Community Support Worker Employee Packet Instructions

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

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

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

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

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

To help you understand each form in the Packet, an explanation and instructions for completing each form is provided below. If you have any questions, please ask a CDCN representative.

New Employee Checklist

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

Employee Data Form

The Employee Data Form is used to gather basic information about the community support worker so their employee file can be set up in CDCN's payroll system.

When filling in this form:

- Complete all of the blanks on the form as labeled (for example, name, physical address, mailing address, phone and so on).
- Write in the name of the participant the employee will be working for.
- Employee signs and dates to indicate that all the information is correct.

Participant-Community Support Worker Employment Agreement

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

When filling in the Agreement:

Page 1:

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

Page 2:

- Read through the agreement

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

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

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

Page 4:

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

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

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

I-9 Employment Eligibility Verification

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

W-4 Form

The W-4 is an IRS form and needs to be completed so the correct amount of federal and state income taxes can be withheld from the employee's pay check. The directions are included 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 can be claimed in box 5 on the form. The smaller the number of allowances that are claimed, the more taxes will be withheld from the employee's pay check. This means they receive less take home pay.

When filling in this form, make sure to:

- Use a W-4 for the correct year
- Mark something in box 3
- 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.

Pay Selection Form

The purpose of this form is for the employee to choose how they will receive their paycheck. CDCN offers two pay options: (1) direct deposit to the employee's bank or credit union account or (2) direct deposit to a Visa pay card. Pay stubs (a summary of the employees pay) are sent by first class mail to the employee's address on file.

When filling in the Pay Selection form:

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

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

Employment Relationship Disclosure Form

This form is used to determine if the employee's relationship to the employer exempts them from paying certain federal and state payroll taxes on their earnings as described on the form.

When filling in this form:

- Write the name of the employee, the employer, and the participant in the boxes on the top of the form. The employer is usually the participant, but not always.
- In section 1, check the boxes to indicate the age of the participant (service recipient), and whether a live-in relationship exists between employee and the service recipient.
- In section 2, indicate the relationship of the employee to the employer by checking the appropriate descriptor.
- Read and familiarize yourself with the information provided in sections 3 and 4.
- Both employee and employer sign and date the form.

Medicaid-Community Support Worker Agreement

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

When filling in this form:

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

Criminal History Check

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

To get a background check:

- The participant must contact the Department of Health and Welfare Criminal History Unit and request a Criminal History Check on the prospective employee (applicant). At that time

the participant can either set up an appointment for the applicant, or the applicant can set up his/her own appointment.

- The agency code used is 1710.
- The cost of the CHC is paid by the employee at the time the person's fingerprints and identification information are taken by the Department of Health and Welfare. This cannot be paid from the participant's budget.
- After the check is complete, the Notice of Clearance letter must be provided with the employee packet.

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

Criminal History Check – Waiver of Liability – Assumption of Risk

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

When filling in this form:

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

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

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

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

CONSUMER DIRECT CARE NETWORK

My Voice, My Choice

EMPLOYEE DATA FORM

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

Physical Address: 887 Paradise Rd (Street) | (Apt/Unit #) | Goober (City) | ID (State) | 12345 (Zip Code)

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

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

Email: emailgoeshere@fakemail.com

Gender: ☑ Male ☐ Female

Date of Birth: 12/25/1948 Social Security Number: 123-45-6789

Name of Participant: Tad Pohl

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

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

Alfred Bino — *Employee Signature*

1/5/2018 — *Date*

CONSUMER DIRECT CARE NETWORK

My Voice, My Choice

NEW EMPLOYEE (CSW) CHECKLIST

Alfred T Bino	/ /	Tad Pohl
Employee Name	Estimated Start Date	Participant Name

Welcome to Consumer Direct Care Network (CDCN)!

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

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

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

Mandatory Forms - all new Employees

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

Forms Required only if Employer waives certain Criminal History Check requirements

1. ☐ Criminal History Check – Waiver of Liability – Assumption of Risk – Failed Criminal History Check

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

Tad Pohl	1/5/18	Tad Pohl
Participant Signature	*Date*	*Printed Name*

Date submitted to CDCN: 1/6/18

00848

CONSUMER DIRECT CARE NETWORK

My Voice, My Choice

EMPLOYMENT RELATIONSHIP DISCLOSURE

Alfred T Bino	Tad Pohl
Employee Name	Employer/Participant Name

Instructions: The employee must answer the following questions.

