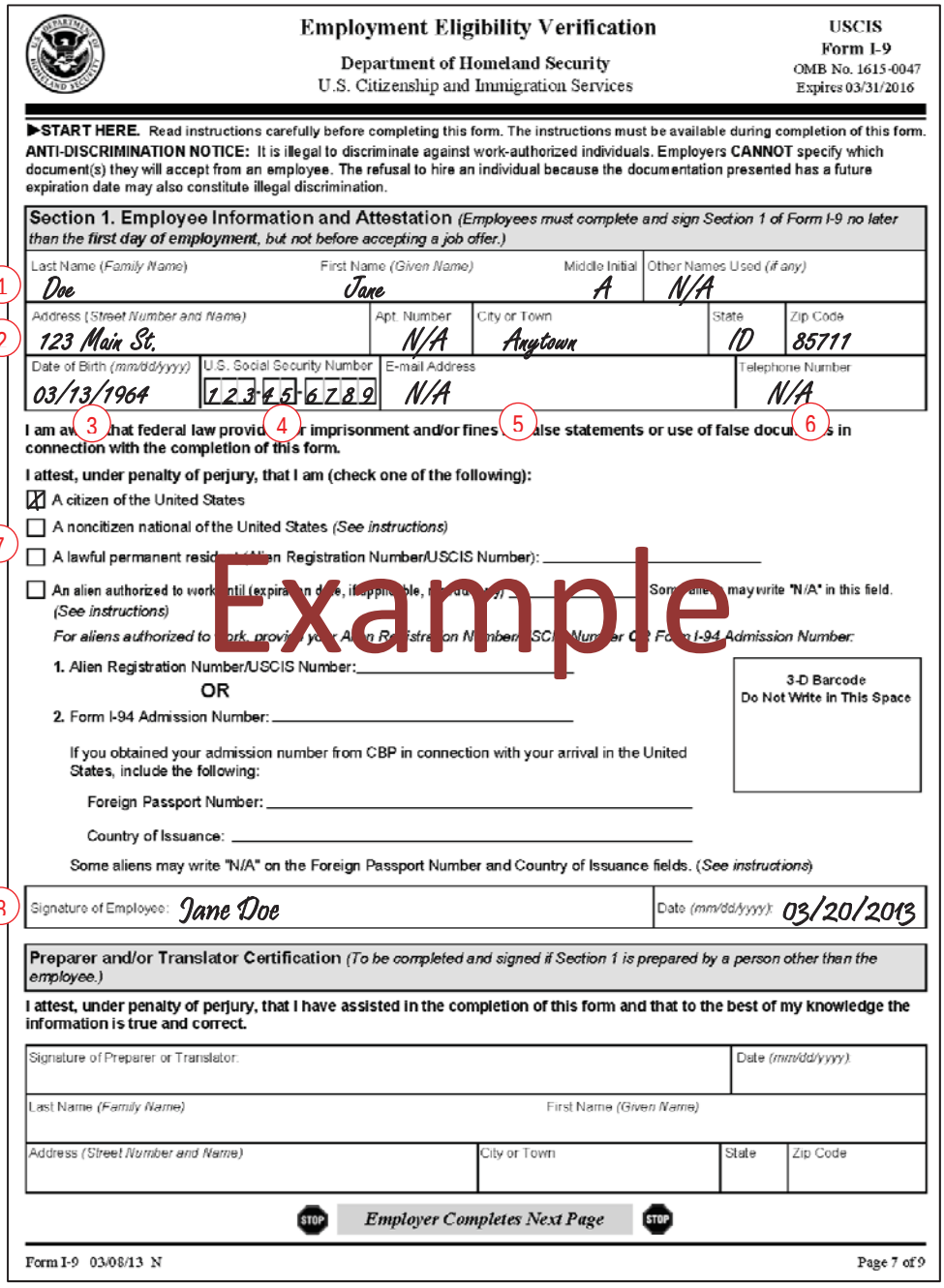
⑤ Print your email address or print "N/A" if you choose not to provide it.

⑥ Print your telephone number or print "N/A" if you choose not to provide it.

⑦ Check the one box that best describes your citizenship or immigration status in the United States.

⑧ Sign and print the date you completed the form. **No later than first day of work for pay.**

⑨ Provide documents to your employer to complete Section 2.



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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

▶START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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

Last Name (Family Name)	First Name (Given Name)	Middle Initial	Other Names Used (if any)
Doe	Jane	A	N/A

Address (Street Number and Name)	Apt. Number	City or Town	State	Zip Code
123 Main St.	N/A	Anytown	ID	85711

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	E-mail Address	Telephone Number
03/13/1964	1 2 3 4 5 6 7 8 9	N/A	N/A

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):

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

For aliens authorized to work, provide your Alien Registration Number/USCIS Number OR Form I-94 Admission Number:

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. *(See instructions)*

3-D Barcode
Do Not Write In This Space

Signature of Employee:	Date (mm/dd/yyyy):
Jane Doe	03/20/2013

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

I attest, under penalty of perjury, that I have assisted in the completion 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)

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

STOP *Employer Completes Next Page* STOP

Form I-9 03/08/13 N Page 7 of 9

Example

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

Instructions for Completing Form I-9 Section 2

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

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

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

Employer (steps 1-10)

① Print employee's name from Section 1: Last, First and Middle Initial.

② Print each document's details in the appropriate List column.

Examine <u>one document from List A</u>

OR

<u>one from List B and one from List C</u>.

Only accept unexpired, original documents (no photocopies).

③ Print the date of the employee's first day of work.

④ Sign the form.

⑤ Print the date you signed the form. **Must be completed and signed within 3 days of employee's first day of work.**

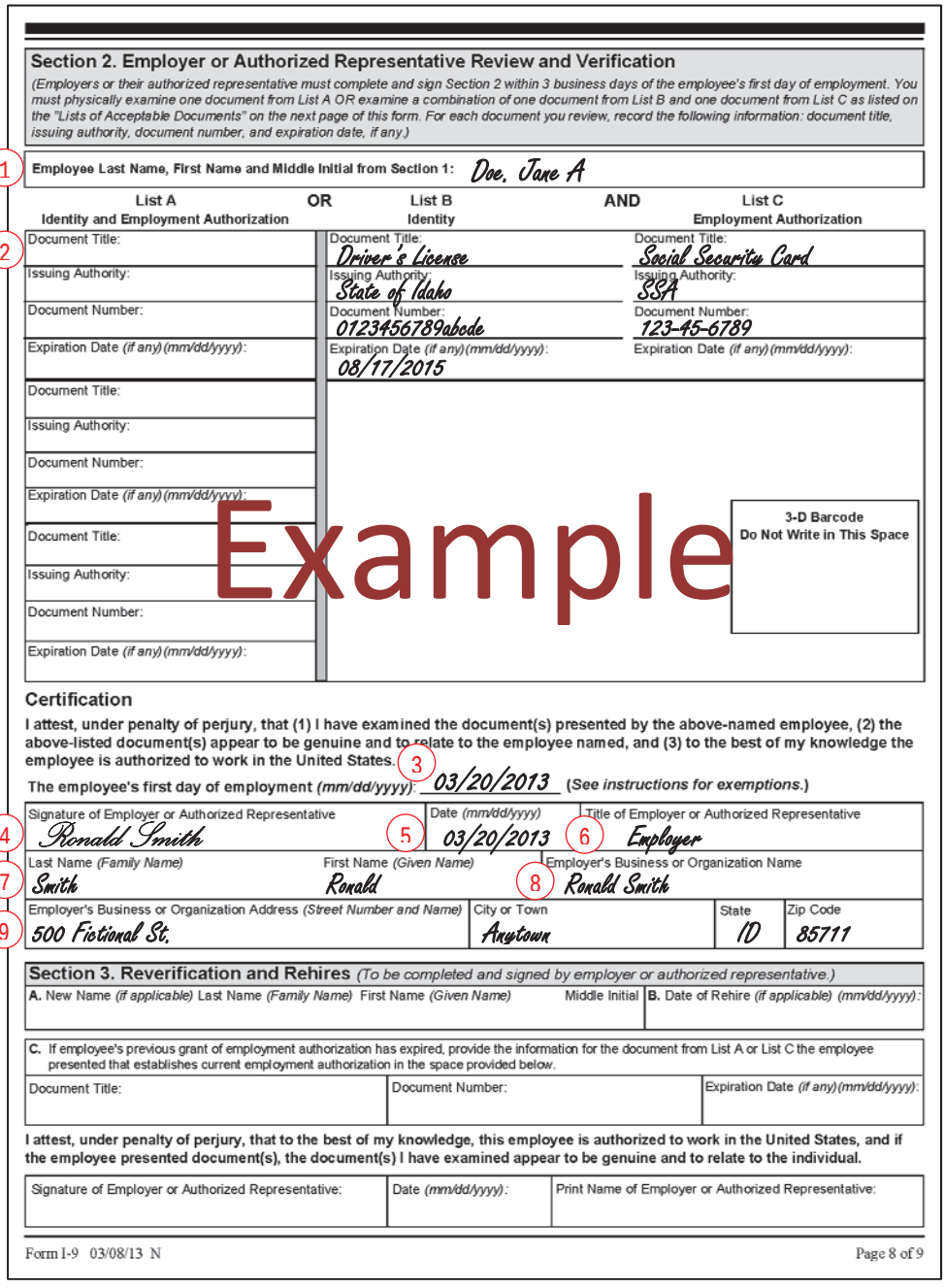
⑥ If not pre-populated, print your title as "Employer."

⑦ Print your last and first name.

⑧ Print your first and last name.

⑨ Print your physical address, city, state and zip code.

⑩ Submit form I-9 to Consumer Direct with the Employee Packet.



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 examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

1 Employee Last Name, First Name and Middle Initial from Section 1: Doe, Jane A

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
2 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: 0123456789abcde		Document Number: 123-45-6789
Expiration Date (if any) (mm/dd/yyyy):		Expiration Date (if any) (mm/dd/yyyy): 08/17/2015		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):				

Example

3-D Barcode 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.

3 **The employee's first day of employment (mm/dd/yyyy):** 03/20/2013 **(See instructions for exemptions.)**

4 Signature of Employer or Authorized Representative	5 Date (mm/dd/yyyy)	6 Title of Employer or Authorized Representative
Ronald Smith	03/20/2013	Employer

7 Last Name (Family Name)	First Name (Given Name)	8 Employer's Business or Organization Name
Smith	Ronald	Ronald Smith

9 Employer's Business or Organization Address (Street Number and Name)	City or Town	State	Zip Code
500 Fictional St.	Anytown	ID	85711

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

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

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current 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:	Date (mm/dd/yyyy):	Print Name of Employer or Authorized Representative:

Form I-9 03/08/13 N Page 8 of 9

Note: These instructions are for informational purposes only. Refer to pages 3 and 4 of Form I-9 Instructions for detailed information.

Instructions for Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

Read all instructions carefully before completing this form.

Anti-Discrimination Notice. It is illegal to discriminate against any work-authorized individual in hiring, discharge, recruitment or referral for a fee, or in the employment eligibility verification (Form I-9 and E-Verify) process based on that individual's citizenship status, immigration status or national origin. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination. For more information, call the Office of Special Counsel for Immigration-Related Unfair Employment Practices (OSC) at 1-800-255-7688 (employees), 1-800-255-8155 (employers), or 1-800-237-2515 (TDD), or visit **www.justice.gov/crt/about/osc**.

What Is the Purpose of This Form?

Employers must complete Form I-9 to document verification of the identity and employment authorization of each new employee (both citizen and noncitizen) hired after November 6, 1986, to work in the United States. In the Commonwealth of the Northern Mariana Islands (CNMI), employers must complete Form I-9 to document verification of the identity and employment authorization of each new employee (both citizen and noncitizen) hired after November 27, 2011. Employers should have used Form I-9 CNMI between November 28, 2009 and November 27, 2011.

General Instructions

Employers are responsible for completing and retaining Form I-9. For the purpose of completing this form, the term "employer" means all employers, including those recruiters and referrers for a fee who are agricultural associations, agricultural employers, or farm labor contractors.

Form I-9 is made up of three sections. Employers may be fined if the form is not complete. Employers are responsible for retaining completed forms. Do not mail completed forms to U.S. Citizenship and Immigration Services (USCIS) or Immigration and Customs Enforcement (ICE).

Section 1. Employee Information and Attestation

Newly hired employees must complete and sign Section 1 of Form I-9 **no later than the first day of employment**. Section 1 should never be completed before the employee has accepted a job offer.

Provide the following information to complete Section 1:

Name: Provide your full legal last name, first name, and middle initial. Your last name is your family name or surname. If you have two last names or a hyphenated last name, include both names in the last name field. Your first name is your given name. Your middle initial is the first letter of your second given name, or the first letter of your middle name, if any.

Other names used: Provide all other names used, if any (including maiden name). If you have had no other legal names, write "N/A."

Address: Provide the address where you currently live, including Street Number and Name, Apartment Number (if applicable), City, State, and Zip Code. Do not provide a post office box address (P.O. Box). Only border commuters from Canada or Mexico may use an international address in this field.

Date of Birth: Provide your date of birth in the mm/dd/yyyy format. For example, January 23, 1950, should be written as 01/23/1950.

U.S. Social Security Number: Provide your 9-digit Social Security number. Providing your Social Security number is voluntary. However, if your employer participates in E-Verify, you must provide your Social Security number.

E-mail Address and Telephone Number (Optional): You may provide your e-mail address and telephone number. Department of Homeland Security **(**DHS) may contact you if DHS learns of a potential mismatch between the information provided and the information in DHS or Social Security Administration (SSA) records. You may write "N/A" if you choose not to provide this information.

All employees must attest in Section 1, under penalty of perjury, to their citizenship or immigration status by checking one of the following four boxes provided on the form:

1. **A citizen of the United States**
2. **A noncitizen national of the United States:** Noncitizen nationals of the United States are persons born in American Samoa, certain former citizens of the former Trust Territory of the Pacific Islands, and certain children of noncitizen nationals born abroad.
3. **A lawful permanent resident:** A lawful permanent resident is any person who is not a U.S. citizen and who resides in the United States under legally recognized and lawfully recorded permanent residence as an immigrant. The term "lawful permanent resident" includes conditional residents. If you check this box, write either your Alien Registration Number (A-Number) or USCIS Number in the field next to your selection. At this time, the USCIS Number is the same as the A-Number without the "A" prefix.
4. **An alien authorized to work:** If you are not a citizen or national of the United States or a lawful permanent resident, but are authorized to work in the United States, check this box.

   If you check this box:

   a. Record the date that your employment authorization expires, if any. Aliens whose employment authorization does not expire, such as refugees, asylees, and certain citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or Palau, may write "N/A" on this line.

   b. Next, enter your Alien Registration Number (A-Number)/USCIS Number. At this time, the USCIS Number is the same as your A-Number without the "A" prefix. If you have not received an A-Number/USCIS Number, record your Admission Number. You can find your Admission Number on Form I-94, "Arrival-Departure Record," or as directed by USCIS or U.S. Customs and Border Protection (CPB).

   (1) If you obtained your admission number from CBP in connection with your arrival in the United States, then also record information about the foreign passport you used to enter the United States (number and country of issuance).

   (2) If you obtained your admission number from USCIS *within the United States*, or you entered the United States without a foreign passport, you must write "N/A" in the Foreign Passport Number and Country of Issuance fields.

Sign your name in the "Signature of Employee" block and record the date you completed and signed Section 1. By signing and dating this form, you attest that the citizenship or immigration status you selected is correct and that you are aware that you may be imprisoned and/or fined for making false statements or using false documentation when completing this form. To fully complete this form, you must present to your employer documentation that establishes your identity and employment authorization. Choose which documents to present from the Lists of Acceptable Documents, found on the last page of this form. You must present this documentation no later than the third day after beginning employment, although you may present the required documentation before this date.

Preparer and/or Translator Certification

The Preparer and/or Translator Certification must be completed if the employee requires assistance to complete Section 1 (e.g., the employee needs the instructions or responses translated, someone other than the employee fills out the information blocks, or someone with disabilities needs additional assistance). The employee must still sign Section 1.

Minors and Certain Employees with Disabilities (Special Placement)

Parents or legal guardians assisting minors (individuals under 18) and certain employees with disabilities should review the guidelines in the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)* on **www.uscis.gov/I-9Central** before completing Section 1. These individuals have special procedures for establishing identity if they cannot present an identity document for Form I-9. The special procedures include **(1)** the parent or legal guardian filling out Section 1 and writing "minor under age 18" or "special placement," whichever applies, in the employee signature block; and **(2)** the employer writing "minor under age 18" or "special placement" under List B in Section 2.

Section 2. Employer or Authorized Representative Review and Verification

Before completing Section 2, employers must ensure that Section 1 is completed properly and on time. Employers may not ask an individual to complete Section 1 before he or she has accepted a job offer.

Employers or their authorized representative must complete Section 2 by examining evidence of identity and employment authorization within 3 business days of the employee's first day of employment. For example, if an employee begins employment on Monday, the employer must complete Section 2 by Thursday of that week. However, if an employer hires an individual for less than 3 business days, Section 2 must be completed no later than the first day of employment. An employer may complete Form I-9 before the first day of employment if the employer has offered the individual a job and the individual has accepted.

Employers cannot specify which document(s) employees may present from the Lists of Acceptable Documents, found on the last page of Form I-9, to establish identity and employment authorization. Employees must present one selection from List A **OR** a combination of one selection from List B and one selection from List C. List A contains documents that show both identity and employment authorization. Some List A documents are combination documents. The employee must present combination documents together to be considered a List A document. For example, a foreign passport and a Form I-94 containing an endorsement of the alien's nonimmigrant status must be presented together to be considered a List A document. List B contains documents that show identity only, and List C contains documents that show employment authorization only. If an employee presents a List A document, he or she should **not** present a List B and List C document, and vice versa. If an employer participates in E-Verify, the List B document must include a photograph.

In the field below the Section 2 introduction, employers must enter the last name, first name and middle initial, if any, that the employee entered in Section 1. This will help to identify the pages of the form should they get separated.

Employers or their authorized representative must:

1. Physically examine each original document the employee presents to determine if it reasonably appears to be genuine and to relate to the person presenting it. The person who examines the documents must be the same person who signs Section 2. The examiner of the documents and the employee must both be physically present during the examination of the employee's documents.
2. Record the document title shown on the Lists of Acceptable Documents, issuing authority, document number and expiration date (if any) from the original document(s) the employee presents. You may write "N/A" in any unused fields.

   If the employee is a student or exchange visitor who presented a foreign passport with a Form I-94, the employer should also enter in Section 2:

   a. The student's Form I-20 or DS-2019 number (Student and Exchange Visitor Information System-SEVIS Number); **and** the program end date from Form I-20 or DS-2019.
3. Under Certification, enter the employee's first day of employment. Temporary staffing agencies may enter the first day the employee was placed in a job pool. Recruiters and recruiters for a fee do not enter the employee's first day of employment.
4. Provide the name and title of the person completing Section 2 in the Signature of Employer or Authorized Representative field.
5. Sign and date the attestation on the date Section 2 is completed.
6. Record the employer's business name and address.
7. Return the employee's documentation.

