Please complete the Data Form prior to printing. This packet is designed for single-sided paper printing.

CONSUMER DIRECT CARE NETWORK

Family-Directed Services

EMPLOYEE DATA FORM

Name: _____ _____ _____
First Middle Last

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

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

Phone #: ( ) _____ ( ) _____
Home Cell

Email: _____

Gender: ☐ Male ☐ Female

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

Name of Child Receiving Service: _____

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

Parent/Guardian Name:

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

_____ _____
Employee Signature Date

CONSUMER DIRECT CARE NETWORK

Family-Directed Services

NEW EMPLOYEE (CSW) CHECKLIST

	/ /	
Employee Name	Estimated Start Date	Child's Name

Welcome to Consumer Direct Care Network (CDCN)!

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

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

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

Mandatory Forms - all new Employees

1. ☐ Employee Data Form
2. ☐ New Employee Checklist (this form)
3. ☐ 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.

_____	_____	_____
Parent/Legal Rep. Signature	*Date*	*Printed Name*

Date submitted to CDCN: ____/____/_____

CONSUMER DIRECT CARE NETWORK

Family-Directed Services

EMPLOYMENT RELATIONSHIP DISCLOSURE

Employee Name	Employer Name	Child Receiving Services 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:

My relationship to the Employer named above (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: _____	

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

<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.

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

Explanation of Employee Exemptions

Idaho Statute 72-1316(2) & 72-1316A (1) & (2)

EIN Holder/Employer = Parent of Child Receiving Services			
Relationship to EIN Holder (Employer)	**FICA**	**FUTA**	**SUTA**
Spouse	No wages permitted	No wages permitted	No wages permitted
Parent	*Exempt **Subject to Tax	Exempt	Exempt
Adoptive or Step Parent	*Exempt **Subject to Tax	Exempt	Exempt
Sibling	Subject to Tax	Subject to Tax	Subject to Tax
Child under age 21	Exempt	Exempt	Exempt
Child over age 21	Subject to Tax	Subject to Tax	Subject to Tax
Grandparent	Subject to Tax	Subject to Tax	Subject to Tax
Grandchild	NA	NA	NA
Domestic Partner	Subject to Tax	Subject to Tax	Subject to Tax

EIN Holder/Employer = Child Receiving Services			
Relationship to EIN Holder (Employer)	**FICA**	**FUTA**	**SUTA**
Spouse	NA	NA	NA
Parent	No wages permitted	No wages permitted	No wages permitted
Adoptive or Step Parent	No wages permitted	No wages permitted	No wages permitted
Sibling	Subject to Tax	Subject to Tax	Subject to Tax
Child under age 21	NA	NA	NA
Child over age 21	NA	NA	NA
Grandparent	Subject to Tax	Subject to Tax	Subject to Tax
Grandchild	NA	NA	NA
Domestic Partner	NA	NA	NA

*Exempt if doesn't meet all 4 of the following criteria;

**Subject to Tax if meet all 4 of the following criteria:

1) A parent is employed by their son or daughter.

2) The employer (son or daughter) has a child or stepchild that lives in the home.

3) The employer is:

- a widow or widower,
- divorced, or
- married and lives with a spouse. But the spouse can't care for the child or stepchild due to a mental or physical condition. The spouse is unable to provide care for at least 4 straight weeks in 3 months.

4) The employer's child or stepchild is: less than 18 year 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.

Instructions for Completing Form I-9 Section 1

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

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

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

Employee (steps 1-9)

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

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

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

④ Print your Social Security Number.