1. Employee-Service Recipient Relationship:

☐ Yes ☐ No I will be residing at the same address as the person receiving services

☐ Yes ☑ No The person receiving services is a minor (less than age 18)

2. Employee-Employer Relationship:

Tell us if you are related to your employer. I am the following (check one):

☐ *Spouse	☐ Parent	☐ Adoptive or Step Parent
☐ Child under age of 21	☐ Child over age of 21	☐ Sibling
☑ Grandparent	☐ Grandchild	☐ Live-together-partners
☐ No Relationship	☐ Other, please describe: _____	

** By program rule, the employer's spouse is not allowed to be a paid employee in the Idaho Self Direction Program.*

<u>If parent was checked above</u>, complete the following:

Yes	No	
☐	☐	My employer (my son or daughter) has a child or step child that lives in the home.
☐	☐	My employer is (1) a widow or widower, (2) divorced or (3) married and lives with a spouse but the spouse can't care for the child or step child due to a mental or physical condition. The spouse is unable to provide care for at least 4 straight weeks in 3 months.
☐	☐	My employer's child or stepchild is less than 18 years old or needs personal care from an adult. Care is needed for at least 4 straight weeks in 3 months due to a mental or physical condition.

3. Relationship Acknowledgment:

I may be exempt from some taxes. It depends on what I checked above. The back of this form shows what taxes I must pay. My local unemployment office can tell me more about FUTA and SUTA taxes.

I must notify Consumer Direct Care Network (CDCN) if this relationship changes. I have 5 days to do so. If I do not, I may have to pay back money that should have been withheld from my pay.

4. Amended Payroll Tax Returns:

CDCN will file all required amended payroll tax returns in instances where there have been over collected Social Security and Medicare taxes from employees' compensation. The employee will receive refunds of over collected Social Security and Medicare taxes directly from CDCN if earnings are less than the IRS threshold published in Circular E for the current tax year. Refunds will be paid to the employee in January immediately following year-end. Employee agrees they will not file a claim for refund of over collected Medicare or Social Security with the IRS.

Alfred Bino	1/5/2018	Tad Pohl	1/5/18
Employee Signature	*Date*	*Employer/Representative Signature*	*Date*

Internal Use Only – Home Office		
Evaluator's Initials: _____	SUTA (subject to tax) ☐ Yes ☐ No	FUTA (subject to tax) ☐ Yes ☐ No

Internal Use Only – Local Office		
Evaluator's Initials: _____	Medicare (subject to tax) ☐ Yes ☐ No	Social Security (subject to tax) ☐ Yes ☐ No

Employment Eligibility Verification

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

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

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

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

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

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*
Bino	Alfred	T	N/A

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

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

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

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

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

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

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*
Alfred Bino	1/5/2018

Preparer and/or Translator Certification (check one):

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

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

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

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

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

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

Employment Eligibility Verification

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

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

Section 2. Employer or Authorized Representative Review and Verification

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

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status
	Bino	Alfred	T	1

List A OR	List B AND	List C
Identity and Employment Authorization	**Identity**	**Employment Authorization**
Document Title	Document Title: Driver's License	Document Title: Social Security Card
Issuing Authority	Issuing Authority: State of Idaho	Issuing Authority: SSA
Document Number	Document Number: DD00011122233344	Document Number: 123-45-6789
Expiration Date *(if any)(mm/dd/yyyy)*	Expiration Date *(if any)(mm/dd/yyyy)*: 12/25/2020	Expiration Date *(if any)(mm/dd/yyyy)*
Document Title		
Issuing Authority		
Document Number		
Expiration Date *(if any)(mm/dd/yyyy)*		
Document Title		
Issuing Authority		
Document Number		
Expiration Date *(if any)(mm/dd/yyyy)*		

Additional Information

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

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

The employee's first day of employment *(mm/dd/yyyy)*: 1/5/18 ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
Tad Pohl	1/5/18	Employer

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

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

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

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

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

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

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

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

Form W-4 (2018)

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

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

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

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

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

General Instructions

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

You can also use the calculator at ***www.irs.gov/W4App*** to determine your tax withholding more accurately. Consider using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2018. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

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

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

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

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

Specific Instructions

Personal Allowances Worksheet

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

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

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

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

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

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

Employee's Withholding Allowance Certificate

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

OMB No. 1545-0074

2018

1 Your first name and middle initial	Last name	2 Your social security number
Alfred, T	Bino	123-45-6789

Home address (number and street or rural route)
887 Paradise Rd

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

3 ☑ Single ☐ Married ☐ Married, but withhold at higher Single rate.
Note: If married filing separately, check "Married, but withhold at higher Single rate."