Employers may, but are not required to, photocopy the document(s) presented. If photocopies are made, they should be made for **ALL** new hires or reverifications. Photocopies must be retained and presented with Form I-9 in case of an inspection by DHS or other federal government agency. Employers must always complete Section 2 even if they photocopy an employee's document(s). Making photocopies of an employee's document(s) cannot take the place of completing Form I-9. Employers are still responsible for completing and retaining Form I-9.

Unexpired Documents

Generally, only unexpired, original documentation is acceptable. The only exception is that an employee may present a certified copy of a birth certificate. Additionally, in some instances, a document that appears to be expired may be acceptable if the expiration date shown on the face of the document has been extended, such as for individuals with temporary protected status. Refer to the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)* or I-9 Central (www.uscis.gov/I-9Central) for examples.

Receipts

If an employee is unable to present a required document (or documents), the employee can present an acceptable receipt in lieu of a document from the Lists of Acceptable Documents on the last page of this form. Receipts showing that a person has applied for an initial grant of employment authorization, or for renewal of employment authorization, are not acceptable. Employers cannot accept receipts if employment will last less than 3 days. Receipts are acceptable when completing Form I-9 for a new hire or when reverification is required.

Employees must present receipts within 3 business days of their first day of employment, or in the case of reverification, by the date that reverification is required, and must present valid replacement documents within the time frames described below.

There are three types of acceptable receipts:

1. A receipt showing that the employee has applied to replace a document that was lost, stolen or damaged. The employee must present the actual document within 90 days from the date of hire.
2. The arrival portion of Form I-94/I-94A with a temporary I-551 stamp and a photograph of the individual. The employee must present the actual Permanent Resident Card (Form I-551) by the expiration date of the temporary I-551 stamp, or, if there is no expiration date, within 1 year from the date of issue.
3. The departure portion of Form I-94/I-94A with a refugee admission stamp. The employee must present an unexpired Employment Authorization Document (Form I-766) or a combination of a List B document and an unrestricted Social Security card within 90 days.

When the employee provides an acceptable receipt, the employer should:

1. Record the document title in Section 2 under the sections titled List A, List B, or List C, as applicable.
2. Write the word "receipt" and its document number in the "Document Number" field. Record the last day that the receipt is valid in the "Expiration Date" field.

By the end of the receipt validity period, the employer should:

1. Cross out the word "receipt" and any accompanying document number and expiration date.
2. Record the number and other required document information from the actual document presented.
3. Initial and date the change.

See the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)* at **www.uscis.gov/I-9Central** for more information on receipts.

Section 3. Reverification and Rehires

Employers or their authorized representatives should complete Section 3 when reverifying that an employee is authorized to work. When rehiring an employee within 3 years of the date Form I-9 was originally completed, employers have the option to complete a new Form I-9 or complete Section 3. When completing Section 3 in either a reverification or rehire situation, if the employee's name has changed, record the name change in Block A.

For employees who provide an employment authorization expiration date in Section 1, employers must reverify employment authorization on or before the date provided.

Some employees may write "N/A" in the space provided for the expiration date in Section 1 if they are aliens whose employment authorization does not expire (e.g., asylees, refugees, certain citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or Palau). Reverification does not apply for such employees unless they chose to present evidence of employment authorization in Section 2 that contains an expiration date and requires reverification, such as Form I-766, Employment Authorization Document.

Reverification applies if evidence of employment authorization (List A or List C document) presented in Section 2 expires. However, employers should not reverify:

1. U.S. citizens and noncitizen nationals; or

2. Lawful permanent residents who presented a Permanent Resident Card (Form I-551) for Section 2.

Reverification does not apply to List B documents.

If both Section 1 and Section 2 indicate expiration dates triggering the reverification requirement, the employer should reverify by the earlier date.

For reverification, an employee must present unexpired documentation from either List A or List C showing he or she is still authorized to work. Employers CANNOT require the employee to present a particular document from List A or List C. The employee may choose which document to present.

To complete Section 3, employers should follow these instructions:

1. Complete Block A if an employee's name has changed at the time you complete Section 3.

2. Complete Block B with the date of rehire if you rehire an employee within 3 years of the date this form was originally completed, and the employee is still authorized to be employed on the same basis as previously indicated on this form. Also complete the "Signature of Employer or Authorized Representative" block.

3. Complete Block C if:

   a. The employment authorization or employment authorization document of a current employee is about to expire and requires reverification; or

   b. You rehire an employee within 3 years of the date this form was originally completed and his or her employment authorization or employment authorization document has expired. (Complete Block B for this employee as well.)

   To complete Block C:

   a. Examine either a List A or List C document the employee presents that shows that the employee is currently authorized to work in the United States; and

   b. Record the document title, document number, and expiration date (if any).

4. After completing block A, B or C, complete the "Signature of Employer or Authorized Representative" block, including the date.

   For reverification purposes, employers may either complete Section 3 of a new Form I-9 or Section 3 of the previously completed Form I-9. Any new pages of Form I-9 completed during reverification must be attached to the employee's original Form I-9. If you choose to complete Section 3 of a new Form I-9, you may attach just the page containing Section 3, with the employee's name entered at the top of the page, to the employee's original Form I-9. If there is a more current version of Form I-9 at the time of reverification, you must complete Section 3 of that version of the form.

What Is the Filing Fee?

There is no fee for completing Form I-9. This form is not filed with USCIS or any government agency. Form I-9 must be retained by the employer and made available for inspection by U.S. Government officials as specified in the **"USCIS Privacy Act Statement"** below.

USCIS Forms and Information

For more detailed information about completing Form I-9, employers and employees should refer to the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)*.

You can also obtain information about Form I-9 from the USCIS Web site at www.uscis.gov/I-9Central, by e-mailing USCIS at **I-9Central@dhs.gov**, or by calling **1-888-464-4218**. For TDD (hearing impaired), call **1-877-875-6028**.

To obtain USCIS forms or the *Handbook for Employers*, you can download them from the USCIS Web site at www.uscis.gov/forms. You may order USCIS forms by calling our toll-free number at **1-800-870-3676**. You may also obtain forms and information by contacting the USCIS National Customer Service Center at **1-800-375-5283**. For TDD (hearing impaired), call **1-800-767-1833**.

Information about E-Verify, a free and voluntary program that allows participating employers to electronically verify the employment eligibility of their newly hired employees, can be obtained from the USCIS Web site at www.dhs.gov/E-Verify, by e-mailing USCIS at **E-Verify@dhs.gov** or by calling **1-888-464-4218**. For TDD (hearing impaired), call **1-877-875-6028.**

Employees with questions about Form I-9 and/or E-Verify can reach the USCIS employee hotline by calling **1-888-897-7781**. For TDD (hearing impaired), call **1-877-875-6028.**

Photocopying and Retaining Form I-9

A blank Form I-9 may be reproduced, provided all sides are copied. The instructions and Lists of Acceptable Documents must be available to all employees completing this form. Employers must retain each employee's completed Form I-9 for as long as the individual works for the employer. Employers are required to retain the pages of the form on which the employee and employer enter data. If copies of documentation presented by the employee are made, those copies must also be kept with the form. Once the individual's employment ends, the employer must retain this form for either 3 years after the date of hire or 1 year after the date employment ended, whichever is later.

Form I-9 may be signed and retained electronically, in compliance with Department of Homeland Security regulations at 8 CFR 274a.2.

USCIS Privacy Act Statement

AUTHORITIES: The authority for collecting this information is the Immigration Reform and Control Act of 1986, Public Law 99-603 (8 USC 1324a).

PURPOSE: This information is collected by employers to comply with the requirements of the Immigration Reform and Control Act of 1986. This law requires that employers verify the identity and employment authorization of individuals they hire for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

DISCLOSURE: Submission of the information required in this form is voluntary. However, failure of the employer to ensure proper completion of this form for each employee may result in the imposition of civil or criminal penalties. In addition, employing individuals knowing that they are unauthorized to work in the United States may subject the employer to civil and/or criminal penalties.

ROUTINE USES: This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The employer will keep this form and make it available for inspection by authorized officials of the Department of Homeland Security, Department of Labor, and Office of Special Counsel for Immigration-Related Unfair Employment Practices.

Paperwork Reduction Act

An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The public reporting burden for this collection of information is estimated at 35 minutes per response, including the time for reviewing instructions and completing and retaining the form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: U.S. Citizenship and Immigration Services, Regulatory Coordination Division, Office of Policy and Strategy, 20 Massachusetts Avenue NW, Washington, DC 20529-2140; OMB No. 1615-0047. **Do not mail your completed Form I-9 to this address.**

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

►START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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

Last Name (*Family Name*)	First Name *(Given Name)*	Middle Initial	Other Names Used *(if any)*

Address (*Street Number and Name)*	Apt. Number	City or Town	State	Zip Code
			Idaho	

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	E-mail Address	Telephone Number
/ /	☐☐☐-☐☐-☐☐☐☐		

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

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

☐ A citizen of the United States

☐ A noncitizen national of the United States *(See instructions)*

☐ A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____ . Some aliens may write "N/A" in this field. *(See instructions)*

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date *(mm/dd/yyyy):*

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

I attest, under penalty of perjury, that I have assisted in the completion 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)*		
Address *(Street Number and Name)*	City or Town	State	Zip Code

STOP ***Employer Completes Next Page*** STOP

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 examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title:		Document Title:		Document Title:
Issuing Authority:		Issuing Authority:		Issuing Authority:
Document Number:		Document Number:		Document Number:
Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				

3-D Barcode
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)*: _____ (*See instructions for exemptions*.)

Signature of Employer or Authorized Representative	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative Employer
Last Name *(Family Name)* First Name *(Given Name)*		Employer's Business or Organization Name
Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State / Zip Code

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

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

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current 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:	Date *(mm/dd/yyyy):*	Print Name of Employer or Authorized Representative:

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

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

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.

00540 - Delete

Form W-4 (2014)

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

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2014 expires February 17, 2015. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,000 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity iincome, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2014. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	**A**	
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less. . . .	**B**	
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	**C**	
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	**D**	
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . .	**E**	
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit . . . (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	**F**	
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $65,000 ($95,000 if married), enter "2" for each eligible child; then **less** "1" if you have three to six eligible children or **less** "2" if you have seven or more eligible children. • If your total income will be between $65,000 and $84,000 ($95,000 and $119,000 if married), enter "1" for each eligible child . . .	**G**	
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ►	**H**	

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Separate here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

► **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2014

1 Your first name and middle initial	Last name	**2 Your social security number**	
Home address (number and street or rural route)		**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code		**4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ► ☐	
5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)		**5**	
6 Additional amount, if any, you want withheld from each paycheck		**6**	$
7 I claim exemption from withholding for 2014, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here . . . . . ►		**7**	

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

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

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number (EIN)

For Privacy Act and Paperwork Reduction Act Notice, see page 2. Cat. No. 10220Q

00884

CONSUMER DIRECT

PAY SELECTION FORM

Name: _____

(please print)

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

Consumer Direct offers the following pay options. Please select <u>one</u> option below.

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

☐ **Bank or Credit Union Direct Deposit** – I authorize Consumer Direct to initiate payroll deposits to (name of bank or financial institution): _____

Account Type (check one): ☐ Checking ☐ Savings

For Checking Accounts:

Attach (tape) a voided check here

Do not attach a deposit slip.

For Savings Accounts: provide a document from your bank with exact numbers to process direct deposits to your account. If the document is larger than a standard-sized check, please provide a separate document. Do not attach a deposit slip because it does not have all the necessary numbers.

I authorize Consumer Direct to process my selected method of pay as indicated. In the event that funds are deposited mistakenly to my account, I authorize Consumer Direct to debit my account to correct the error. It is my responsibility to confirm that each deposit has occurred and to pay any fees caused by overdrafts on my account. Deposits will be made on each payday unless I notify my employer, in writing, of my request to stop direct deposits. I understand that Consumer Direct reserves the right to refuse any direct deposit request, that all direct deposits are made through an Automated Clearing House (ACH), and that the processing is subject to ACH terms and limitations, as well as those of my financial institution. I understand that I may still receive a paper check while my selected method of pay is being set up.

☐ **Opt-Out (decline or stop direct deposit)** – I decline direct deposit and authorize Consumer Direct to issue me pay checks and to mail them to my address on file. I accept that I may not receive my paycheck on paydays due to USPS First Class mail delays or operations.

_____ _____

Signature Date

00842

Rev. 10/05/2014

Your Pay

FASTER. SAFER. EASIER.

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

Immediately loaded to your card on payday | **Available to use** right away | **Protected** if lost or stolen[1]

About the Focus Card

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

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

Getting Started is Easy

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

Sign Up!

$0.00 No cost to sign up.

No credit check or bank account required.[2]

And Save!

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

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

Please select the US Bank Focus Card Direct Deposit option on your Consumer Direct Pay Selection Form to enroll.

Consumer Direct

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

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

focus

Getting Started

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

Follow the activation instructions that accompany your card.

Features

Cash Back Rewards

For purchases at certain retail and restaurant locations.

Savings Account

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

Cash Reload Networks[5]

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

Text and Email Alerts[4]

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

Mobile Banking App[4]

Quickly see your account balance and transaction history.

Track Spending

Online | Phone | Email | Text[4] | Mobile App

Fee Schedule

Activity		Cost		
Monthly Account Maintenance		Free		
Purchases at Point-of-Sale (Domestic)		Free		
Cash Back with Purchases (Domestic)		Free		
ATM Transactions		Cash Withdrawal	Declined Withdrawal	Balance Inquiry
The owner of any Non-U.S. Bank or Non-MoneyPass ATM may assess an additional surcharge fee for any ATM transaction that you complete.	U.S. Bank ATM	Free	Free	Free
	MoneyPass® ATM	Free	Free	Free
	Allpoint® ATM	Free	Free	Free
	Other ATM	$2.00	$0.50	$1.00
	International ATM	$3.00	$0.50	$1.00
Teller Cash Withdrawal		Free		
Teller Cash Withdrawal Decline		$0.00		
Customer Service Automated Phone Service, Online, Live Phone Representative		Free		
Text or Email Alerts[4]		Free		
Inactivity After 90 consecutive days. Not assessed if balance is $0.00.		$2.00 Per Month		
Monthly Paper Statement		If requested – $2.00		
Card Replacement				
Non-Personalized Issued by employer (If applicable to your program)		$5.00		
Personalized		Standard $5.00; Expedited $15.00; Overnight $25.00		
ChekToday Convenience Checks (If applicable to your program)	Check Authorization	Free		
	Check Order	Free; Expedited $35.00		
	Check Return	$25.00		
	Stop Payment	$25.00		
	Lost/Stolen Check	$25.00		
	Void Check	Free		
	Check Reversal	$25.00		
	Check Copy	$10.00		
Foreign Transaction		Up to 3% of transaction amount		

Transaction Limits	Count	Amount
Maximum Card Balance	N/A	$40,000
Purchases (includes cash back)	20 per day	$4,000 per day
Cash Loads (If applicable to your program)	3 per day	$950 per day
Teller Cash Withdrawal	5 per day	$2,525 per day
ATM Withdrawal	5 per day	$1,525 per day; $1,025 max transaction
Loads or Deposits	10 per day	$20,000 per day
Signature-based POS returns	4 per day	N/A
Pending ACH Credits	5 per day	$5,000 per day
ACH Loads	5 per day	$20,000 per day

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

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

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

Idaho Fiscal Employer Agent
Family-Directed Services
EMPLOYMENT RELATIONSHIP DISCLOSURE

Employee Name	FEIN Holder Name	Child Name

Instructions: Each Employee must provide the following information about their relationship with the employer (FEIN Holder) and the Family Directed Services recipient (child receiving services) before employment begins. You must review, complete all the sections below, and sign and date at the bottom of the form. This information is required to begin employment.

1) EMPLOYEE/FEIN HOLDER RELATIONSHIP DISCLOSURE:
Before employment, my existing relationship with the above-named **FEIN Holder (please check one):**

- ☐ Parent (Exempt)
- ☐ Spouse (Exempt)
- ☐ Sibling
- ☐ No relationship
- ☐ Step Parent (Exempt)
- ☐ Child, under age 21 (Exempt)
- ☐ Legal Representative/Power of Attorney
- ☐ Other, please describe: _____

2) EMPLOYEE/CHILD RECEIVING SERVICES RELATIONSHIP DISCLOSURE:
Before employment, my existing relationship with the above-named **Child (please check one)**:

- ☐ Parent (Not allowed to be a paid employee)
- ☐ No relationship
- ☐ Sibling
- ☐ Step Parent (Not allowed to be a paid employee)
- ☐ Guardian (Not allowed to be a paid employee)
- ☐ Other, please describe: _____

3) RELATIONSHIP AND EMPLOYMENT ACKNOWLEDGMENTS:

• **All Employees are Subject to Federal and State Tax Withholding -** I understand that regardless of my relationship with the FEIN Holder, I am subject to all employment requirements including criminal background checks (unless waived by the Participant) and Federal and State tax withholdings.

• **Federal and state taxation rules change frequently.** *Please consult with your tax advisor if you have any questions on completion of your W-4. If you discover that your tax situation has changed during the year, you may submit a revised W-4 for withholding adjustments on future pay.*

• **Exempt Employees -** If my relationship with the FEIN Holder indicates Exempt above, I understand I am entering into an employment relationship that is exempt from FICA (Social Security), Medicare, FUTA (Federal Unemployment) and SUTA (State Unemployment) and those taxes will not be withheld or applied on my paycheck.

• **By not paying into certain taxes it means I am not earning Social Security history work credits.** When you work and pay into FICA (Social Security), you earn work credits toward Social Security benefits. If my relationship with the FEIN Holder indicates Exempt above, I understand I will not earn Social Security Work Credits.

• **I understand that if I am the Parent, Step Parent, or Guardian of the Child named above, I cannot be a paid Employee in the Family Directed Services option.**

4) AMENDED PAYROLL TAX RETURNS: Consumer Direct will file all required amended payroll tax returns in instances where there have been overcollected Social Security and Medicare taxes from employees' compensation. The employee will receive refunds of overcollected social security and Medicare taxes directly from Consumer Direct. These refunds will be paid to the employee in January immediately following year-end. The employee agrees that they have not, or will not file a claim for refund of overcollected Medicare or Social Security with the IRS.

_____ _____

Employee Signature *Date*

00841

IDAHO DEPARTMENT OF
HEALTH & WELFARE

MEDICAID-SUPPORT BROKER AGREEMENT

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

The Support Broker acknowledges that even though he/she is the employee of a participant in the Self-Directed Community Supports Option, the Department, through the Fiscal Employer Agent, is the source of payment for the Support Broker's wages for services performed under the Self-Directed Community Supports Option. Because of the unique relationships of the participant, the Department, and the Fiscal Employer Agent, the Support Broker acknowledges and agrees to the following:

1. That the Support Broker is a provider under the Idaho Medicaid Self-Directed Community Supports Option.

2. To promptly notify the Fiscal Employer Agent, of any change of address or other Support Broker contact information.

3. To accept, as payment in full for all Self-Directed Community Supports services, payments made by the Fiscal Employer Agent, and will make no additional charge except as allowed by the Medicaid Option.

4. To provide all Support Broker services according to the Participant- Support Broker Employment Agreement and all duties and responsibilities in accordance with the rules pertaining to the Support Broker contained in Idaho Administrative Procedures Act (IDAPA) 16.03.13, "Consumer-Directed Services."