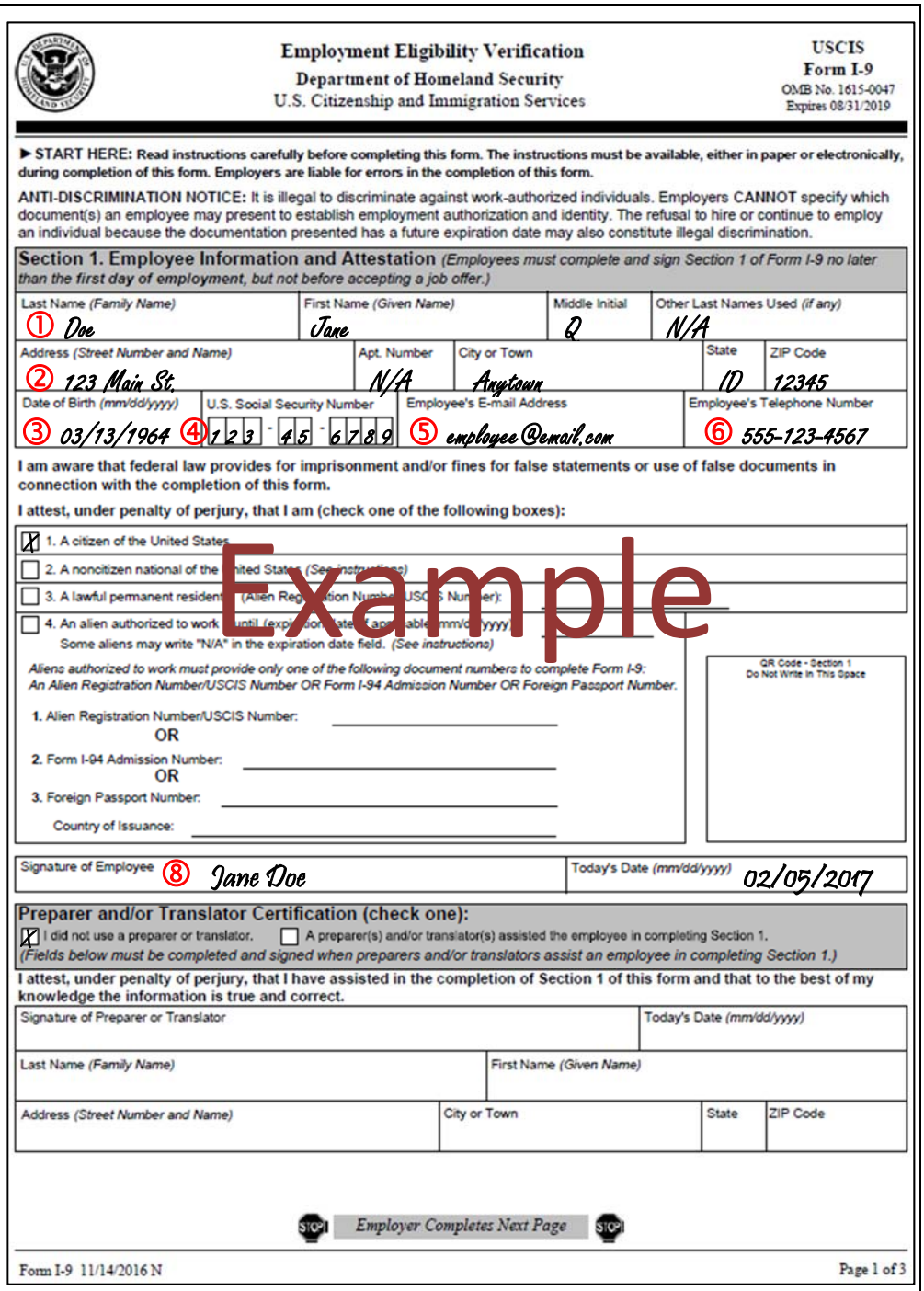
⑤ Print your email address or print "N/A" if you choose to not provide it.

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

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

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

⑨ Check the box that indicates whether or not you were assisted by a preparer or translator.



Employment Eligibility Verification
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)
① Doe	Jane	Q	N/A

Address (Street Number and Name)	Apt. Number	City or Town	State	ZIP Code
② 123 Main St.	N/A	Anytown	ID	12345

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
③ 03/13/1964	④ 123-45-6789	⑤ employee@email.com	⑥ 555-123-4567

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

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

⑦
- [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)
⑧ Jane Doe	02/05/2017

⑨ **Preparer and/or Translator Certification (check one):**
- [X] I did not use a preparer or translator.
- [ ] A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

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

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

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

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

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

STOP *Employer Completes Next Page* STOP

Form I-9 11/14/2016 N — Page 1 of 3

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

Instructions for Completing Form I-9 Section 2

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

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

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

Employer (steps 1-10)

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

② Enter the number representing employee's citizenship status checked in Section 1.