4 **If your last name differs from that shown on your social security card, check here. You must call 800-772-1213 for a replacement card.** ▶ ☐

5	Total number of allowances you're claiming (from the applicable worksheet on the following pages)	5	0
6	Additional amount, if any, you want withheld from each paycheck	6	$
7	I claim exemption from withholding for 2018, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ▶	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.) ▶ Alfred Bino

Date ▶ 1/5/2018

8 Employer's name and address (**Employer:** Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)	9 First date of employment	10 Employer identification number (EIN)

CONSUMER DIRECT CARE NETWORK

PAY SELECTION FORM

Employee Name: Alfred T Bino
(please print)

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

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

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

☑ **Bank or Credit Union Direct Deposit** – I authorize CDCN to initiate payroll deposits to (name of bank or financial institution): US Bank

Account Type (check one): ☑ Checking ☐ Savings

For Checking Accounts:

Attach (tape) a voided check here

Do not attach a deposit slip.

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

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

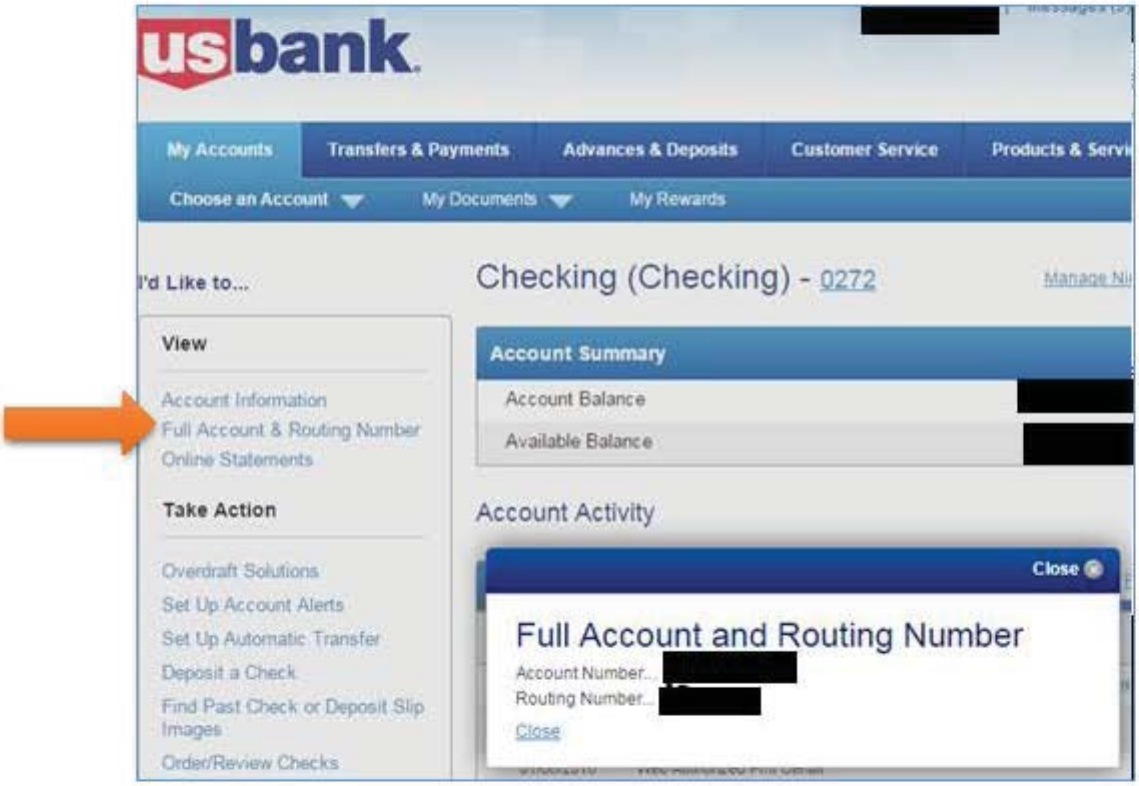
Alfred Bino
Signature

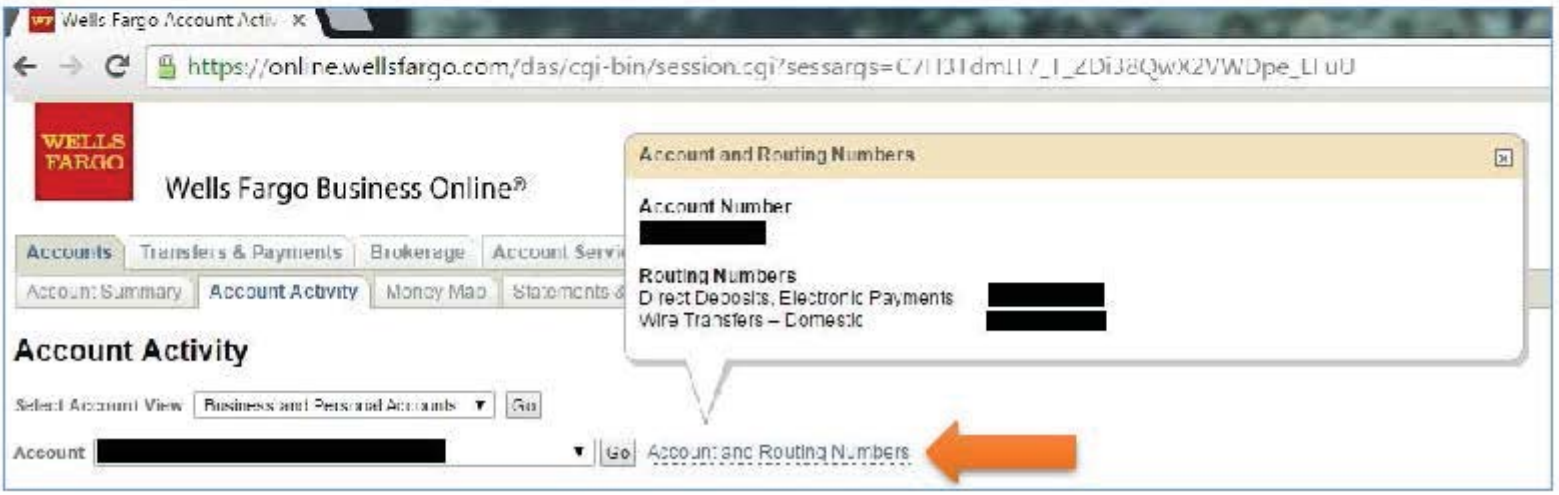
1/5/2018
Date

02593

Account and Routing Numbers for Pay Selection Form

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





IDAHO DEPARTMENT OF
HEALTH & WELFARE

PARTICIPANT-COMMUNITY SUPPORT WORKER EMPLOYMENT AGREEMENT

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

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

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

1. CSW services are to be provided in accordance with the Participant's SDCS Support and Spending Plan, and the SDCS rules, outlined in IDAPA 16.03.13, "Consumer-Directed Services."

2. It is mutually understood that CSW is the employee of the Participant, and that the Participant directs, controls and approves the CSW's work.

3. The CSW is hired to assist the Participant and assumes no legal liability for the Participant's conduct.

4. The CSW promises that he/she meets the following minimum qualifications to be a CSW, as outlined in Section 136 of IDAPA 16.03.13, "Consumer-Directed Services."

5. The parties mutually agree that CSW is an employee of the Participant and is not an employee of the SDCS Option or the Fiscal Employer Agent (FEA), and agree that the CSW is not entitled to nor will make claim for any employee benefits from the SDCS Option or the FEA, including but not limited to, worker's compensation, disability, life or health insurance.

6. The CSW agrees to notify the Participant immediately in the event he/she is unable to provide the agreed services due to sickness, injury or personal emergency. The CSW must obtain the Participant's written approval in advance for any pre-planned absence.