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

6. The Support Broker acknowledges that they are an employee of the participant and not an employee of the Department or the Fiscal Employer Agent, and agrees that the Support Broker is not entitled to, nor will make claim for, any employee benefits from the Department or the Fiscal Employer Agent, including worker's compensation, disability, life and/or health insurance.

The provisions of this agreement represent the entirety of the agreement between the parties. It may be amended only in writing with all parties consenting by their signature.

_____

SUPPORT BROKER Date

Dear Support Broker,

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

The annual Open Enrollment Period for the Health Insurance Marketplace is usually scheduled to begin on November 15th each year for coverage starting January 1st of each year. This is the ***one*** time of year where you can apply for private health insurance coverage through the marketplace. To confirm Open Enrollment Period dates for this year, please contact www.HealthCare.gov. ***NOTE****: You can apply for Medicaid or CHIP (Children's Health Insurance Program) any time of year.*

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

If you have any questions about healthcare reform or the online application process, please contact the Health Insurance Marketplace Call Center at 1-800-318-2596 or visit www.HealthCare.gov.

Thank you,
Human Resources Department
for Consumer Direct and the Consumer Direct Family of Companies

Health Care Marketplace

PART A: General Information

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please call 1-800-318-2596 or visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

In the Idaho self-directed care model, the Participant is the employer of record and the managing employer. **Health insurance is not being offered by your employer.** You and your family may be able to obtain health coverage through the Marketplace, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.

Medicaid Coverage

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

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

- Contact your state Medicaid agency online at www.healthandwelfare.idaho.gov or call their Customer Service Center at 1-877-456-1233.

- Fill out an application for coverage in the Health Insurance Marketplace at www.healthcare.gov/marketplace.

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

Online Services through My Direct Care

www.mydirectcare.com

Employers and Employees associated with Consumer Direct have access to online services available through a secure website www.mydirectcare.com. The primary benefits of this secure site include:

- Online time entry and approval. Provides an efficient and error-minimizing way to enter time into the Consumer Direct payroll system. The electronic timesheets provide information on the status of all time and payroll entries.
- Spending summaries. Provide up to date budget and spending information. Both summary and detailed information is available regarding staff gross wages, employer related taxes, and vendor payments.
- The Job Board. A tool for employers to post job openings and for job seekers to respond. New applicants and existing employees wishing to work more hours can post their availability.

Figure 1. My Direct Care Home Page with Login

Note on terminology: My Direct Care uses the terms "Client" and “Participant” for Medicaid program recipients. In the descriptions below, the terms “Client” and "Participant" refer to the individual enrolled in Idaho’s Self-Direction program. The term Employer refers to the Participant.

User Registration

Consumer Direct will issue User ID numbers to employers and employees after approving completed enrollment packets. Once you have your ID number you can self-register at My Direct Care and establish your Login Name, Password and User Profile. To register, follow these steps:

1. Enter www.mydirectcare.com in the address bar or click on the My Direct Care links on the Idaho Consumer Direct website. This will take you to the home page of My Direct Care as shown in Figure 1.
2. Click on the ***User Registration*** tab to open the User Registration page (Figure 2).
3. In the *Register As* field, select Employee if you are an employee. Select Participant if you are the Employer (Figure 3).

Figure 2. Opening User Registration Page

4. After selecting a Registration Type, fill in the additional fields that appear (Figure 4).
   - *State* – select Idaho.
   - *User ID* – enter the ID provided to you by Consumer Direct. Call the Consumer Direct office if you have not received your ID.
   - *Date of Birth* – enter in the format shown.
   - *Zip Code* – enter in the format shown.
   - *SSN* – this field only appears for Employees. Enter the last 4 digits of your social security number.

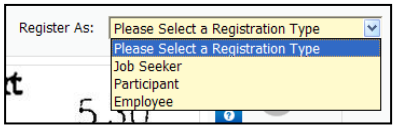


Figure 3. Selecting a Registration Type

Note to Employers: User Registration fields are specific to the Participant. Date of Birth and Zip Code must be those of the Participant.

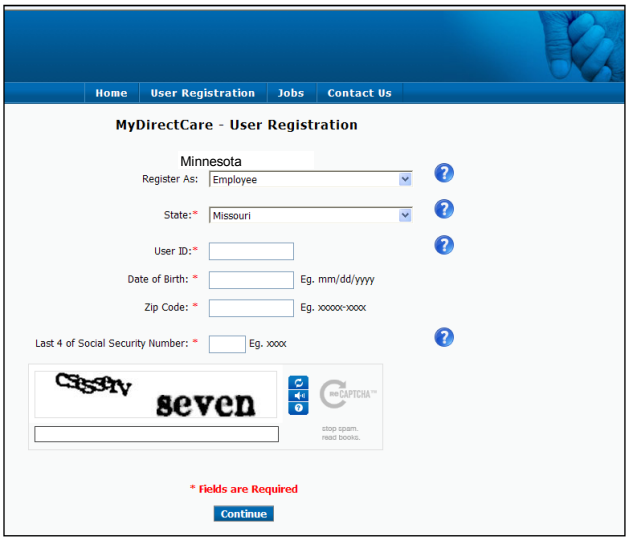


Figure 4. User Registration Page Fields

5. Enter the security phrase as two unique words separated by a space. Click continue. Since this is your first time using My Direct Care, you will now be directed to a User Registration Profile page (Figure 5).

6. Complete your User Registration Profile – This is where you will set up your login name and password for logging into My Direct Care. You will also provide contact information and answer two security questions, which may be used later if you forget your password and need to reset it.

   Your password must be at least seven characters in length, and contain at least one special character (#,%,&,*,+, etc.) and at least one number. You may wish to write this down and keep in a secure location. You will enter your login name and password every time you login to My Direct Care.

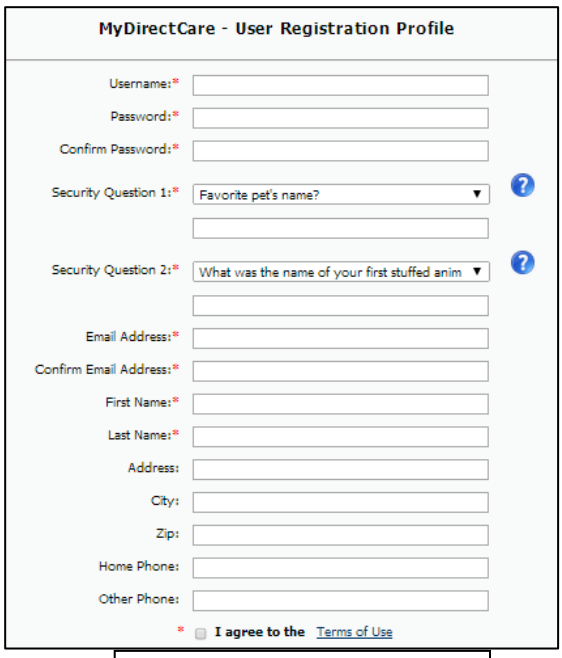


Figure 5. User Registration Profile

7. Finish the Registration Process - When you have completed all the profile fields, check the "I agree to the Terms of Use" checkbox at the bottom of the page. After checking the box, a "Register" button will appear (Figure 6). Clicking the button will complete the registration process and direct you back to the home page.

Figure 6. Register button

8. You can now login and begin using online services – The login area is in the upper left corner of the home page, next to the padlock (Figure1). Enter your login name and password into the fields and click on the Login button.

After you have successfully registered, your User Profile information can be updated at any time by selecting ***Settings*** tab and Update Your Online Information from the main menu. To change your password, select Settings and Update Password from the main menu.

Overview of the Time Entry and Approval Process

- Upon completion of a scheduled shift, the Employee will log into My Direct Care and enter the shift worked. Time entry for each shift will include the Participant's name, the service provided (Service Code), and beginning and ending shift times.
- Shifts should be entered after they are worked.
- Time is due for approval every two weeks. Time must be approved by **Wednesday at midnight MST** of timesheet due weeks or payment could be delayed.
- Once the time has been approved by the Employer, entries can be processed and paid by Consumer Direct.

Employee Time Entry

Select ***Service Card*** from the top menu (Figure 7).

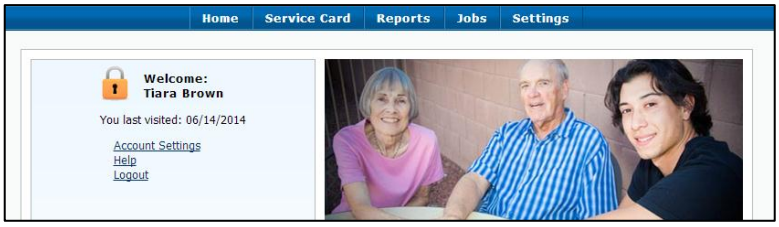
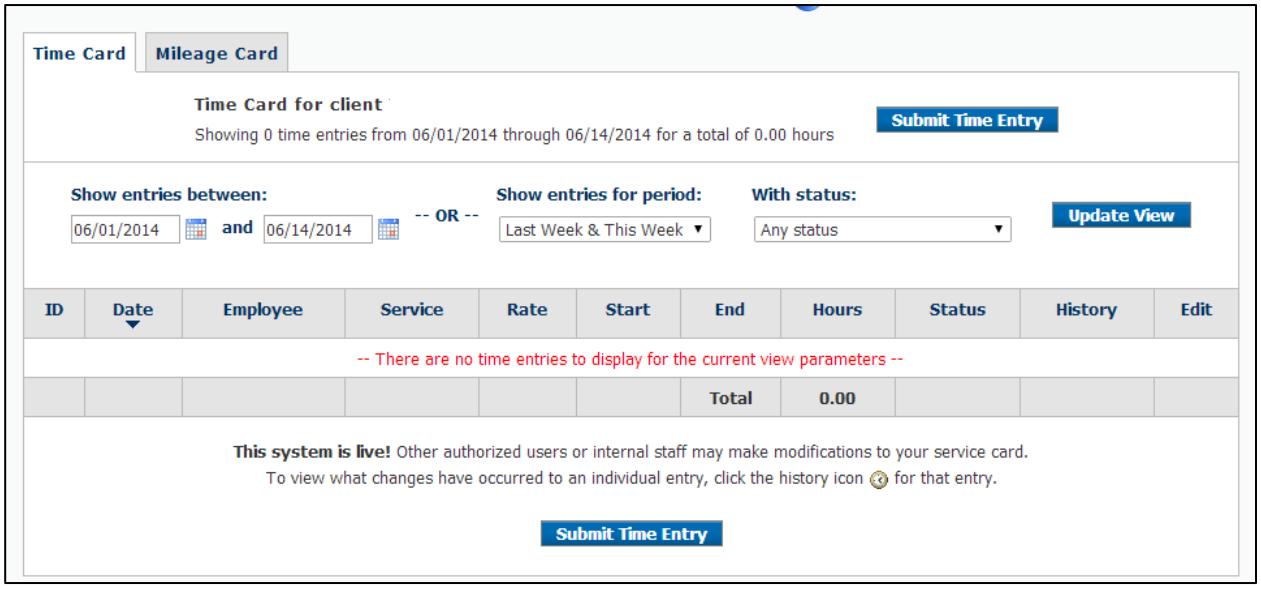


Figure 7. Employee Main Menu

Time Card will open (Figure 8). The current pay period will display by default. You can navigate to other weeks by changing the dates in the "show entries between" area or using the drop down menu under the "show entries for period" area.



Create a New Time Entry by clicking the "Submit Time Entry" button. This will open the service card window (Figure 9).

Enter the following information for each shift worked:

- Service Date – enter date in the format shown or select date using the calendar icon.
- Client – from the drop down, select the Participant worked for.
- Service Code – from the drop down, select the code for the service provided.
- Start Time – enter the start time in the format show and select AM or PM.
- End Time: enter the end time.

Figure 9. Service Card

Click on the "Submit Time Entry" button when you have entered all the information for the shift worked.

Note: Time entries can only be made after a shift is completed. Trying to enter a date or starting/ending time in the future will be denied and return an error message.

You will receive a pop-up window (Figure 10) asking if you would like to create another time enter. Click yes or no.

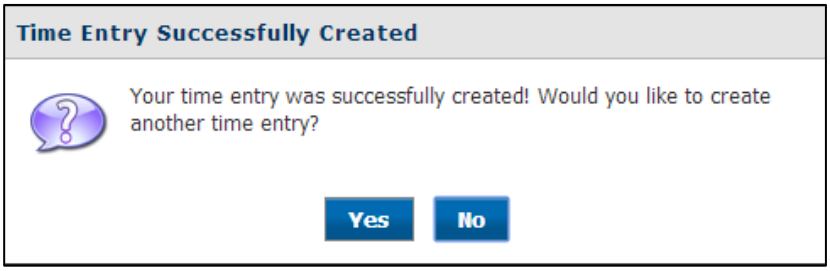


Figure 10. Time Entry Pop-up

Your time will appear in the time card area once it has been entered (Figure 11). This area will display the service date, employee/client names, rate of part, hours worked, and the status of where the entry is at in the payroll process. Click the status icon to see what each symbol means (Figure 12).

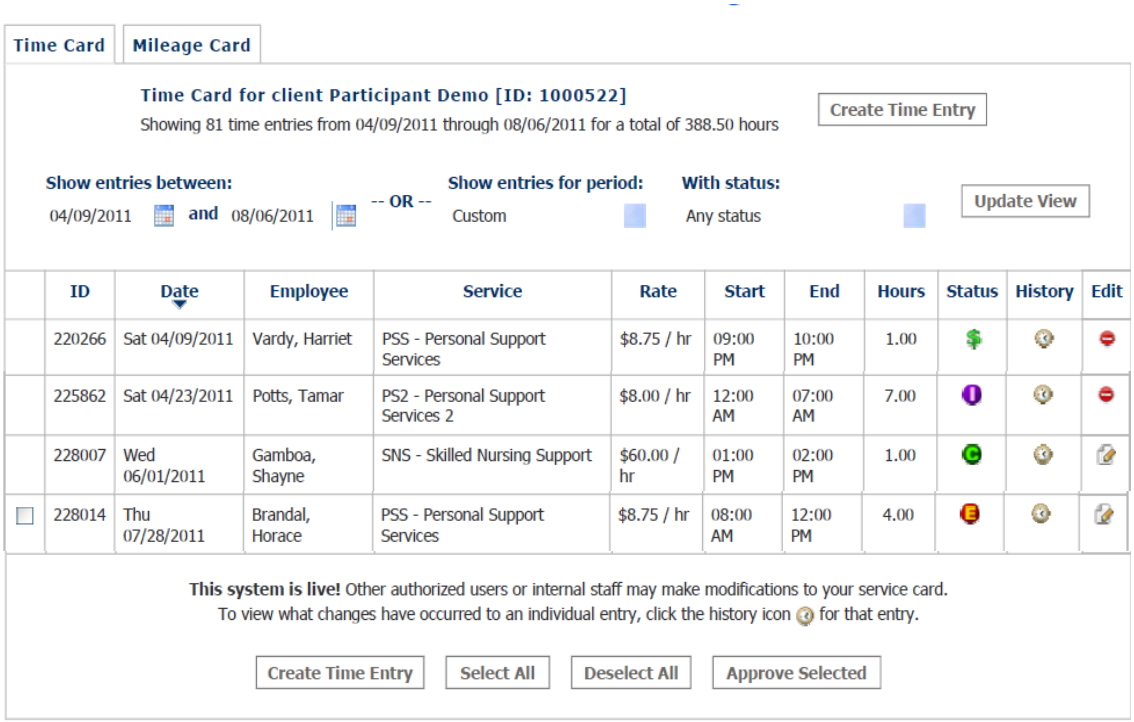


Figure 11. Time Card

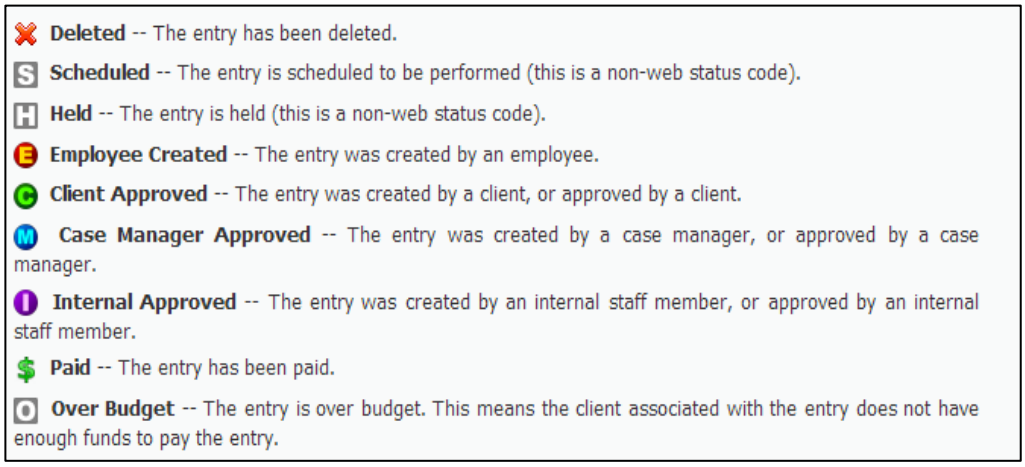


Figure 12. Payroll Status

Edit or Delete Time Entry

If you saved a time entry with the wrong information, click the edit icon in the time card area (Figure 11) to make corrections to the entry. Edits are no longer allowed to the entry once this symbol appears .

Once you click the edit icon, the edit time entry box will display (Figure 13). Make the necessary corrections, add a comment on why you are correcting the entry, and click the "update time entry" button.

To delete the entry, click the "delete time entry" button and add a comment on why the entry is being deleted.

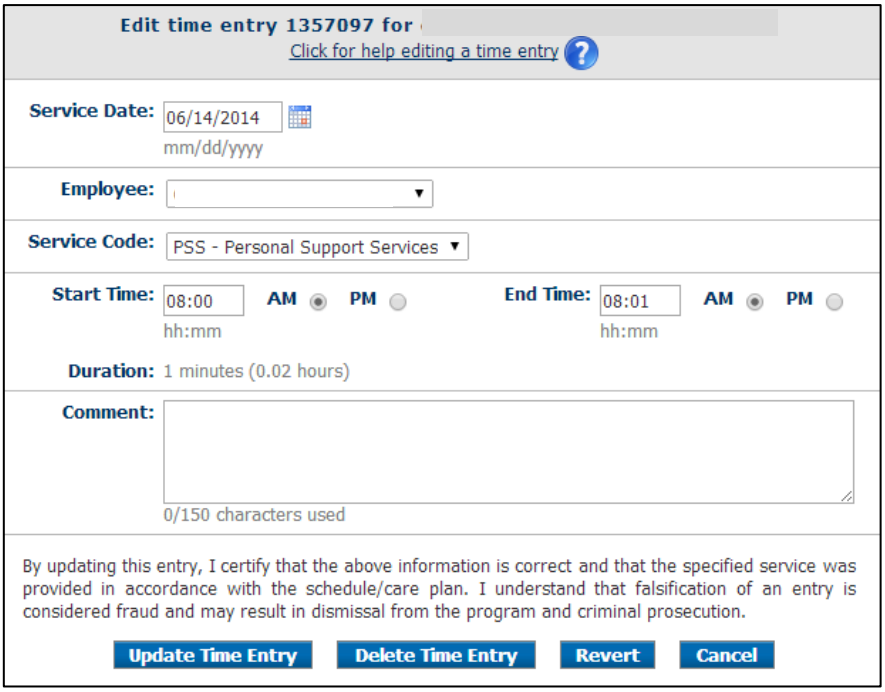


Figure 13. Edit Time Entry

Employer Time Approval

For Employers, the online time approval process is similar to a paper time sheet process in that both systems require review and approval of Employee time entries. With the online timesheet system it minimizes data entry errors and provides the Employer with far more information regarding the exact status of their budget, payroll, and Employee hours.