③ Examine each document and note the details in the appropriate List column.

<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).

④ Print the date of the employee's first day of work.

⑤ Sign the form.

⑥ Print the date you signed the form. **Must be completed and signed within 3 days of employee's first day of work.**

⑦ If not pre-populated, print your title as "Employer."

⑧ Print your last then first name.

⑨ Print your first and last name.

⑩ Print physical address where services are provided: street, city, state and zip code.

Section 2. Employer or Authorized Representative Review and Verification

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

Employee Info from Section 1	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
	① Doe	Jane	Q	② 1

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title	③	Document Title: Driver's License		Document Title: Social Security Card
Issuing Authority		Issuing Authority: State of Residence		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): 08/17/2020		Expiration Date (if any)(mm/dd/yyyy): N/A
Document Title		Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				

Example

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

The employee's first day of employment *(mm/dd/yyyy)*: ④ 02/05/2017 *(See instructions for exemptions)*

Signature of Employer or Authorized Representative	Today's Date(mm/dd/yyyy)	Title of Employer or Authorized Representative
⑤ Ronald Smith	⑥ 02/05/2017	⑦ Employer

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
⑧ Smith	Ronald	⑨ Ronald Smith

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code
⑩ 500 Fictional St.	Anytown	ID	85018

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

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

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 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)*

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

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

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

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

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(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)*

Preparer and/or Translator Certification (check one):

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

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

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

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

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

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

03149

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 a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

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

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

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

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

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

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

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

00540

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**
Home address (number and street or rural route)	**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married filing separately, check "Married, but withhold at higher Single rate."	
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 800-772-1213 for a replacement card.** ► ☐	

5	Total number of allowances you're claiming (from the applicable worksheet on the following pages) . . .	**5**	
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.) ► **Date** ►

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)

your wages and other income, including income earned by a spouse, during the year.

Line G. Other credits. You might be able to reduce the tax withheld from your paycheck if you expect to claim other tax credits, such as the earned income tax credit and tax credits for education and child care expenses. If you do so, your paycheck will be larger but the amount of any refund that you receive when you file your tax return will be smaller. Follow the instructions for Worksheet 1-6 in Pub. 505 if you want to reduce your withholding to take these credits into account.

Deductions, Adjustments, and Additional Income Worksheet

Complete this worksheet to determine if you're able to reduce the tax withheld from your paycheck to account for your itemized deductions and other adjustments to income such as IRA contributions. If you do so, your refund at the end of the year will be smaller, but your paycheck will be larger. You're not required to complete this worksheet or reduce your withholding if you don't wish to do so.

You can also use this worksheet to figure out how much to increase the tax withheld from your paycheck if you have a large amount of nonwage income, such as interest or dividends.

Another option is to take these items into account and make your withholding more accurate by using the calculator at *www.irs.gov/W4App*. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Two-Earners/Multiple Jobs Worksheet

Complete this worksheet if you have more than one job at a time or are married filing jointly and have a working spouse. If you don't complete this worksheet, you might have too little tax withheld. If so, you will owe tax when you file your tax return and might be subject to a penalty.

Figure the total number of allowances you're entitled to claim and any additional amount of tax to withhold on all jobs using worksheets from only one Form W-4. Claim all allowances on the W-4 that you or your spouse file for the highest paying job in your family and claim zero allowances on Forms W-4 filed for all other jobs. For example, if you earn $60,000 per year and your spouse earns $20,000, you should complete the worksheets to determine what to enter on lines 5 and 6 of your Form W-4, and your spouse should enter zero ("-0-") on lines 5 and 6 of his or her Form W-4. See Pub. 505 for details.

Another option is to use the calculator at *www.irs.gov/W4App* to make your withholding more accurate.