7. The Participant shall train the CSW on the duties and responsibilities of the CSW and shall be responsible for approving the accuracy of CSW's time records.

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

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

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

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

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

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

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

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

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

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

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

13. Terms and conditions of work. **Effective Date:** 1/5/2018.

COLUMN A	B	C		D		E
Service needed	Type of Support ☑ **only one box per row**	Number of hours per year OR Number of miles/year		Wage per hour OR Wage per mile		Annual Cost
Respite	☑ Personal PSS ☐ Job JSS ☐ Transportation TSS (hourly) ☐ Learning LSS ☐ Emotional ESS ☐ Skilled Nursing SNS ☐ Relationship RSS ☐ Transportation Mileage Reimbursement (MR)	260	x	$ 10.00	=	$ 2,600.00 Sub-Total
Overnight Care	☐ Personal PSS ☐ Job JSS ☐ Transportation TSS (hourly) ☐ Learning LSS ☐ Emotional ESS ☐ Skilled Nursing SNS ☐ Relationship RSS ☐ Transportation Mileage Reimbursement (MR) ☑ **Code for second rate of pay / hour** PS2 **Fill in code**	192	x	$ 7.25	=	$ 1,392.00 Sub-Total
	☐ Personal PSS ☐ Job JSS ☐ Transportation TSS (hourly) ☐ Learning LSS ☐ Emotional ESS ☐ Skilled Nursing SNS ☐ Relationship RSS ☑ Transportation Mileage Reimbursement (MR) ☐ **Code for second rate of pay / hour** _____ **Fill in code** ☐ **Code for third rate of pay / hour** _____ **Fill in code**	5,000	x	$ 0.50	=	$ 2,500.00 Sub-Total
	☐ Personal PSS ☐ Job JSS ☐ Transportation TSS (hourly) ☐ Learning LSS ☐ Emotional ESS ☐ Skilled Nursing SNS ☐ Relationship RSS ☐ Transportation Mileage Reimbursement (MR) ☐ **Code for second rate of pay / hour** _____ **Fill in code** ☐ **Code for third rate of pay / hour** _____ **Fill in code**		x		=	$ Sub-Total
	☐ Personal PSS ☐ Job JSS ☐ Transportation TSS (hourly) ☐ Learning LSS ☐ Emotional ESS ☐ Skilled Nursing SNS ☐ Relationship RSS ☐ Transportation Mileage Reimbursement (MR) ☐ **Code for second rate of pay / hour** _____ **Fill in code** ☐ **Code for third rate of pay / hour** _____ **Fill in code**		x		=	$ Sub-Total
	☐ Personal PSS ☐ Job JSS ☐ Transportation TSS (hourly) ☐ Learning LSS ☐ Emotional ESS ☐ Skilled Nursing SNS ☐ Relationship RSS ☐ Transportation Mileage Reimbursement (MR) ☐ **Code for second rate of pay / hour** _____ **Fill in code** ☐ **Code for third rate of pay / hour** _____ **Fill in code**		x		=	$ Sub-Total
					Total Cost of Agreement:	$ 6,492.00

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

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

This cannot be left blank

Age Criteria for CSWs:

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

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

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

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

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

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

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

Tad Pohl — 1/5/2018

PARTICIPANT — Date

LEGAL GUARDIAN (IF APPLICABLE) — Date

Alfred Bino — 1/5/2018

CSW — Date

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IDAHO DEPARTMENT OF HEALTH & WELFARE

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

MEDICAID – COMMUNITY SUPPORT WORKER AGREEMENT

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

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

Alfred T Bino

Printed name of CSW

Alfred Bino 1/5/2018

Signature of CSW Date

Note: Each CSW must sign personally.

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IDAHO DEPARTMENT OF
HEALTH & WELFARE

Criminal History Check
Waiver of Liability - Assumption of Risk

Participant Name: Tad Pohl **MID #** _____ **Date:** 1/5/2018

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

Relationship to the Participant: Grandfather

Description of Service: CSW

Reason:

He is family and I trust him.

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

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

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

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

Tad Pohl 1/5/2018
Signature of Individual Date

Signature of Legal Guardian (if applicable) Date

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

Comments:

Stanley Cripp 1/5/2018
Signature of Support Broker Date