Approving Time

All entries with an E indicates the shift was submitted for approval by the Employee. The Employer must review all entries and verify the times are correct.

You can manually select each entry to approve using the check box on the far left side of the entry or you can select all entries by clicking the "select all" button. To approve the selected time, click the "approve selected" button.

A C will now appear indicating the shift was approved by the "client" (Employer).
After you have approved the entries, Consumer Direct will complete the payroll process.

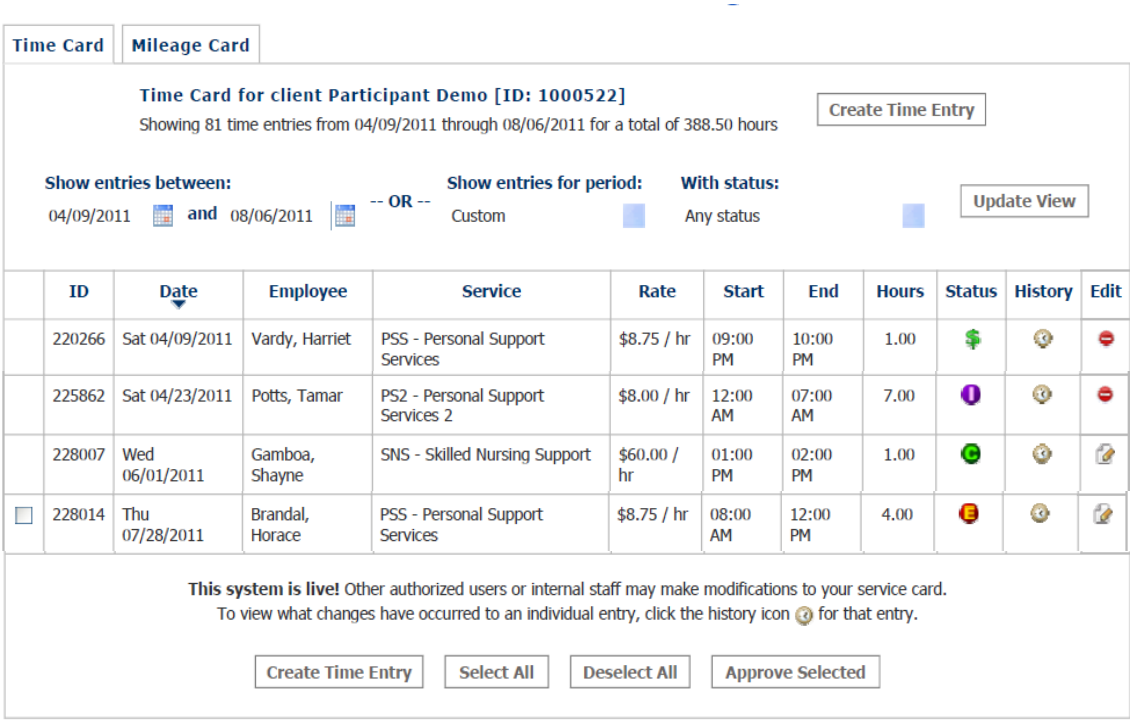


Figure 11. Time Card

Note: employers can create time entries for employes by following the same steps for employee time entry. If the employer creats the entry it automatically approves the time.

Reports

My Direct Care provides access to custom budget and spending reports, which are available to both Employers and Support Brokers. The reports fall into two primary categories: **Spending Summary and Spending Detail**. To access Reports, click ***Reports*** from the top menu. This will open a page allowing you to choose between a Spending Summary and a Spending Detail Report (Figure 14). Clicking on either report link will open a blank report in a new browser window.

Figure 14. Choosing a Report Type

When the report window opens, you will need to select the parameters at the top of the report window and click on the ***View Report*** button in the upper right hand corner to generate the report. After your report has been generated, you can export the report to one of several file formats, such as to a PDF, or to a Microsoft Word or Excel file by selecting your export file choice (Figure 15) and clicking on the ***Export*** button.

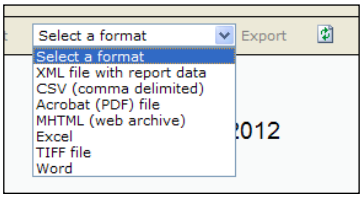
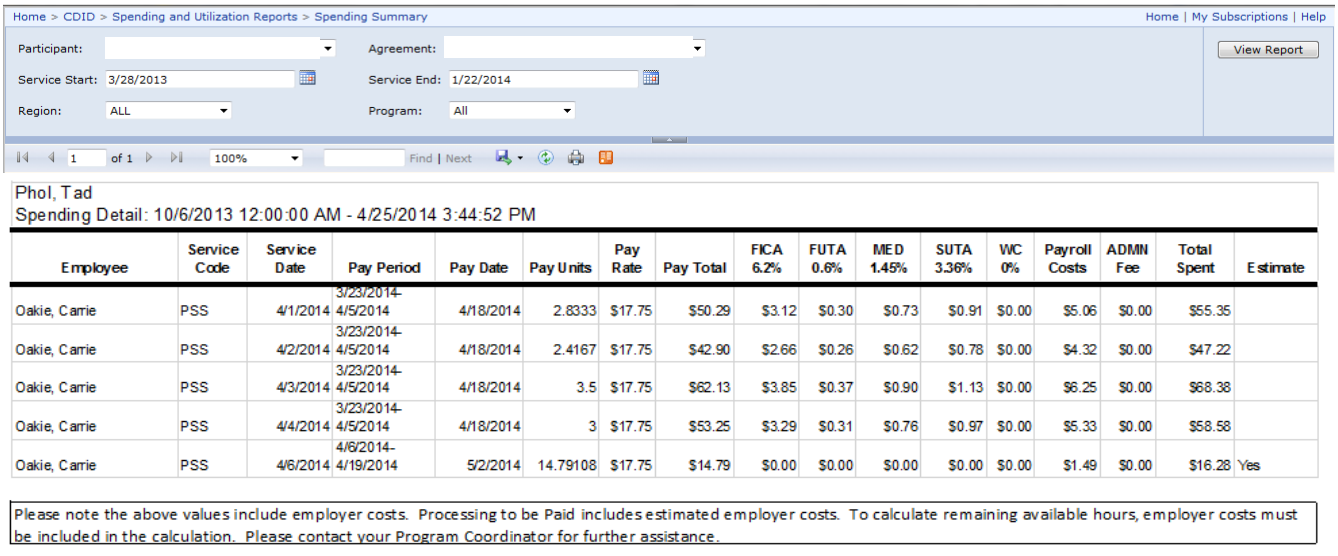


Figure 15. Report Export Options

Spending Detail Report

The Spending Detail Report (Figure 16) details the Participant's spending between the dates selected for the report range. The report shows all spending and is broken down by employee and vendor. The Spending Detail Report provides highly detailed spending data to support and provide enhanced clarity to the information in the Spending Summary. The format of this report is program dependent.



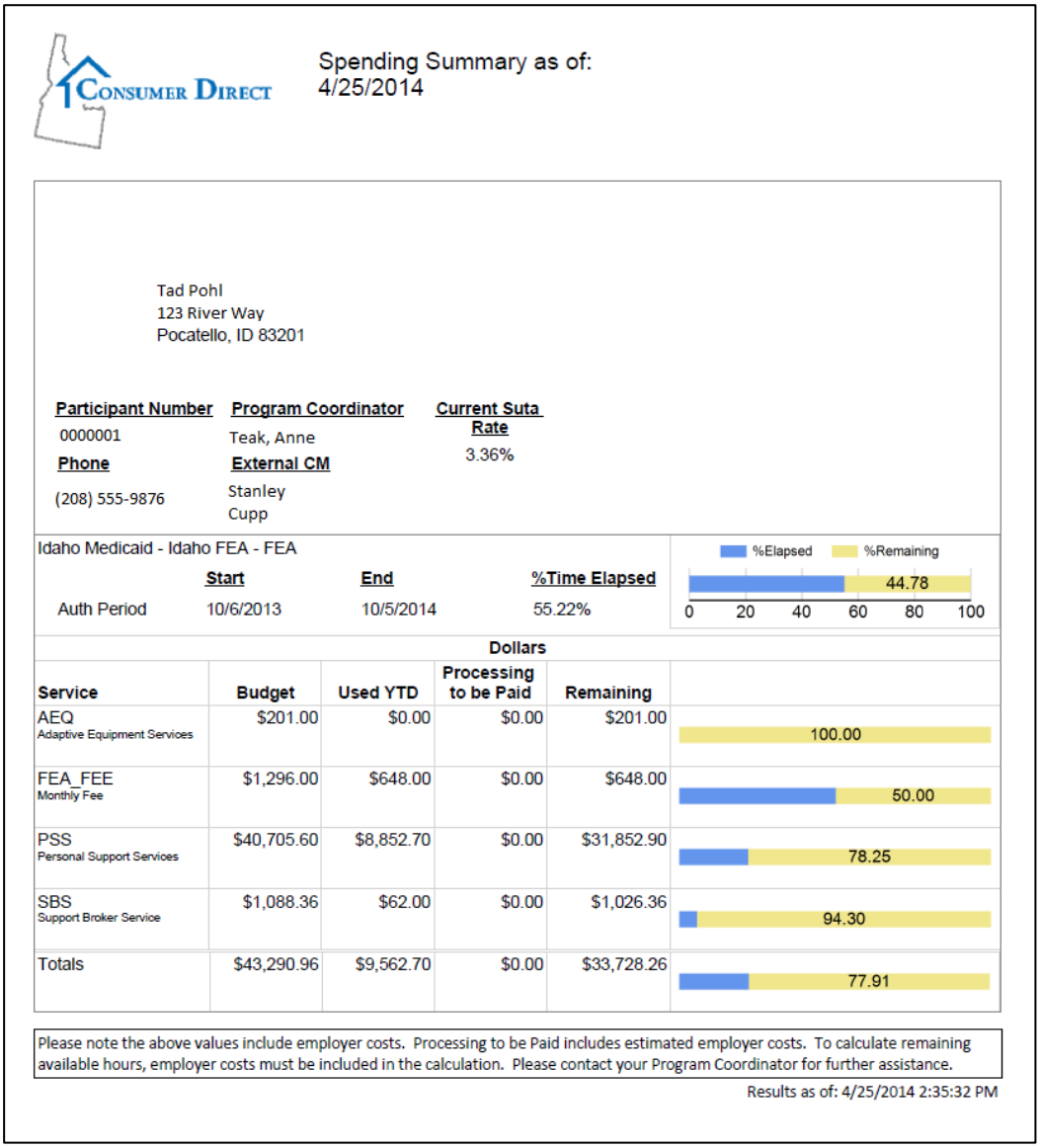
Employee	Service Code	Service Date	Pay Period	Pay Date	Pay Units	Pay Rate	Pay Total	FICA 6.2%	FUTA 0.6%	MED 1.45%	SUTA 3.36%	WC 0%	Payroll Costs	ADMN Fee	Total Spent	Estimate
Oakie, Carrie	PSS	4/1/2014	3/23/2014-4/5/2014	4/18/2014	2.8333	$17.75	$50.29	$3.12	$0.30	$0.73	$0.91	$0.00	$5.06	$0.00	$55.35	
Oakie, Carrie	PSS	4/2/2014	3/23/2014-4/5/2014	4/18/2014	2.4167	$17.75	$42.90	$2.66	$0.26	$0.62	$0.78	$0.00	$4.32	$0.00	$47.22	
Oakie, Carrie	PSS	4/3/2014	3/23/2014-4/5/2014	4/18/2014	3.5	$17.75	$62.13	$3.85	$0.37	$0.90	$1.13	$0.00	$6.25	$0.00	$68.38	
Oakie, Carrie	PSS	4/4/2014	3/23/2014-4/5/2014	4/18/2014	3	$17.75	$53.25	$3.29	$0.31	$0.76	$0.97	$0.00	$5.33	$0.00	$58.58	
Oakie, Carrie	PSS	4/6/2014	4/6/2014-4/19/2014	5/2/2014	14.79108	$17.75	$14.79	$0.00	$0.00	$0.00	$0.00	$0.00	$1.49	$0.00	$16.28	Yes

Please note the above values include employer costs. Processing to be Paid includes estimated employer costs. To calculate remaining available hours, employer costs must be included in the calculation. Please contact your Program Coordinator for further assistance.

Figure 16. Spending Detail Report

Spending Summary Report

The Spending Summary (Figure 17) is a report summarizing the Participant's year-to-date spending against their Approved Plan. The report indicates the approved service codes, the amount spent per code and the elapsed time for the authorization period. This report provides a concise status of spending and the remaining budget, both overall and per service code.



Spending Summary as of:
4/25/2014

Tad Pohl
123 River Way
Pocatello, ID 83201

Participant Number	Program Coordinator	Current Suta Rate
0000001	Teak, Anne	3.36%
Phone	**External CM**	
(208) 555-9876	Stanley Cupp	

Idaho Medicaid - Idaho FEA - FEA

	Start	End	%Time Elapsed
Auth Period	10/6/2013	10/5/2014	55.22%

Dollars

Service	Budget	Used YTD	Processing to be Paid	Remaining	
AEQ Adaptive Equipment Services	$201.00	$0.00	$0.00	$201.00	100.00
FEA_FEE Monthly Fee	$1,296.00	$648.00	$0.00	$648.00	50.00
PSS Personal Support Services	$40,705.60	$8,852.70	$0.00	$31,852.90	78.25
SBS Support Broker Service	$1,088.36	$62.00	$0.00	$1,026.36	94.30
Totals	$43,290.96	$9,562.70	$0.00	$33,728.26	77.91

Please note the above values include employer costs. Processing to be Paid includes estimated employer costs. To calculate remaining available hours, employer costs must be included in the calculation. Please contact your Program Coordinator for further assistance.

Results as of: 4/25/2014 2:35:32 PM

Figure 17. Spending Summary Report

Job Board

The Job Board is a tool that provides another means for recruiting new or additional assistance. It provides a method for Job Seekers to find Participants who need assistance. When an Employer posts a job (Job Poster), the posting will remain active for 30 days and allows the Job Poster to include as much detail as desired, including notes and requirements. Job Seekers can review the postings and submit an emailed application to the Job Poster via the Job Board. Following the 30-day active period, the posts are archived. Archived posts can be edited, deleted, or reposted as needed. The Job Poster's name, address, email and other contact information remains confidential throughout the process.

Job Poster

When a Job Poster hovers over the ***Jobs*** link on the top menu (Figure 18), three submenus become available, including Post a Job, Edit/Delete Your Jobs, and View Archived Posts.

Figure 18. Job Openings Submenu

Post a Job: Clicking on the "Post a Job" link will open a form for entering the job description (Figure 19). Complete all the fields with as much information as possible before submitting the job post. If needed, you can always edit the entry later.

Edit/Delete Your Jobs: This provides a listing of current jobs posted by the Employer and provides options to edit or delete each entry (Figure 20).

View Archived Posts: These are postings that have expired or have been manually archived (Figure 21).

The Job Poster receives an email when a Job Seeker submits their resume to the Job Board, which contains the Job Seeker's application information for review. The Job Seeker's email address is included to facilitate direct communication between the Job Poster and the Job Seeker.

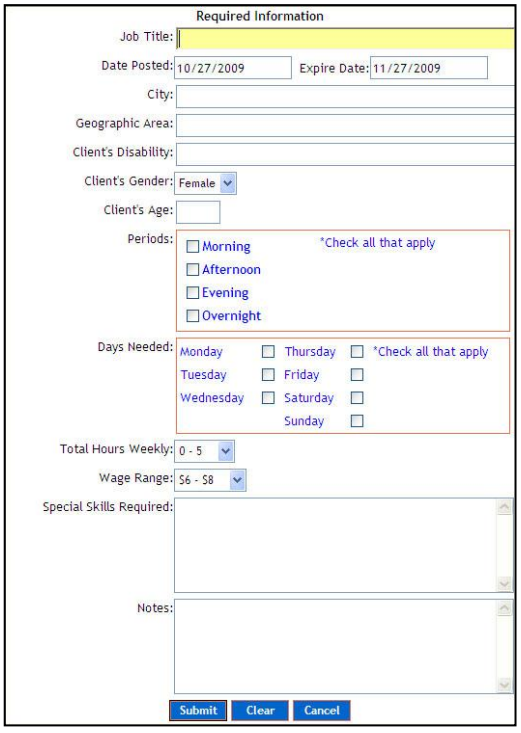
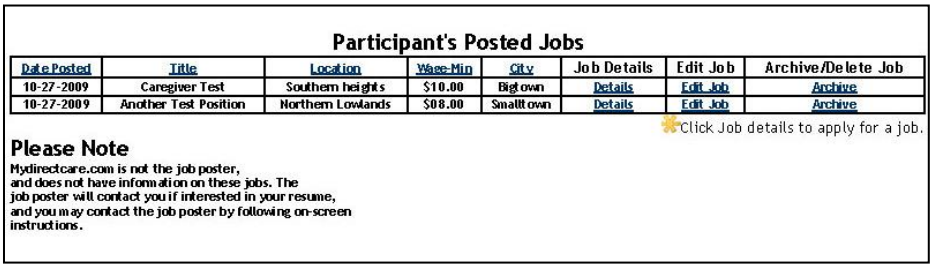


Figure 19. Job Posting Form



Participant's Posted Jobs

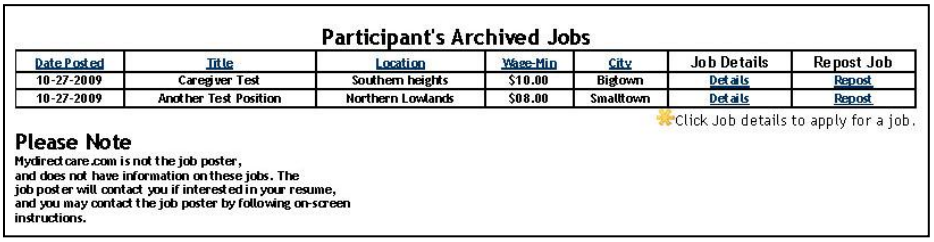
Date Posted	Title	Location	Wage-Min	City	Job Details	Edit Job	Archive/Delete Job
10-27-2009	Caregiver Test	Southern heights	$10.00	Bigtown	Details	Edit Job	Archive
10-27-2009	Another Test Position	Northern Lowlands	$08.00	Smalltown	Details	Edit Job	Archive

Click Job details to apply for a job.

Please Note

Mydirectcare.com is not the job poster, and does not have information on these jobs. The job poster will contact you if interested in your resume, and you may contact the job poster by following on-screen instructions.

Figure 20. Edit/Delete Posted Jobs



Participant's Archived Jobs

Date Posted	Title	Location	Wage-Min	City	Job Details	Repost Job
10-27-2009	Caregiver Test	Southern heights	$10.00	Bigtown	Details	Repost
10-27-2009	Another Test Position	Northern Lowlands	$08.00	Smalltown	Details	Repost

Click Job details to apply for a job.