Tip: If you have a working spouse and your incomes are similar, you can check the "Married, but withhold at higher Single rate" box instead of using this worksheet. If you choose this option, then each spouse should fill out the Personal Allowances Worksheet and check the "Married, but withhold at higher Single rate" box on Form W-4, but only one spouse should claim any allowances for credits or fill out the Deductions, Adjustments, and Additional Income Worksheet.

Instructions for Employer

Employees, do not complete box 8, 9, or 10. Your employer will complete these boxes if necessary.

New hire reporting. Employers are required by law to report new employees to a designated State Directory of New Hires. Employers may use Form W-4, boxes 8, 9, and 10 to comply with the new hire reporting requirement for a newly hired employee. A newly hired employee is an employee who hasn't previously been employed by the employer, or who was previously employed by the employer but has been separated from such prior employment for at least 60 consecutive days. Employers should contact the appropriate State Directory of New Hires to find out how to submit a copy of the completed Form W-4. For information and links to each designated State Directory of New Hires (including for U.S. territories), go to ***www.acf.hhs.gov/programs/css/employers***.

If an employer is sending a copy of Form W-4 to a designated State Directory of New Hires to comply with the new hire reporting requirement for a newly hired employee, complete boxes 8, 9, and 10 as follows.

Box 8. Enter the employer's name and address. If the employer is sending a copy of this form to a State Directory of New Hires, enter the address where child support agencies should send income withholding orders.

Box 9. If the employer is sending a copy of this form to a State Directory of New Hires, enter the employee's first date of employment, which is the date services for payment were first performed by the employee. If the employer rehired the employee after the employee had been separated from the employer's service for at least 60 days, enter the rehire date.

Box 10. Enter the employer's employer identification number (EIN).

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for yourself . . . . . **A** _____

B Enter "1" if you will file as married filing jointly . . . . . **B** _____

C Enter "1" if you will file as head of household . . . . . **C** _____

D Enter "1" if:
- You're single, or married filing separately, and have only one job; or
- You're married filing jointly, have only one job, and your spouse doesn't work; or
- Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.

D _____

E **Child tax credit.** See Pub. 972, Child Tax Credit, for more information.
- If your total income will be less than $69,801 ($101,401 if married filing jointly), enter "4" for each eligible child.
- If your total income will be from $69,801 to $175,550 ($101,401 to $339,000 if married filing jointly), enter "2" for each eligible child.
- If your total income will be from $175,551 to $200,000 ($339,001 to $400,000 if married filing jointly), enter "1" for each eligible child.
- If your total income will be higher than $200,000 ($400,000 if married filing jointly), enter "-0-" . . . . . **E** _____

F **Credit for other dependents.**
- If your total income will be less than $69,801 ($101,401 if married filing jointly), enter "1" for each eligible dependent.
- If your total income will be from $69,801 to $175,550 ($101,401 to $339,000 if married filing jointly), enter "1" for every two dependents (for example, "-0-" for one dependent, "1" if you have two or three dependents, and "2" if you have four dependents).
- If your total income will be higher than $175,550 ($339,000 if married filing jointly), enter "-0-" . . . . . **F** _____

G **Other credits.** If you have other credits, see Worksheet 1-6 of Pub. 505 and enter the amount from that worksheet here . . **G** _____

H Add lines A through G and enter the total here . . . . . ▶ **H** _____

For accuracy, complete all worksheets that apply.
- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, or if you have a large amount of nonwage income and want to increase your withholding, see the **Deductions, Adjustments, and Additional Income Worksheet** below.
- If you **have more than one job at a time** or are **married filing jointly and you and your spouse both work**, and the combined earnings from all jobs exceed $52,000 ($24,000 if married filing jointly), see the **Two-Earners/Multiple Jobs Worksheet** on page 4 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 above.

Deductions, Adjustments, and Additional Income Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income.