Please Note

Mydirectcare.com is not the job poster, and does not have information on these jobs. The job poster will contact you if interested in your resume, and you may contact the job poster by following on-screen instructions.

Figure 21. Archived Posts

Job Seeker

When a Job Seeker selects the ***Jobs*** link from the top menu, they are taken directly to a User Registration screen where they must register before viewing and applying for posted jobs. Once registered, a Job Seeker can view and apply for posted jobs. Once an application has been submitted via the Job Board, an email is generated that transmits their application to the Job Poster for review. A confirmation email is sent to the Job Seeker to verify that the email was transmitted. The Job Seeker's email address is included with their application email to facilitate direct communication between the Job Poster and the Job Seeker.

IDAHO'S SELF DIRECTION PROGRAM

FISCAL EMPLOYER AGENT SERVICES

PAYING FOR YOUR SUPPORTS

This Paying for Your Supports Packet includes the forms you need to use so that employees, vendors (such as businesses), independent contractors and agencies can be paid for providing your services and supports. The Packet also includes some other information that you will need.

You can fill out these payment forms based on information contained in this Packet. We think you will be able to fill them out by looking at the examples in the Packet. For each required form, the Paying for Your Supports Packet includes a blank form and an example form that explains how you the form should be completed.

If you have questions about how to fill out any of the forms, please call Consumer Direct right away for help. Our toll free number is: 1-888-898-0470

If you want more help, you also could stop by the Consumer Direct office at: 280 E. Corporate Drive, Suite 210, Meridian, Monday - Friday, 8:00 am - 5:00 pm.

Employees and some service providers (such as independent contractors or agencies) cannot be paid until they have been enrolled. First, they must complete required Employment Agreement forms with the Participant (which are included in other Packets). Then, after the Agreements are completed, payment for services can be made. Employees are paid after time sheets and mileage reimbursement forms, included in the Packet, are completed and submitted. Other workers and vendors are paid by completing request for vendor payment forms from this Packet.

The Paying for Your Supports Packet contains:

- ➔ Idaho Time Sheet
- ➔ Instructions for Idaho Time Sheet
- ➔ Payroll Schedule
- ➔ Request for Vendor Payment
- ➔ Mileage Reimbursement Form
- ➔ Instructions for Mileage Reimbursement

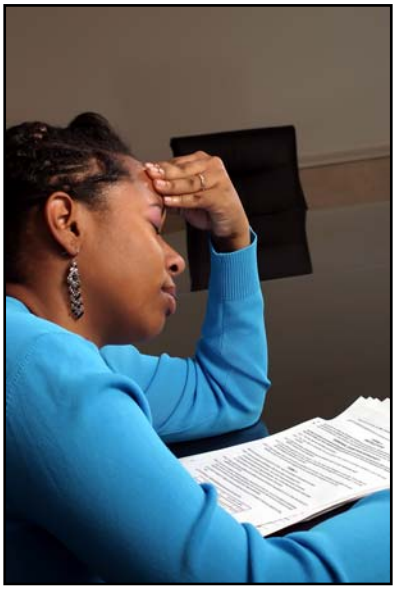
The directions for filling out these forms are described below.

Paying Employees:

Idaho Time Sheet: Employees must complete and sign a time sheet before they can be paid. You must review and sign the time sheet to show that you approve it. Remember, your employee can only be paid through this program for the hours worked that are approved in your Support and Spending Plan. This means that you can only approve hours on the time sheet for services that have been approved on your Support and Spending Plan. These hours must be for services you outlined on the Participant-Community Support Worker Employment Agreement or Participant-Support Broker Employment Agreement.

The time sheet is completed to report your employee's hours worked. The instructions for the Idaho time sheet are included in this packet. Please use these instructions when filling out a time sheet. It is a good idea to review the time sheet form before you fill it out. That way you can ask questions before you actually have to complete the form.

This Packet includes a sample time sheet that is filled out correctly. You can refer to this example, when you complete the time sheet and approve it for your employees. Please use the example so that you don't make mistakes. Mistakes on a time sheet can cause your employee's pay to be late.



You and your employee both sign the time sheet to show that it is correct. After the time sheet is finished, you can return it to Consumer Direct by mail, email or fax.

Mail them to: Consumer Direct
280 E. Corporate Drive, Suite 210
Meridian, Idaho 83642-2953

Email them to: InfoCDID@ConsumerDirectOnline.net

Fax them to: (208) 898-0417 or Toll Free 1-877-898-0417

If you prefer, you can drop off time sheets at the Consumer Direct office Monday - Friday, 8:00 - 5:00 (during work hours) or use our drop box (mail slot) after hours.

It would be a good idea for you to keep a copy of your employee's time sheet each time one is sent or faxed in. That way if there are any questions, you will have a copy.

If your employee(s) needs more time sheets, you can get more by calling Consumer Direct and a staff person will send you more. You can also download time sheets from Consumer Direct's website at http:\\consumerdirectonline.net.

Remember, if you want to change an employee's hourly pay, there must be enough money in your Support and Spending Plan category of service to cover the yearly cost of the wage increase. If the wage increase is beyond the amount that is available in the Service and Support Plan category, you must contact your Regional Care Manger and ask to change your Support and Spending Plan. You also must complete a new Participant-Community Support Worker Employment Agreement with the employee to show the new hourly pay rate. Please check the "Wages and Cost to You" Form in the Employee Packet so you can see about how much the total hourly cost will be for the new wage you want to pay. It is very important to make sure that your Support and Spending Plan budget has enough money in the service category to cover the yearly total cost of the higher wage.

Payroll Schedule: The Payroll Schedule form shows when time sheets are due. This is the date time sheets must be received by mail, fax or dropped off at Consumer Direct. Time sheets must be submitted by midnight. The Payroll Schedule also shows the date and day for pay day. Your employees are paid on pay day. Pay day is every two weeks and is always on a Friday. Employees will be paid by check or direct deposit. **Remember, any time sheet received by Consumer Direct after the Payroll Schedule due date will be paid on the following pay date (the next pay date).**

Request for Vendor Payment: The Request for Vendor Payment form is used to pay three different kinds of vendors:

1) An agency which provides workers as Community Support Workers. The agency must sign a Participant-Agency/Community Support Worker Agreement (see the Packet for Other Service Providers and Vendors for more details).
2) Independent contractors who provide supports but are not your employees. They must sign a Participant-Independent Contractor Work Agreement (see the Packet for Other Service Providers and Vendors for more details).
3) Other businesses, professionals and service providers who are not employees or independent contractors.

The Request for Vendor Payment form also is used to obtain payment for items (such as home modifications, ramps, adaptive equipment, direct therapy services, therapeutic recreation services or other allowed items). The goods, supports and services that vendors provide must be approved in your Support and Spending Plan.

All vendor payments are made by check. Checks for an Agency or Independent Contractor will be sent directly to them at the address indicated on the Request for Vendor Payment form. Checks for a Business, Professional or other Service Provider will be made out to the vendor, but mailed to the Participant who is responsible for delivering it to the vendor. Checks are sent on the same days as the pay dates listed on the Payroll Schedule. No check will be sent if the item is not approved on your Support and Spending Plan. Also, no check will be sent for any item you have already purchased.

The Request for Vendor Payment form must be filled out completely, and you must attach the documents (paperwork) to show what was purchased and its cost. You must attach a copy of one of the following: a voided receipt, an invoice or a signed bid/estimate.

When you fill out a Request for Vendor Payment form, please:

- Print the Participant's name and the Employer's ID number.
- Put a check in the box to show if the vendor is an agency, an independent contractor or another business, professional or service provider.
- Print the name of the vendor (agency, independent contractor or business) that the check should be made out to.
- Print the name of the vendor who performed the work or provided the item.
- Print the vendor's address.
- Print the city, state and zip code of the vendor.
- Under "Date of Invoice", write the date the invoice was actually provided (for example, by an agency) or the date on the voided receipt or invoice obtained from a vendor or an independent contractor. Check to make sure the invoice has a date. Use that date on the Request for Vendor Payment form.
- Under "Category Code" write the service code (the 3 letters for the service category) that the item or service fits under:

  a. SBS, SB2, SB3 = Support Broker Support
  b. PSS, PS2, PS3 = Personal Support
  c. JSS, JS2, JS3 = Job Support
  d. TSS, TS2, TS3 = Transportation Support
  e. LSS, LS2, LS3 = Learning Support
  f. RSS, RS2, RS3 = Relationship Support
  g. ESS, ES2, ES3 = Emotional Support

h. SNS, SN2, SN3 = Skilled Nursing Support
i. AEQ = Adaptive Equipment

- Under "Description" write the specific item or service that was purchased.
- Under "Amount" write the exact cost (amount) of the item or service.
- Use the four lines in the box on the form to include up to four different kinds of purchased items or services.
- Sign and date the bottom of the form to show the your (Participant's) approval.
- Make sure to attach the required receipt, purchase order, invoice or signed bid/estimate to the Request for Vendor Payment.
- Remember to include sales tax for items purchased from a vendor.
- The completed Request for Vendor Payment form should be mailed or faxed to Consumer Direct at:

Consumer Direct
280 E. Corporate Drive, Suite 210
Meridian, Idaho 83642-2953

Toll Free Fax: 1-877-898-0417
Fax: (208) 898-0417

Email: InfoCDID@ConsumerDirectOnline.net

Remember to keep a copy of the Request for Vendor Payment Form when you send or fax the original to Consumer Direct.

Mileage Reimbursement form: The Mileage Reimbursement form is used to pay a person who transports you and is paid by the mile. This form is filled out to pay your employee mileage for transporting you (a person who provides Transportation Support for you). A Community Support Worker can be paid an hourly wage + transportation mileage for the same date and time of service when he/she provides transportation services for a Participant. That means, your Community Support Worker can submit a Mileage Reimbursement form and an Idaho time sheet for the same activity. But, a Support Broker cannot be paid both an hourly wage and transportation mileage for transporting a Participant. That means your Support Broker cannot be paid an hourly wage under Transportation Support to drive you somewhere and also submit a Mileage Reimbursement form to pay mileage for driving you to the same place.

The directions for filling out the Mileage Reimbursement form are included in this packet.

Please return completed forms to Consumer Direct. You can mail, fax or drop off forms at our office (the address and fax number are on page 2 and page 5 above).

REQUEST FOR VENDOR PAYMENT

INTERNAL USE ONLY

_____ Participant Name & ID
_____ Vendor Name & Address
_____ Agency/IC Agreement (if needed)
_____ W-9 On File or Attached (if needed)
_____ Item/Service is Authorized
_____ Service Code on VPR Matches SSP
_____ VPR Amount is Approved on SSP
_____ Funds are Available
_____ Date Stamp

Check To: ___Participant ___Vendor

Mail or Drop Off

Consumer Direct
280 E. Corporate Dr. Suite 210
Meridian, ID 83642-2953

Send Via Email:

InfoCDID@ConsumerDirectOnline.net

or

Toll Free Fax: 1-877-898-0417

Laura Jones	5432123
Name of Participant Receiving Services	Consumer Direct Participant ID #

Please check if vendor is: ☐ Agency ☐ Independent Contractor
☒ Other Business, Professional or Service Provider

Vendor Name	Dixon's Learning Center
Address	123 Apple St.
City/State/Zip	Treetop, ID 55501

Date of Invoice (mm/dd/yy)	**Service Category Code**	**Description of Service (Items, Service Dates, S&H, etc.)**	**Amount**
2/2/09	LSS	Augmentative Communication Device	$525.00
		Total Check Amount	$525.00

EXAMPLE

Please attach a copy of the voided receipt, agency invoice or signed bid/estimate.

- **Due by midnight on Monday of timesheet week** for payment to be issued on the following pay date. Vendor Payment requests are processed following the payroll calendar. Late requests will be processed and paid with the next regular payroll cycle.
- Checks for **"Other Business, Professional, or Service Provider"** will be made out to the Vendor and **mailed to the Participant/Legal Guardian.**
- Checks for **"Agencies" and "Independent Contractors**" will be made out to the Vendor and **sent directly to them**. Agency and Independent Contractor Agreements are needed for payment.
- It is the responsibility of the Participant/Legal Guardian to ensure the Vendor receives payment by the required date.
- Please verify with Consumer Direct if a W-9 is needed for the item(s)/services requested.

Laura Jones
Participant/Legal Guardian Signature

2/11/09
Date

00846

Rev. 06/10/2014

Dixon's Learning Center

INVOICE

Participant: Laura Jones

Identification Number: 123456789
Invoice Date: 02/05/2009

Services Rendered	**Amount:**
2/2/09 Augmentative Communication Device, including review of device and evaluation of augmentative communication device use with Speech Therapist Lori Mitchell	$525.00

Total Due: **$525.00**

EXAMPLE

DUE DATE: 3/15/2009

REQUEST FOR VENDOR PAYMENT

INTERNAL USE ONLY
_____ Participant Name & ID
_____ Vendor Name & Address
_____ Agency/IC Agreement (if needed)
_____ W-9 On File or Attached (if needed)
_____ Item/Service is Authorized
_____ Service Code on VPR Matches SSP
_____ VPR Amount is Approved on SSP
_____ Funds are Available
_____ Date Stamp
Check To: ___Participant ___Vendor

Mail or Drop Off

Consumer Direct
280 E. Corporate Dr. Suite 210
Meridian, ID 83642-2953

Send Via Email:

InfoCDID@ConsumerDirectOnline.net

or

Toll Free Fax: 1-877-898-0417

Name of Participant Receiving Services	Consumer Direct Participant ID #

Please check if vendor is: ☐ Agency ☐ Independent Contractor
☐ Other Business, Professional or Service Provider

Vendor Name
Address
City/State/Zip

Date of Invoice (mm/dd/yy)	**Service Category Code**	**Description of Service (Items, Service Dates, S&H, etc.)**	**Amount**
		Total Check Amount	

Please attach a copy of the voided receipt, agency invoice or signed bid/estimate.

- **Due by midnight on Monday of timesheet week** for payment to be issued on the following pay date. Vendor Payment requests are processed following the payroll calendar. Late requests will be processed and paid with the next regular payroll cycle.
- Checks for **"Other Business, Professional, or Service Provider"** will be made out to the Vendor and **mailed to the Participant/Legal Guardian.**
- Checks for **"Agencies" and "Independent Contractors**" will be made out to the Vendor and **sent directly to them**. Agency and Independent Contractor Agreements are needed for payment.
- It is the responsibility of the Participant/Legal Guardian to ensure the Vendor receives payment by the required date.
- Please verify with Consumer Direct if a W-9 is needed for the item(s)/services requested.

_____ ____ /____ /____

Participant/Legal Guardian Signature *Date*

00846

Rev. 06/10/2014

PAPER TIMESHEETS

Timelines

- Due every two weeks - **Monday at midnight**
- Employees are paid every two weeks
- See the Payroll Calendar for due dates and pay dates
- Late timesheets may not be paid until the following pay period

How to submit timesheet

- Fax, email, postal mail, or in person
- Call to verify faxes were received
- Keep a copy of the timesheet for your records

Consumer Direct
280 East Corporate Drive, Suite 210
Meridian, ID 83642

Fax: 208-898-0417 or Toll Free: 877-898-0417
Email: infoCDID@consumerdirectonline.net

Where to get more timesheets

- Online at: www.ConsumerDirectID.com under the 'forms' tab
- By contacting Consumer Direct

How to fill out timesheet

- See the timesheet instructions page on how to fill out the timesheet

Why did the timesheet get sent back to me?

- Illegible handwriting
- Errors on the timesheet
- Missing information
- Whiteout usage
- Employee is not authorized to work
- Time submitted is before the plan start date

What do I do if a timesheet was sent back to me?

- Make the necessary corrections and send back to Consumer Direct
- Corrected timesheets are due the same week as timesheets - **Wednesday by 4 pm MST.**
    - Employees will not get paid until the next pay date if corrected timesheets miss the deadline.

How to make corrections

- Draw a single line through the mistake and initial
- Write the corrected information next to the old information or write on a new line
- Do not use whiteout as timesheets are legal documents. Complete a new timesheet if whiteout was used.

Timesheet Instructions

Want to avoid the hassle of paper timesheets? Enter your time the quick, easy, and secure way at www.mydirectccare.com!

These items must be completed for your timesheet to be processed:

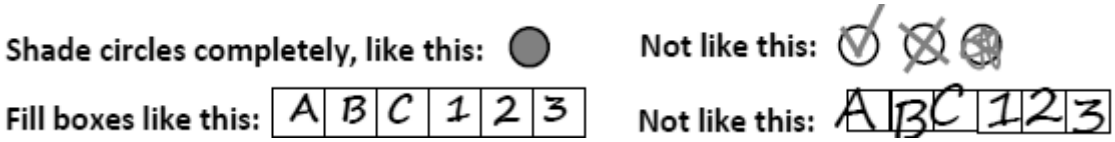
- **Employee Name**
- **Employee ID**
- **Sunday that started your work week**
  - For example, if your first day worked was Tuesday the 12th, this would be Sunday the 10th
- **Participant Name**
- **Participant ID**
- **Participant Signature & Date**
  - Must be dated on or after the last day worked.
- **Employee Signature & Date**
  - Must be dated on or after the last day worked.

Each line of time must include:

- Service Date
- Time In with AM/PM
- Time Out with AM/PM
- Service Code

Make sure your timesheet is filled out completely and correctly, with all entries made neatly inside the boxes. Payment may be delayed if letters or numbers are not printed neatly inside the boxes WITHOUT touching any lines, or are not readable. Fill AM/PM bubbles completely. **See examples below**.

Please continue on a second timesheet if you run out of room on the first. Bold items on the list to the left must also be filled in on the second timesheet.



Please use service codes that are approved on the support and spending plan.

SERVICE CODES			
[illegible]		Relationship Support Services	RSS
Adaptive Equipment Services	AEQ	Relationship Support Serv 2	RS2
Emotional Support Services	ESS	Relationship Support Serv 3	RS3
Emotional Support Serv 2	ES2	Support Broker Service	SBS
Emotional Support Serv 3	ES3	Support Broker Services 2	SB2
Job Support Services	JSS	Support Broker Services 3	SB3
Job Support Services 2	JS2	Skilled Nursing Support	SNS
Job Support Services 3	JS3	Skilled Nursing Support 2	SN2
Learning Support Services	LSS	Skilled Nursing Support 3	SN3
Learning Support Services 2	LS2	Transport Mileage	TSM
Learning Support Services 3	LS3	Transportation Support Service	TSS
Personal Support Services	PSS	Transportation Support Serv 2	TS2
Personal Support Services 2	PS2	Transportation Support Serv 3	TS3
Personal Support Services 3	PS3		

Back page is for information only. Please do not submit it with your timesheet.

Draft

1. **Employee Name**. Print Employee's name.

2. **Employee ID**. Nine digit employee ID number.

3. **Participant Name**. Print Member's name.

4. **Participant ID**. Nine digit member ID number.

5. **Sunday that started your work week**. The date of the Sunday at the beginning of the work week, in MM/DD/YY format. For example, if the first day of the week you worked was Tuesday, 12/18/13, then this would be **12/16/13**.

6. **Service Date**. The date that you worked this shift, in MM/DD format.

7. **Time In**. The time your shift began, in **HH:MM** format. Choose **AM** or **PM** by filling in the correct circle.

8. **Time Out**. The time your shift ended, in **HH:MM** format. Choose **AM** or **PM** by filling in the correct circle.

9. **Service Code**. The code for the service you performed this shift. Start your code in the **FIRST** box. Leave any extra boxes empty.

10. **Employee Signature**.

11. **Employee Signature Date**. In MM/DD/YY format. This must be dated **on or after** the last day worked.

12. **Member/Managing Party Signature**.

13. **Member Signature Date**. In MM/DD/YY format. This must be dated **on or after** the last day worked.

TIMESHEET INSTRUCTIONS

Make sure your timesheet is filled out completely and correctly. All entries must be printed neatly inside the boxes, without touching any border (see examples below). Bubbles must be filled completely. If letters or numbers are not within the boxes, or are not readable, payment may be delayed. Each shift worked must include Service Date, Time In with AM/PM, Time Out with AM/PM, and Service Code.

Underlined items in the list to the left must be completed correctly for a timesheet to be paid.

Shade circles completely, like this: ● **Not like this:** ✓ ⊗ ⊘

Fill boxes like this: A B C 1 2 3 **Not like this:** A BC 12 3

CONSUMER DIRECT

Idaho TIMESHEET

Toll Free: 1-877-270-9580
Toll Free Fax: 1-877-898-0417
280 Corporate Drive, Suite 210
Meridian, ID 83642-2953

For the week of service, timesheets are due the following Monday by Midnight if faxed, or dropped off and postmarked by Monday if by mail. Due to the timing of the payroll cycle late timesheets will result in late pay.

Employee Name (Please Print)	Employee ID	Sunday that started your work week
1	2	5 MM / DD / YY
Participant Name (Please Print)	**Participant ID**	
3	4	**Please see back for instructions.**

	Service Date (MM/DD)	Time In		Time Out		Service Code
	6 /	7 :	○ AM ○ PM	8 :	○ AM ○ PM	9
2	/	:	○ AM ○ PM	:	○ AM ○ PM	
3	/	:	○ AM ○ PM	:	○ AM ○ PM	
4	/	:	○ AM ○ PM	:	○ AM ○ PM	
5	/	:	○ AM ○ PM	:	○ AM ○ PM	
6	/	:	○ AM ○ PM	:	○ AM ○ PM	
7	/	:	○ AM ○ PM	:	○ AM ○ PM	
8	/	:	○ AM ○ PM	:	○ AM ○ PM	
9	/	:	○ AM ○ PM	:	○ AM ○ PM	
10	/	:	○ AM ○ PM	:	○ AM ○ PM	
11	/	:	○ AM ○ PM	:	○ AM ○ PM	
12	/	:	○ AM ○ PM	:	○ AM ○ PM	
13	/	:	○ AM ○ PM	:	○ AM ○ PM	

I, the Employee, certify that I have worked the hours and services indicated above. False information or misrepresentation constitutes Medicaid Fraud.

Employee Signature: 10 11 **Date:** MM / DD / YY

I, the Participant or Legal Guardian, certify that the above Employee worked the hours listed for this Participant, the services were provided in accordance with the Support & Spending Plan, and the Participant was NOT in a hospital, nursing home, or institution. Falsification of this time sheet is considered Medicaid Fraud and may result in dismissal from the program and/or criminal prosecution.

Participant Signature: 12 13 **Date:** MM / DD / YY

Timesheets must be signed AFTER the work is completed. Advance timesheets will not be accepted.

Draft

Revised 2/7/2014

CONSUMER DIRECT

Toll Free: 1-888-898-0470
Toll Free Fax: 1-877-898-0417
280 Corporate Drive, Suite 210
Meridian, ID 83642-2953

Idaho TIMESHEET

Timesheets are due no later than midnight on the Monday following the pay period. Please use the Consumer Direct pay calendar for reference. Due to the timing of the payroll cycle, late timesheets will result in late pay.

Employee Name (Please Print): Mickey Smith

Employee ID: 5171256672

Sunday that started your work week: 02 / 02 / 14 (MM / DD / YY)

Participant Name (Please Print): Laura Gluekert

Participant ID: 5432123

Please see back for instructions.

	Service Date (MM/DD)	Time In	Time Out	Service Code
1	02 / 02	08:00 ● AM ○ PM	12:00 ○ AM ● PM	PSS
2	02 / 03	09:00 ● AM ○ PM	01:00 ○ AM ● PM	PSS
3	02 / 04	01:00 ○ AM ● PM	05:30 ○ AM ● PM	PSS
4	02 / 05	08:00 ● AM ○ PM	12:00 ○ AM ● PM	PSS
5	02 / 06	11:00 ○ AM ● PM	06:00 ○ AM ● PM	PSS
6	02 / 07	08:00 ● AM ○ PM	12:00 ○ AM ● PM	PSS
7	/	: ○ AM ○ PM	: ○ AM ○ PM	
8	/	: ○ AM ○ PM	: ○ AM ○ PM	
9	/	: ○ AM ○ PM	: ○ AM ○ PM	
10	/	: ○ AM ○ PM	: ○ AM ○ PM	
11	/	: ○ AM ○ PM	: ○ AM ○ PM	
12	/	: ○ AM ○ PM	: ○ AM ○ PM	
13	/	: ○ AM ○ PM	: ○ AM ○ PM	

EXAMPLE

I, the Employee, certify that I have worked the hours and services indicated above. False information or misrepresentation constitutes Medicaid Fraud.

Employee Signature: Mickey Smith **Date (MM/DD/YY):** 02 / 07 / 14

I, the Participant or Legal Guardian, certify that the above Employee worked the hours listed for this Participant, the services were provided in accordance with the Support & Spending Plan, and the Participant was NOT in a hospital, nursing home, or institution. Falsification of this time sheet is considered Medicaid Fraud and may result in dismissal from the program and/or criminal prosecution.

Participant Signature: Laura Gluekert **Date (MM/DD/YY):** 02 / 08 / 14

Timesheets must be signed AFTER the work is completed. Advance timesheets will not be accepted.

Draft

CONSUMER DIRECT

Toll Free: 1-888-898-0470
Toll Free Fax: 1-877-898-0417
280 Corporate Drive, Suite 210
Meridian, ID 83642-2953

Idaho TIMESHEET

Timesheets are due no later than midnight on the Monday following the pay period. Please use the Consumer Direct pay calendar for reference. Due to the timing of the payroll cycle, late timesheets will result in late pay.

Employee Name (Please Print)

Employee ID

Sunday that started your work week MM / DD / YY

Participant Name (Please Print)

Participant ID

Please see back for instructions.

	Service Date (MM/DD)	Time In	Time Out	Service Code
1	/	: AM PM	: AM PM	
2	/	: AM PM	: AM PM	
3	/	: AM PM	: AM PM	
4	/	: AM PM	: AM PM	
5	/	: AM PM	: AM PM	
6	/	: AM PM	: AM PM	
7	/	: AM PM	: AM PM	
8	/	: AM PM	: AM PM	
9	/	: AM PM	: AM PM	
10	/	: AM PM	: AM PM	
11	/	: AM PM	: AM PM	
12	/	: AM PM	: AM PM	
13	/	: AM PM	: AM PM	

I, the Employee, certify that I have worked the hours and services indicated above. False information or misrepresentation constitutes Medicaid Fraud.

Employee Signature: _____ **Date:** MM / DD / YY

I, the Participant or Legal Guardian, certify that the above Employee worked the hours listed for this Participant, the services were provided in accordance with the Support & Spending Plan, and the Participant was NOT in a hospital, nursing home, or institution. Falsification of this time sheet is considered Medicaid Fraud and may result in dismissal from the program and/or criminal prosecution.

Participant Signature: _____ **Date:** MM / DD / YY

Timesheets must be signed AFTER the work is completed. Advance timesheets will not be accepted.

Draft

Revised 2/7/2014

Idaho
Mileage Reimbursement

Mileage forms are due every two weeks. Mileage forms are due by the Monday following the end of the service period by Midnight if faxed or dropped off, and postmarked by Monday if mailed. Due to the timing of the payroll cycle, late mileage forms will result in late pay. Mileage forms must be signed AFTER all work is completed. Advance mileage forms will not be accepted. **Want to avoid the hassle of paper timesheets & mileage forms? Enter your time the quick, easy, and secure way at www.mydirectcare.com today!**

Employee Name (Please Print)

Employee ID

Participant Name (Please Print)

Participant ID

For best results:
* Use BLACK ink
* Print clearly inside the boxes
* Fill out the Mileage Reimbursement completely and accurately

	Service Date (MM/DD)	Mileage - Rounded to nearest mile	Service Code
1	/ /		
2	/ /		
3	/ /		
4	/ /		
5	/ /		
6	/ /		
7	/ /		
8	/ /		
9	/ /		
10	/ /		
11	/ /		
12	/ /		
13	/ /		

I, the Employee, certify that I have provided the services indicated above and that the Participant was not in a hospital, nursing home, or institution. False information or misrepresentation constitutes Medicaid Fraud.

Employee Signature: _____ **Date:** MM / DD / YY

I, the Participant or Legal Guardian, certify that the above Employee provided the services listed for this Participant, the services were provided in accordance with the Support & Spending Plan, and the Participant was NOT in a hospital, nursing home, or institution. Falsification of this time sheet is considered Medicaid Fraud and may result in dismissal from the program and/or criminal prosecution.

Participant Signature: _____ **Date:** MM / DD / YY

Toll-Free: 1-888-898-0470 ♦ Toll-Free Fax: 1-877-898-0417
280 E. Corporate Dr. Suite 210 ♦ Meridian, ID 83642-2953

Mileage Reimbursement Instructions

Want to avoid the hassle of paper timesheets & mileage forms? Enter your time the quick, easy, and secure way at www.mydirectccare.com!

These items must be completed for your timesheet to be processed:	Each line of time must include:

• **Employee Name**
• **Employee ID**
• **Participant Name**
• **Participant ID**
• **Participant Signature & Date**
  o Must be dated on or after the last day worked.
• **Employee Signature & Date**
  o Must be dated on or after the last day worked.
	• Service Date
	• Mileage rounded to nearest mile
	• Service Code
	
	Make sure your mileage form is filled out completely and correctly, with all entries made neatly inside the boxes. Payment may be delayed if letters or numbers are not printed neatly inside the boxes WITHOUT touching any lines, or are not readable.
	
	Please continue on a second mileage form if you run out of room on the first. Bold items on the list to the left must also be filled in on the second form.

For best results use BLACK ink

Service Code
TSM

Back page is for information only. Please do not submit it with your mileage form.

4056

Revised 7/25/2014

Family-Directed Services Option

FISCAL EMPLOYER AGENT SERVICES

PACKET FOR OTHER SERVICE PROVIDERS AND VENDORS

Welcome to Idaho's Family-Directed Services Option! We are pleased that you will be working with and providing services to a family in this program. You will be helping Idaho meet its goal of giving people with disabilities more choice and control over their services.

Consumer Direct is very pleased to work with families and others who will be providing services and supports. Consumer Direct is a Fiscal Employer Agent for the Family-Directed Services Option. We are like a personal banker or payroll service company. We process payroll, file taxes, pay for services provided by other businesses or agencies and bill the state program for services provided by other businesses and agencies and bill the state program for services. Consumer Direct provides the family with the necessary paperwork to get set up as an employer. We also provide the paperwork for the other individuals to get enrolled as family service (support) providers. Once other service providers are enrolled, we process all of the forms and pay them as directed by the family (employer). Consumer Direct has over fourteen years of experience in many different states assisting people with directing their supports and services. We specialize in a range of self-directed service models."

In some situations, the people who provide services and supports are not employees of the Participant's Representative. In these situations, the Representative's role is to:

- Complete an employment agreement with an Agency if the Agency will provide workers for the Participant's Representative (employer).
- Complete a work agreement with an Independent Contractor who is going to do work for the Participant's Representative (employer).
- Complete the paperwork that is required to pay an agency or independent contractor.

- Pay the agency or the independent contractor directly if they work for the Participant's Representative doing things that are not approved in the Participant's Support and Spending Plan (the Participant's Representative pays…the Family-Directed Services option of the My Choice, My Voice Program does not pay).
- Approve and sign a timesheet that the agency requires for their employee.
- Keep required records, receipts and invoices.

This Packet for Other Service Providers includes the forms that the Participant's Representative needs to complete with you so you can be enrolled to provide services (supports) for the Participant. You and the Participant's Representative can fill out the forms to set you up as a service provider based on information contained in this Packet. We think you will be able to fill them out by looking at the instructions in the Packet. If you have questions about how to fill out any of the forms, please call Consumer Direct right away so we can help. Our toll free number is 1-888-898-0470.

If you want more help, you also could stop by the Consumer Direct office at 280 E. Corporate Drive, Suite 210, Meridian, during business hours Monday - Friday, 8:00 am - 5:00 pm.

When you have completed all of the forms, please mail or fax them to Consumer Direct at:

Consumer Direct
280 E. Corporate Drive, Suite 210
Meridian, Idaho 83642-2953

Toll Free Fax: 1-877-898-0417
Fax: (208) 898-0417

You also could drop off the form at Consumer Direct's office.

It is very important that you complete these forms and return them to Consumer Direct as quickly as possible. You cannot be ready to start work for a Participant until you have been enrolled to provide services.

The forms in the Packet for Other Service Providers are:

- ✓ Instructions for Hiring an Independent Contractor
- ✓ Participant-Independent Contractor Work Agreement
- ✓ Criminal History Check (2)
- ✓ Instructions for Hiring an Agency to Provide Community Support
- ✓ Participant-Agency/Community Support Worker Employment Agreement

Participant-Independent Contractor Work Agreement and Instructions: This Work Agreement Form is completed when the Participant's Representative wants to hire an independent contractor to provide services. The issue of who is an independent contractor is a complex one. A copy of IRS guidance about this issue is included in the Packet. Please look at this to decide if someone is an independent contractor. It is the responsibility of the Participant's Representative to decide if someone will be an independent contractor.

The directions for completing the Work Agreement are included with the form ("Instructions for Hiring an Independent Contractor"). Please review the directions carefully. Then follow the directions to fill out the form correctly. An independent contractor also must submit a W-9 in order to be enrolled as a service provider. A copy of a W-9 is included in the Packet.

Criminal History Check: A Participant's Representative can choose not to have a criminal history background check on an independent contractor. This means the criminal history background check is waived. If the Participant's Representative chooses this option, he/she has to complete a written statement that explains his/her choice. There are two forms in the Packet related to the criminal history check. If the Participant's Representative chooses not to have the criminal history check done, he/she must complete the "Criminal History Check: Waiver of Liability - Assumption of Risk" Form. If an independent contractor has failed a criminal history background check, the Participant's Representative still can consider employing the person. But, in this situation, the Participant's Representative has to fill out the "Criminal History Check: Waiver of Liability - Assumption of Risk - Failed Criminal History Check". These forms are attached to the Participant-Independent Contractor Work Agreement. The Participant's Representative and the independent contractor both need to read these forms carefully.

Participant-Agency/Community Support Worker Employment Agreement and Instructions: This Employment Agreement Form is completed when the Participant's Representative wants to hire an agency whose workers will provide services or supports. The agency employs the worker as a Community Support Worker. The directions for completing the Employment Agreement are included with the form ("Instructions for Hiring an Agency to Provide Community Support"). Please review the directions carefully. Then follow the directions to fill out the form correctly.

The agency must complete a criminal history check for the Community Support Worker, unless the

Participant's Representative has signed a waiver of the criminal history check. If a criminal history check is done, the Community Support Worker must have cleared the criminal history background check in order to work.

Other Vendors: Other businesses, professionals or service providers sometimes provide goods, supports and services for the Participant. They are not independent contractors or agencies (who provide Community Support Workers). Examples of things other vendors might provide could include (but are not limited to) minor home modifications, communication aids, direct therapy services, therapeutic recreation, certain courses or training materials associated with categories of service on the Support and Spending Plan, public transportation and adaptive equipment and supplies.

We look forward to enrolling you as the Participant's service (supports) provider. Please feel free to contact us with any questions. Consumer Direct's toll free number is 1-888-898-0470.

Remember, when you have finished either of the Agreement forms, please return the form to Consumer Direct as soon as possible. Please mail, fax or drop off the forms to Consumer Direct at:

Consumer Direct
280 E. Corporate Drive, Suite 210
Meridian, Idaho 83642-2953

Toll Free Fax: 1-877-898-0417
Fax: (208) 898-0417

07/17/07

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG -- Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-5747
FAX: (208) 332-7286

INSTRUCTIONS FOR HIRING AN AGENCY TO PROVIDE COMMUNITY SUPPORT

Self direction participants who want to hire an agency to provide community support workers must follow this process:

1. Contact the agency which employs the community support worker(s) who participant wants to hire.
- Request that the agency partners with participant so that participant can employ specific worker(s) from the agency.
- Explain to the agency that they are responsible for processing payroll, payroll taxes and reporting of income and taxes for the workers.
- Worker(s) remain employees of the agency.
- Present the agency or contractor with a copy of the *Participant – Agency/Community Support Worker Employment Agreement* for review. (See attached *Agreement.*)
- Explain that the agency is responsible for tasks as detailed in the *Employment Agreement.*

2. Once the agency agrees to partner with participant, complete *Employment Agreement.*
- The *Employment Agreement* must include total cost associated with the agreement.
- As per the *Agreement*, the community support worker(s) must either complete a criminal history check or obtain a signed Waiver of the criminal history check from participant.
- The verification number of the criminal history check must be included on the *Employment Agreement* or the signed Waiver must be provided.

3. *The Support and Spending Plan* must reflect the total cost of the *Employment Agreement.*
- *The Support and Spending Plan* must be authorized by the regional care manager.

4. Submit the *Participant – Agency/ Community Support Worker Employment Agreement* to the Regional Care Manager.

5. **The Regional Care Manager will ensure that the worker(s) is not listed on the Medicaid Exclusion (from Medicaid payment) list and that the Criminal History Background Check is complete or a Waiver is signed.**

6. The community support worker must provide participant and the agency with a time sheet detailing their work hours each pay period that they work.
   - Participant must validate and sign the time sheet.
   - The community support worker submits the time sheet to the agency.

7. The agency must provide participant with an *Invoice* each pay period which matches the time sheet.
   - Participant must sign and date the *Invoice* for it to be valid.

8. The participant submits the *Invoice* with a *Vendor Request for Payment* form to Consumer Direct each pay period, using the pay period chart Consumer Direct has provided.
   - The *Invoice* can include information on more than one worker, as long as time sheets have been signed.
   - The *Invoice* can include different codes and different rates of pay per worker.

9. The FEA reimburses the agency the amount specified on the *Invoice*.

10. The agency pays the community support worker.

11. Additional terms regarding the *Employment Agreement* can be negotiated and added to the Agreement in the space provided.

IDAHO DEPARTMENT OF
HEALTH & WELFARE

Participant- Agency / Community Support Worker Employment Agreement

This agreement is hereby made between _____, a participant of the Self-Directed Community Supports (SDCS) Option, a Medicaid option administered by the Department of Health and Welfare (the department), and _____, an agency.

It is mandatory to identify specific community support workers (CSW) who will be supplying services under this agreement.

The names of the individuals who will provide community support services under this agreement are:

_____

_____

The participant wants to hire the agency to provide a CSW for services under the SDCS Option. In exchange, the agency will bill for and provide payment to the CSW 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.

The CSW will remain an employee of the agency and the agency agrees to provide services that might otherwise be the responsibility of the participant, as detailed in the "Additional Terms" section. To these mutual purposes, the parties promise and agree as follows:

1. The CSW services are to be provided in accordance with the participant's SDCS Option Support and Spending Plan, and the SDCS Option rules, outlined in *IDAPA 16.03.13*, "Consumer-Directed Services."
2. The CSW remains the employee of the agency but will provide services as directed, controlled, and approved by the participant.
3. The CSW is hired to help the participant and assumes no legal liability for the participant's conduct.
4. The agency will ensure that the CSW meets the minimum qualifications to be a CSW, as outlined in Section 136 of *IDAPA 16.03.13*, "Consumer-Directed Services."
5. The CSW is an employee of the agency and is not an employee of the SDCS Option or the 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 insurance, or health insurance.

00873

6. The agency will notify the participant immediately in the event the CSW 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. Unless the participant specifies otherwise in the "Additional Terms" section of this agreement, the agency will train the CSW on the duties and responsibilities of a CSW.

8. The agency will be responsible for ensuring the accuracy of CSW's time records.

9. The agency will train the CSW and require the CSW to provide services in a safe, courteous, and professional manner. The agency 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*.

10. The agency will train the CSW and require the CSW to report any observed physical, sexual, or mental abuse, and any exploitation or neglect of the participant to adult protection authorities immediately.

11. The agency cannot provide or bill for services until:

    - An authorized "Support and Spending Plan" has been submitted to the FEA.
    - The CSW has either cleared the criminal history background check or has a waiver signed by the participant.

12. The agency will not be paid for services until:

    - A time sheet has been submitted to and signed by the participant.
    - An invoice that correlates to the CSW's time sheet has been supplied by the agency and signed by the participant.
    - The invoice has been submitted to the FEA.

13. Medicaid funding can only pay for services that are provided. Under the SDCS option, Medicaid will not reimburse the agency or the CSW for any vacation time, holiday time, overtime, or sick time. Medicaid will not pay wages at an hourly amount in excess of this agreement.

    The agency will ensure that any CSW who performs paid work in excess of 40 hours a week or works for less than minimum wage has met the criteria for exemption from the requirements for overtime and minimum wage, according to the Fair Labor Standards Act and the Idaho Department of Commerce and Labor.

The agency will provide the following services to the participant:

COLUMN A	B	C		D		E
Service Needed	**Type of Support** ☑ only one box	**Number of hours/ year OR Number of miles/year**		**Wage per hour Or Rate per mile**		**Annual Cost**
	☐ Personal PSS ☐ Emotional ESS ☐ Job JSS ☐ Skilled Nursing SNS ☐ Transportation TSS ☐ Relationship RSS ☐ Learning LSS ☐ Transportation Mileage Reimbursement		x		=	$ Sub-Total
	☐ Personal PSS ☐ Emotional ESS ☐ Job JSS ☐ Skilled Nursing SNS ☐ Transportation TSS ☐ Relationship RSS ☐ Learning LSS ☐ Transportation Mileage Reimbursement ☐ **Code for second rate of pay/hour** _____ **Fill in code**		x		=	$ Sub-Total
	☐ Personal PSS ☐ Emotional ESS ☐ Job JSS ☐ Skilled Nursing SNS ☐ Transportation TSS ☐ Relationship RSS ☐ Learning LSS ☐ Transportation Mileage Reimbursement ☐ **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 ☐ Emotional ESS ☐ Job JSS ☐ Skilled Nursing SNS ☐ Transportation TSS ☐ Relationship RSS ☐ Learning LSS ☐ Transportation Mileage Reimbursement ☐ **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 ☐ Emotional ESS ☐ Job JSS ☐ Skilled Nursing SNS ☐ Transportation TSS ☐ Relationship RSS ☐ Learning LSS ☐ Transportation Mileage Reimbursement ☐ **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 ☐ Emotional ESS ☐ Job JSS ☐ Skilled Nursing SNS ☐ Transportation TSS ☐ Relationship RSS ☐ Learning LSS ☐ Transportation Mileage Reimbursement ☐ **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:					$

00875

The CSW must meet the following specific qualifications in order to provide the above services including attaching a copy of the certification/licensure, if applicable, as outlined in subsections 120.05 and 150.01:

15. Additional terms of this agreement are as follows:

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

Participant Date

Legal Guardian (if applicable) Date

Agency if Applicable Date

00876

200902

IDAHO DEPARTMENT OF
HEALTH & WELFARE

Criminal History Check
Waiver of Liability - Assumption of Risk

Participant Name: _____MID # _____ Date: _____

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

Relationship to the Participant:_____

Description of Service: _____

Reason:_____

_____

_____

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

_____

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

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

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

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

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

Comments:

_____

_____
Signature of Support Broker Date

00867

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 _____

00868

Form **W-9**
(Rev. August 2013)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____

☐ Other (see instructions) ▶

Exemptions (see instructions):
Exempt payee code (if any) _____
Exemption from FATCA reporting code (if any) _____

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
☐☐☐ – ☐☐ – ☐☐☐☐

Employer identification number
☐☐ – ☐☐☐☐☐☐☐

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below), and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

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

Future developments. The IRS has created a page on IRS.gov for information about Form W-9, at *www.irs.gov/w9*. Information about any future developments affecting Form W-9 (such as legislation enacted after we release it) will be posted on that page.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, payments made to you in settlement of payment card and third party network transactions, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct.

Note. If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States:

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity,
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust, and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS a percentage of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code* on page 3 and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships* on page 1.

What is FATCA reporting? The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code* on page 3 and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account, for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name/disregarded entity name" line.

Partnership, C Corporation, or S Corporation. Enter the entity's name on the "Name" line and any business, trade, or "doing business as (DBA) name" on the "Business name/disregarded entity name" line.

Disregarded entity. For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulation section 301.7701-2(c)(2)(iii). Enter the owner's name on the "Name" line. The name of the entity entered on the "Name" line should never be a disregarded entity. The name on the "Name" line must be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on the "Name" line. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on the "Business name/disregarded entity name" line. If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Note. Check the appropriate box for the U.S. federal tax classification of the person whose name is entered on the "Name" line (Individual/sole proprietor, Partnership, C Corporation, S Corporation, Trust/estate).

Limited Liability Company (LLC). If the person identified on the "Name" line is an LLC, check the "Limited liability company" box only and enter the appropriate code for the U.S. federal tax classification in the space provided. If you are an LLC that is treated as a partnership for U.S. federal tax purposes, enter "P" for partnership. If you are an LLC that has filed a Form 8832 or a Form 2553 to be taxed as a corporation, enter "C" for C corporation or "S" for S corporation, as appropriate. If you are an LLC that is disregarded as an entity separate from its owner under Regulation section 301.7701-3 (except for employment and excise tax), do not check the LLC box unless the owner of the LLC (required to be identified on the "Name" line) is another LLC that is not disregarded for U.S. federal tax purposes. If the LLC is disregarded as an entity separate from its owner, enter the appropriate tax classification of the owner identified on the "Name" line.

Other entities. Enter your business name as shown on required U.S. federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name/disregarded entity name" line.

Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the *Exemptions* box, any code(s) that may apply to you. See *Exempt payee code* and *Exemption from FATCA reporting code* on page 3.

Exempt payee code. Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends. Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following codes identify payees that are exempt from backup withholding:

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)

2—The United States or any of its agencies or instrumentalities

3—A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities

4—A foreign government or any of its political subdivisions, agencies, or instrumentalities

5—A corporation

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States

7—A futures commission merchant registered with the Commodity Futures Trading Commission

8—A real estate investment trust

9—An entity registered at all times during the tax year under the Investment Company Act of 1940

10—A common trust fund operated by a bank under section 584(a)

11—A financial institution

12—A middleman known in the investment community as a nominee or custodian

13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 5[2]
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney, and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Reg. section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Reg. section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)

J—A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited Liability Company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at *www.ssa.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting IRS.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, or 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on the "Name" line must sign. Exempt payees, see *Exempt payee code* earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship or disregarded entity owned by an individual	The owner [3]
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulation section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity [4]
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulation section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or "DBA" name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 1.

***Note.** Grantor also must provide a Form W-9 to trustee of trust.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov*. You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: *spam@uce.gov* or contact them at *www.ftc.gov/idtheft* or 1-877-IDTHEFT (1-877-438-4338).

Visit IRS.gov to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

02/2009

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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INSTRUCTIONS FOR HIRING AN INDEPENDENT CONTRACTOR TO PROVIDE SERVICES

Self direction participants who want to hire an independent contractor to provide services must follow this process:

1. Participant contacts the independent contractor. The independent contractor is referred to as 'contractor'.

2. Participant explains the process of how the contractor will be paid:
   - The contractor will present an Invoice to Participant based on the Participant – Independent Contractor Work Agreement;
   - Participant submits Invoice to the Fiscal Agent (FEA);
   - Fiscal Agent (FEA) sends Participant a check made out to the Contractor;
   - Participant gives check to Contractor.
   - Pay periods are as per schedule published by FEA.

3. Once the agency agrees to partner with participant, complete *Participant – Independent Contractor Work Agreement.*
   - The *Work Agreement* must include total cost associated with the agreement.
   - As per the *Work Agreement*, the contractor must either complete a criminal history check or obtain a signed Waiver of the criminal history check from Participant.

4. *The Support and Spending Plan* must reflect the total cost of the *Work Agreement.*
   - *The Support and Spending Plan* must be authorized by the regional care manager.

5. Submit the *Participant – Contractor Work Agreement* to the FEA.

6. The FEA will provide the Contractor with a **W-9 form** that must be completed by the contractor.

7. The contractor must provide participant and the agency with an Invoice detailing their work each pay period that they work.
   - Participant must validate the Invoice.

8. The participant submits the ***Invoice*** with a ***Vendor Request for Payment*** form to the FEA each pay period.
   - The ***Invoice*** can include more than one code and more than one rate of pay.

9. The FEA sends a check made out to Contractor to the Participant for the amount specified on the Request for Vendor Payment.

10. Participant gives check to Contractor.

11. Additional terms regarding the ***Work Agreement*** can be negotiated and added to the Agreement in the space provided.

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Employee or Independent Contractor?

An employer must generally withhold federal income taxes, withhold and pay over social security and Medicare taxes, and pay unemployment tax on wages paid to an employee. An employer does not generally have to with-hold or pay over any federal taxes on payments to independent contractors.

Common-Law Rules

To determine whether an individual is an employee or an independent contractor under the common law, the relationship of the worker and the business must be examined. In any employee-independent contractor determination, all information that provides evidence of the degree of control and the degree of independence must be considered.
Facts that provide evidence of the degree of control and independence fall into three categories: behavioral control, financial control, and the type of relationship of the parties. These facts are discussed next.

Behavioral control. Facts that show whether the business has a right to direct and control how the worker does the task for which the worker is hired include the type and degree of:

Instructions that the business gives to the worker. An employee is generally subject to the business' instructions about when, where, and how to work. All of the following are examples of types of instructions about how to do work.

- When and where to do the work.
- What tools or equipment to use.
- What workers to hire or to assist with the work.
- Where to purchase supplies and services.
- What work must be performed by a specified individual.
- What order or sequence to follow.

The amount of instruction needed varies among different jobs. Even if no instructions are given, sufficient behavioral control may exist if the employer has the right to control how the work results are achieved. A business may lack the knowledge to instruct some highly specialized professionals; in other cases, the task may require little or no instruction. The key consideration is whether the business has retained the right to control the details of a worker's performance or instead has given up that right.

Training that the business gives to the worker. An employee may be trained to perform services in a particular manner. Independent contractors ordinarily use their own methods.

Financial control. Facts that show whether the business has a right to control the business aspects of the worker's job include:

The extent to which the worker has unreimbursed business expenses. Independent contractors are more likely to have unreimbursed expenses than are employees. Fixed ongoing costs that are incurred regardless of whether work is currently being performed are especially important. However, employees may also incur unreimbursed expenses in connection with the services that they perform for their employer.

The extent of the worker's investment. An independent contractor often has a significant investment in the facilities or tools he or she uses in performing services for someone else. However, a significant investment is not necessary for independent contractor status.

The extent to which the worker makes his or her services available to the relevant market. An independent contractor is generally free to seek out business opportunities. Independent contractors often advertise, maintain a visible business location, and are available to work in the relevant market.

How the business pays the worker. An employee is generally guaranteed a regular wage amount for an hourly, weekly, or other period of time. This usually indicates that a worker is an employee, even when the wage or salary is supplemented by a commission. An independent contractor is often paid a flat fee or on a time and materials basis for the job. However, it is common in some professions, such as law, to pay independent contractors hourly.

The extent to which the worker can realize a profit or loss. An independent contractor can make a profit or loss.

Type of relationship. Facts that show the parties' type of relationship include:

- ***Written contracts describing the relationship the parties intended to create.***
- ***Whether or not the business provides the worker with employee-type benefits, such as insurance, a pension plan, vacation pay, or sick pay.***
- ***The permanency of the relationship.*** If you engage a worker with the expectation that the relationship will continue indefinitely, rather than for a specific project or period, this is generally considered evidence that your intent was to create an employer-employee relationship.
- ***The extent to which services performed by the worker are a key aspect of the regular business of the company.*** If a worker provides services that are a key aspect of your regular business activity, it is more likely that you will have the right to direct and control his or her activities. For example, if a law firm hires an attorney, it is likely that it will present the attorney's work as its own and would have the right to control or direct that work. This would indicate an employer-employee relationship.

IRS help. If you want the IRS to determine whether or not a worker is an employee, file Form SS-8, Determination of Worker Status for Purposes of Federal Employment Taxes and Income Tax Withholding, with the IRS.

IDAHO DEPARTMENT OF
HEALTH & WELFARE

PARTICIPANT- INDEPENDENT CONTRACTOR

WORK AGREEMENT

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

_____ , an independent contractor, hereafter referred to as 'Contractor.'

The Participant desires to engage Contractor to provide services under the SDCS Option. In exchange, Contractor will bill 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 invoices submitted by Contractor and approved by the Participant. To these mutual purposes, the parties promise and agree as follows:

1. Contractor services are to be provided in accordance with the Participant's SDCS Option Support and Spending Plan, and the SDCS Option rules, outlined in IDAPA 16.03.13, "Consumer-Directed Services."

2. It is mutually understood that Contractor is an independent worker and not the employee of the participant and as such, is responsible for filing tax information with the Internal Revenue Service.

3. Contractor will provide services as directed, controlled and approved by the participant.

4. Contractor is hired to assist the Participant and assumes no legal liability for the Participant's conduct.

5. Contractor ensures that he/she meets the minimum qualifications to be a support worker, as outlined in Section 136 of IDAPA 16.03.13, "Consumer-Directed Services."

6. The parties mutually agree that Contractor is not an employee of the SDCS Option or the Fiscal/Employer Agent, and agree that Contractor is not entitled to nor will make claim for any employee benefits from the SDCS Option or the Fiscal Employer Agent, including but not limited to, worker's compensation, disability, life or health insurance.

7. Contractor agrees to notify the Participant immediately in the event the he/she is unable to provide the agreed services due to sickness, injury or personal emergency.

8. Contractor agrees to provide services in a safe, courteous and professional manner. Any physical, sexual or mental abuse or neglect of the Participant by the contractor 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. Contractor agrees to report any observed physical, sexual or mental abuse, exploitation or neglect of Participant to Adult Protection Services authorities immediately.

10. Contractor understands and agrees that he/she cannot provide or bill for services until:

a.) An authorized Support and Spending Plan has been submitted to the FEA.
b.) Contractor has either cleared the criminal history background check or has had a Waiver signed by the Participant.

11. Contractor understands he/she will not be paid for services until:

a.) An invoice has been submitted to and signed by the participant.

b.) The invoice has been submitted to the FEA.

c.) The Participant's Support and Spending Plan authorizes the service that Contractor has completed.

12. It is mutually understood that Medicaid funding can only pay for services rendered. Under the SDCS option, Medicaid will not reimburse Contractor for any vacation time, holiday time, overtime or sick time. Medicaid will not pay wages at an amount in excess of this agreement.

Contractor will provide the following service(s) to the Participant:

Service needed	**Type of Support** ☑ only one box	Frequency How often or how many hours:		Duration: How long a period of time will the service be offered:		Annual Cost
	☐ Personal PSS / ☐ Emotional ESS ☐ Job JSS / ☐ Skilled Nursing SNS ☐ Transportation TSS / ☐ Relationship RSS ☐ Learning LSS		**x**		**=**	$ Sub-Total
Service needed	**Type of Support** ☑ only one box					Annual Cost
	☐ Personal PSS / ☐ Emotional ESS ☐ Job JSS / ☐ Skilled Nursing SNS ☐ Transportation TSS / ☐ Relationship RSS		**x**		**=**	$

	☐ Learning LSS					Sub-Total
Service needed	**Type of Support** ☑ only one box					Annual Cost
	☐ Personal PSS / ☐ Emotional ESS ☐ Job JSS / ☐ Skilled Nursing SNS ☐ Transportation TSS / ☐ Relationship RSS ☐ Learning LSS		**x**		**=**	$ Sub-Total
	TOTAL COST OF AGREEMENT				**=**	$ TOTAL

Contractor must meet the following specific qualifications in order to provide the above services including attaching copy of certification/licensure, if applicable, as outlined in Subsections 120.05 and 150.01:

_____

_____

Additional terms of this agreement are as follows:

_____

_____

_____

_____

_____

Unless the Criminal History Background Check is Waived, the Community Support Worker or Contractor has applied for a Criminal History Background Check through the Department of Health and Welfare. **The Employer Identification Number for the Criminal History Background Check is 1710. Use this number when applying for the background check. This number allows the Department of Health and Welfare, Division of Medicaid, and its contracting fiscal intermediary to access results of the background check.**

Contractor gives permission to the Department of Health and Welfare, Division of Medicaid, to notify the Participant (Employer) of the results of the Criminal History Background Check.

_____
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 Contractor cannot receive Medicaid dollars if he is on a federal or state Medicaid exclusion list.

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 worker or Contractor performance.

PARTICIPANT Date

LEGAL GUARDIAN (IF APPLICABLE) Date

INDEPENDENT CONTACTOR Date

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 Contractor) _____ to be subject to Criminal History Check requirements.

Relationship to the Participant: _____

Description of Service: _____

Reason: _____

_____

_____

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

_____

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

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

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

_____ _____

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

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

Comments:

_____

_____

Signature of Support Broker Date

00881

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 Contractor) _____ . 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 am the support broker for this participant and have provided education and counseling to _____ regarding the risks of waiving a criminal history check for this individual.
Comments:

_____

_____

Signature _____

00882

Form **W-9**
(Rev. August 2013)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____

☐ Other (see instructions) ▶

Exemptions (see instructions):
Exempt payee code (if any) _____
Exemption from FATCA reporting code (if any) _____

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
☐☐☐ – ☐☐ – ☐☐☐☐

Employer identification number
☐☐ – ☐☐☐☐☐☐☐

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below), and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

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

Future developments. The IRS has created a page on IRS.gov for information about Form W-9, at *www.irs.gov/w9*. Information about any future developments affecting Form W-9 (such as legislation enacted after we release it) will be posted on that page.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, payments made to you in settlement of payment card and third party network transactions, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct.

Note. If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States:

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity,
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust, and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS a percentage of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code* on page 3 and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships* on page 1.

What is FATCA reporting? The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code* on page 3 and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account, for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name/disregarded entity name" line.

Partnership, C Corporation, or S Corporation. Enter the entity's name on the "Name" line and any business, trade, or "doing business as (DBA) name" on the "Business name/disregarded entity name" line.

Disregarded entity. For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulation section 301.7701-2(c)(2)(iii). Enter the owner's name on the "Name" line. The name of the entity entered on the "Name" line should never be a disregarded entity. The name on the "Name" line must be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on the "Name" line. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on the "Business name/disregarded entity name" line. If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Note. Check the appropriate box for the U.S. federal tax classification of the person whose name is entered on the "Name" line (Individual/sole proprietor, Partnership, C Corporation, S Corporation, Trust/estate).

Limited Liability Company (LLC). If the person identified on the "Name" line is an LLC, check the "Limited liability company" box only and enter the appropriate code for the U.S. federal tax classification in the space provided. If you are an LLC that is treated as a partnership for U.S. federal tax purposes, enter "P" for partnership. If you are an LLC that has filed a Form 8832 or a Form 2553 to be taxed as a corporation, enter "C" for C corporation or "S" for S corporation, as appropriate. If you are an LLC that is disregarded as an entity separate from its owner under Regulation section 301.7701-3 (except for employment and excise tax), do not check the LLC box unless the owner of the LLC (required to be identified on the "Name" line) is another LLC that is not disregarded for U.S. federal tax purposes. If the LLC is disregarded as an entity separate from its owner, enter the appropriate tax classification of the owner identified on the "Name" line.

Other entities. Enter your business name as shown on required U.S. federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name/disregarded entity name" line.

Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the *Exemptions* box, any code(s) that may apply to you. See *Exempt payee code* and *Exemption from FATCA reporting code* on page 3.

Exempt payee code. Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends. Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following codes identify payees that are exempt from backup withholding:

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)

2—The United States or any of its agencies or instrumentalities

3—A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities

4—A foreign government or any of its political subdivisions, agencies, or instrumentalities

5—A corporation

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States

7—A futures commission merchant registered with the Commodity Futures Trading Commission

8—A real estate investment trust

9—An entity registered at all times during the tax year under the Investment Company Act of 1940

10—A common trust fund operated by a bank under section 584(a)

11—A financial institution

12—A middleman known in the investment community as a nominee or custodian

13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 5[2]
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney, and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Reg. section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Reg. section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)

J—A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited Liability Company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at *www.ssa.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting IRS.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, or 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on the "Name" line must sign. Exempt payees, see *Exempt payee code* earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship or disregarded entity owned by an individual	The owner [3]
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulation section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity [4]
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulation section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or "DBA" name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 1.

***Note.** Grantor also must provide a Form W-9 to trustee of trust.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov*. You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: *spam@uce.gov* or contact them at *www.ftc.gov/idtheft* or 1-877-IDTHEFT (1-877-438-4338).

Visit IRS.gov to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

Service Codes and Their Meanings

Timesheet Service Codes:

- **SBS** **SB2, SB3** for “Support Broker Support”
- **PSS** **PS2, PS3** for “Personal Support ”
- **JSS** **JS2, JS3** for “Job Support”
- **TSS** **TS2, TS3** for “Transportation Support”
- **LSS** **LS2, LS3** for “Learning Support”
- **RSS** **RS2, RS3** for “Relationship Support”
- **ESS** **ES2, ES3** for “Emotional Support”
- **SNS** **SN2, SN3** for “Skilled Nursing Support”

Vendor Service Code:

- **AEQ** for “Adaptive Equipment”

Mileage Reimbursement Form Service Code:

- **TSM** for “Transportation Support Mileage”

***Use the modifier with the service letters when the CSW is being paid more than 1 rate of pay per service code. Please see the Employment Agreement Instructions for further detail.**

CONSUMER DIRECT

IDAHO Fiscal Employer Agent
PARTICIPANT/EMPLOYEE FEEDBACK FORM

Directions: Please complete all the sections except the gray one at the bottom of the page. Mail or fax the form to Consumer Direct.

Name: _____ **Date:** _____
(Please Print)

You are a (Please check): ☐ **Participant** ☐ **Employee** ☐ **Agency**

Address: _____

City: _____ **State:** _____ **Zip:** _____

Telephone: _____ **Email:** _____

Please check the box that applies: ☐ **Compliment** ☐ **Suggestion** ☐ **Complaint**

Would you like us to contact you? ☐ **Yes** ☐ **No** **If yes, how:** ☐ **phone** ☐ **email** ☐ **mail**

Please describe the compliment, suggestion or complaint:

Please fax, mail or drop off completed and signed form to:

Toll Free Fax: 1-877-898-0417
Consumer Direct
280 E. Corporate Drive, Suite 210
Meridian, ID 83642-2953

For Consumer Direct Office Use:

Date Received: ____/____/____ Signature: _____

Action Taken: ☐ Resolved ☐ Not Resolved ☐ Submitted to Program Manager
Plan: (Please use back of form)

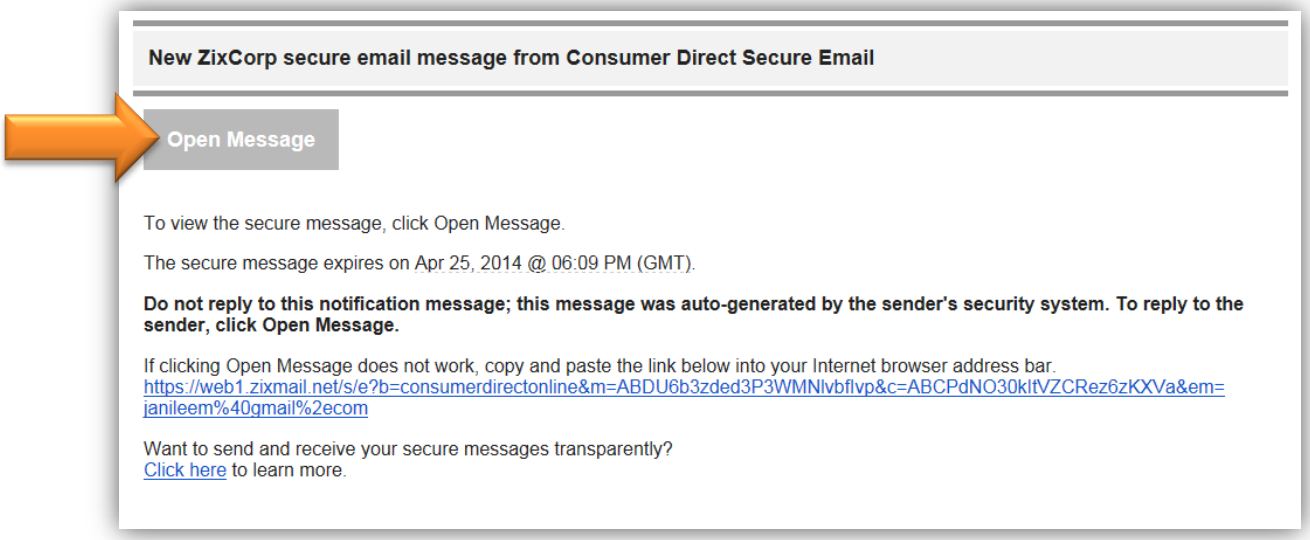
00889

Accessing Secure Email Sent by Consumer Direct

Consumer Direct uses a secure messaging system to send protected health information.

Below is an example of a secure message. This is not spam so do not delete.

Step 1: To view the message click the "open message" button.

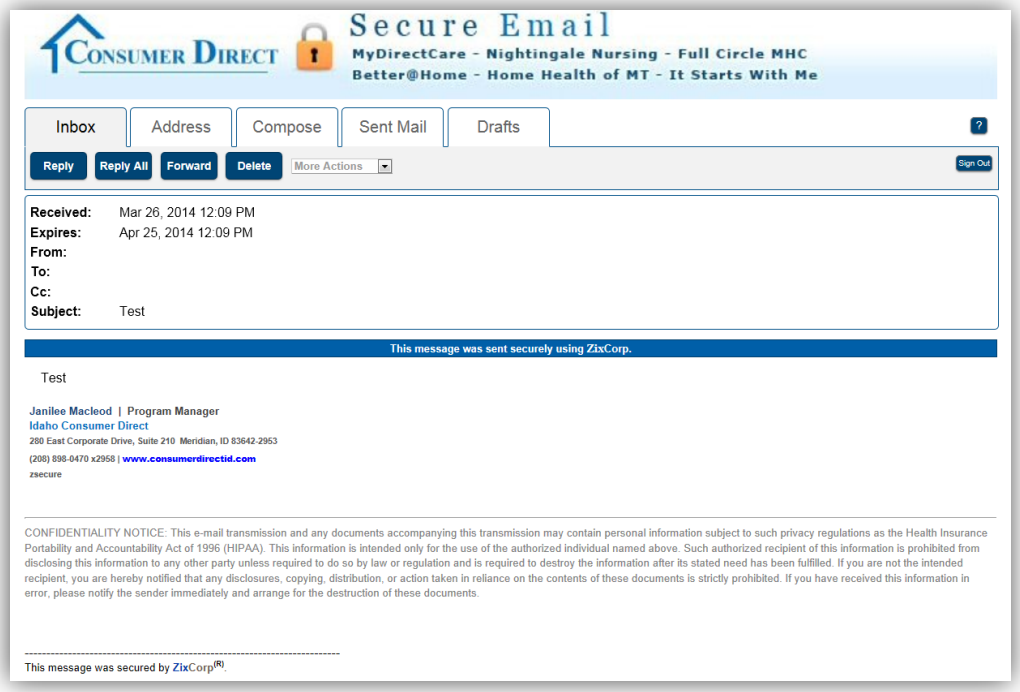


Step 2:

You will need to register the first time you view a secure email. This is different than your web portal login. Create a password. Passwords must meet the password rules. Enter your password and click the register button.

<u>Step 2 Continued</u>: If you've already created a password, you will get the login screen below. Enter your password and click the sign in button.

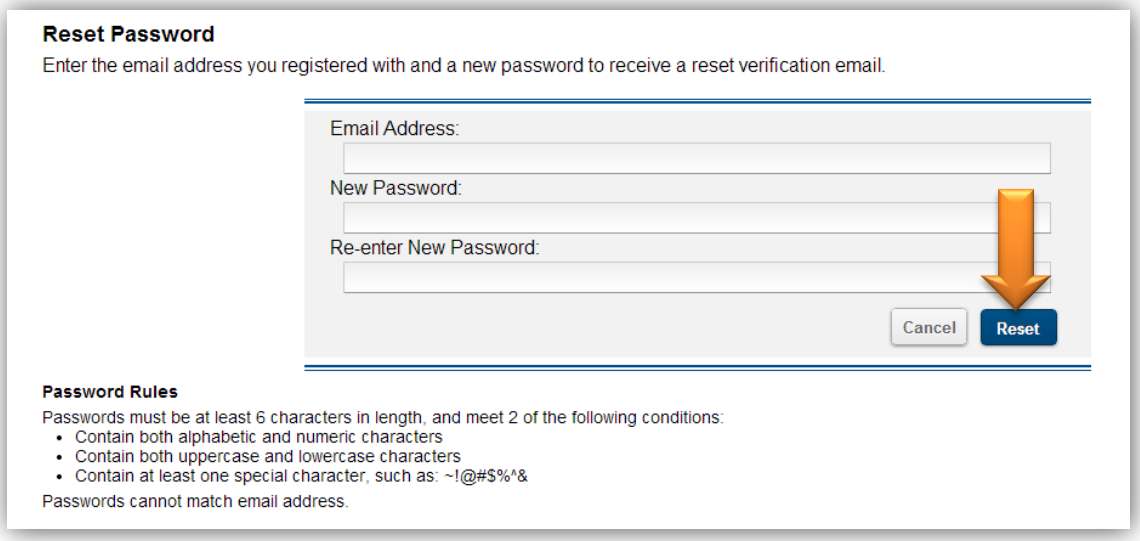
<u>Step 3</u>: After signing in you will be able to read and respond to your message(s). Messages do expire so print or save the email if you wish to keep it. Remember to check your spam/junk folder often.



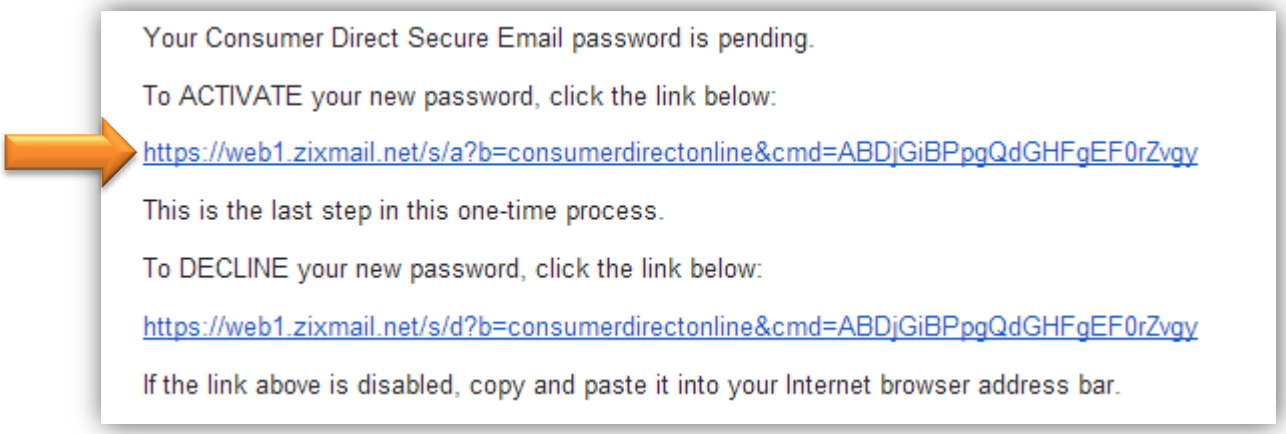
Changing Your Secure Email Password

Step 1: From the login screen, click the reset button under the "forgot your password" section.

Step 2: Enter your e-mail address and new password. Click the reset button.



<u>Step 3</u>: You will receive an e-mail with the links below. Click the activate link to accept your new password.



Your Consumer Direct Secure Email password is pending.

To ACTIVATE your new password, click the link below:

https://web1.zixmail.net/s/a?b=consumerdirectonline&cmd=ABDjGiBPpgQdGHFgEF0rZvgy

This is the last step in this one-time process.

To DECLINE your new password, click the link below:

https://web1.zixmail.net/s/d?b=consumerdirectonline&cmd=ABDjGiBPpgQdGHFgEF0rZvgy

If the link above is disabled, copy and paste it into your Internet browser address bar.

<u>Step 4</u>: You will receive the message below after you click the activation link. Click the continue button to proceed to the login screen.

CONSUMER DIRECT

Secure Email

MyDirectCare - Nightingale Nursing - Full Circle MHC

Better@Home - Home Health of MT - It Starts With Me

Activation Successful

You have successfully activated your new password. Click Continue to return to the Sign In page.

Continue

Note: Your password is important. Please store it in a safe place.

CONSUMER DIRECT

IDAHO Fiscal Employer Agent
Wages and Cost to You

As you know, it costs you more to employ someone than just their wages. As an employer, by law, you have to additionally pay ½ of your employee's Social Security and Medicare payment, as well as Federal and State Unemployment taxes. The amount you pay for each of these is a percentage of payroll. These include:

Social Security	-6.200%	
Medicare	-1.450%	← These percentages do not change
Federal Unemployment	-0.600%	
State Unemployment	-1.906%	← This is an average rate. Your actual rate may vary.

What this means is that for every $1.00 you pay in wages, you have to additionally pay approximately $0.10 in taxes. **You do not need to worry about the calculations or actually paying these amounts. Consumer Direct will do that on your behalf.**

The following table is provided so you will know your cost to employ someone, based on various wage amounts. The "Cost to You" column is simply the wage multiplied by the total of the percentages listed above. You are free to pay your employees other amounts than those listed in the table; just multiply the amount you want to pay by 1.10156 and you will get the Cost to You, or give us a call, we will help you know your costs.

Employee Wage	Cost to You	Employee Wage	Cost to You	Employee Wage	Cost to You	Employee Wage	Cost to You	
$ 6.55	$ 7.22	$ 9.00	$ 9.91	$ 13.00	$ 14.32	$ 18.00	$ 19.83	MAX
$ 6.60	$ 7.27	$ 9.25	$ 10.19	$ 13.25	$ 14.60	$ 18.50	$ 20.38	SUPPORT
$ 6.75	$ 7.44	$ 9.50	$ 10.46	$ 13.50	$ 14.87	$ 18.72	$ 20.62	BROKER
$ 6.80	$ 7.49	$ 9.75	$ 10.74	$ 13.75	$ 15.15	$ 19.00	$ 20.93	
$ 7.00	$ 7.71	$ 10.00	$ 11.02	$ 14.00	$ 15.42	$ 19.50	$ 21.48	
$ 7.10	$ 7.82	$ 10.25	$ 11.29	$ 14.25	$ 15.70	$ 20.00	$ 22.03	
$ 7.25	$ 7.99	$ 10.50	$ 11.57	$ 14.50	$ 15.97	$ 20.50	$ 22.58	
$ 7.50	$ 8.26	$ 10.75	$ 11.84	$ 14.75	$ 16.25	$ 21.00	$ 23.13	
$ 7.75	$ 8.54	$ 11.00	$ 12.12	$ 15.00	$ 16.52	$ 21.50	$ 23.68	
$ 7.80	$ 8.59	$ 11.25	$ 12.39	$ 15.25	$ 16.80	$ 22.00	$ 24.23	
$ 8.00	$ 8.81	$ 11.50	$ 12.67	$ 15.50	$ 17.07	$ 22.50	$ 24.79	
$ 8.10	$ 8.92	$ 11.75	$ 12.94	$ 15.75	$ 17.35	$ 23.00	$ 25.34	
$ 8.25	$ 9.09	$ 12.00	$ 13.22	$ 16.00	$ 17.62	$ 23.50	$ 25.89	
$ 8.50	$ 9.36	$ 12.25	$ 13.49	$ 16.50	$ 18.18	$ 24.00	$ 26.44	
$ 8.75	$ 9.64	$ 12.50	$ 13.77	$ 17.00	$ 18.73	$ 24.50	$ 26.99	
$ 8.80	$ 9.69	$ 12.75	$ 14.04	$ 17.50	$ 19.28	$ 25.00	$ 27.54	

Note: The higher the rate you pay your employee(s), the faster you will use up your budgeted amount.

CONSUMER DIRECT

IDAHO Fiscal Employer Agent
EMPLOYEE TERMINATION FORM

Termination Notice
(Complete when terminating an employee)

Employee Name:	ID Number:
Termination Date:	
Forwarding Address: City/State/Zip:	
Instructions and/or Notes:	

Participant Name (Print)

Employee Name (Print)

Participant Parent/Legal Rep. Signature

Employee Signature (if applicable)

Date

Date

Please fax, mail or drop off completed and signed form to:

Toll Free Fax: 1-877-898-0417
Consumer Direct
280 E. Corporate Drive, Suite 210
Meridian, ID 83642-2953

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