1 Enter an estimate of your 2018 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income. See Pub. 505 for details . . . . . **1** $ _____

2 Enter:
- $24,000 if you're married filing jointly or qualifying widow(er)
- $18,000 if you're head of household
- $12,000 if you're 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 2018 adjustments to income and any additional standard deduction for age or blindness (see Pub. 505 for information about these items) . . . . . **4** $ _____

5 **Add** lines 3 and 4 and enter the total . . . . . **5** $ _____

6 Enter an estimate of your 2018 nonwage income (such as dividends or interest) . . . . . **6** $ _____

7 **Subtract** line 6 from line 5. If zero, enter "-0-". If less than zero, enter the amount in parentheses . . . **7** $ _____

8 **Divide** the amount on line 7 by $4,150 and enter the result here. If a negative amount, enter in parentheses. Drop any fraction . . . . . **8** _____

9 Enter the number from the **Personal Allowances Worksheet,** line H above . . . . . **9** _____

10 **Add** lines 8 and 9 and enter the total here. If zero or less, enter "-0-". If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1, page 4. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 . . . . . **10**

Two-Earners/Multiple Jobs Worksheet

Note: Use this worksheet *only* if the instructions under line H from the **Personal Allowances Worksheet** direct you here.

1 Enter the number from the **Personal Allowances Worksheet,** line H, page 3 (or, if you used the **Deductions, Adjustments, and Additional Income Worksheet** on page 3, the number from line 10 of that worksheet) . . . . . 1 _____

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you're married filing jointly and wages from the highest paying job are $75,000 or less and the combined wages for you and your spouse are $107,000 or less, don't 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 2018. For example, divide by 18 if you're paid every 2 weeks and you complete this form on a date in late April when there are 18 pay periods remaining in 2018. 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 - $5,000	0	$0 - $7,000	0
5,001 - 9,500	1	7,001 - 12,500	1
9,501 - 19,000	2	12,501 - 24,500	2
19,001 - 26,500	3	24,501 - 31,500	3
26,501 - 37,000	4	31,501 - 39,000	4
37,001 - 43,500	5	39,001 - 55,000	5
43,501 - 55,000	6	55,001 - 70,000	6
55,001 - 60,000	7	70,001 - 85,000	7
60,001 - 70,000	8	85,001 - 90,000	8
70,001 - 75,000	9	90,001 - 100,000	9
75,001 - 85,000	10	100,001 - 105,000	10
85,001 - 95,000	11	105,001 - 115,000	11
95,001 - 130,000	12	115,001 - 120,000	12
130,001 - 150,000	13	120,001 - 130,000	13
150,001 - 160,000	14	130,001 - 145,000	14
160,001 - 170,000	15	145,001 - 155,000	15
170,001 - 180,000	16	155,001 - 185,000	16
180,001 - 190,000	17	185,001 and over	17
190,001 - 200,000	18		
200,001 and over	19		

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 - $24,375	$420	$0 - $7,000	$420
24,376 - 82,725	500	7,001 - 36,175	500
82,726 - 170,325	910	36,176 - 79,975	910
170,326 - 320,325	1,000	79,976 - 154,975	1,000
320,326 - 405,325	1,330	154,976 - 197,475	1,330
405,326 - 605,325	1,450	197,476 - 497,475	1,450
605,326 and over	1,540	497,476 and over	1,540

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 aren't required to provide the information requested on a form that's 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.

CONSUMER DIRECT CARE NETWORK

PAY SELECTION FORM

Employee Name: _____
(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): _____

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**.

_____ _____

Signature *Date*

02593

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.

To enroll, please select the US Bank Focus Card Direct Deposit option on your Consumer Direct Care Network Pay Selection Form.

CONSUMER DIRECT CARE NETWORK

[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) Personalized		$5.00 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 DEPARTMENT OF
HEALTH & WELFARE

PARTICIPANT-COMMUNITY SUPPORT WORKER EMPLOYMENT AGREEMENT

This agreement is hereby made between _____, a Participant of
Participant's Name
the Family-Directed Community Supports (FDCS) Option, a Medicaid Option administered by the Department of Health and Welfare (Department), and _____,
CSW's Name
a Community Support Worker (CSW).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13. Terms and conditions of work. **Effective Date: ___________________.**

COLUMN A Service needed	B Type of Support ☑ **only one box per row**	C Number of hours per year OR Number of miles/year		D Wage per hour OR Wage per mile		E Annual Cost
	☐ Personal PSS ☐ Job JSS ☐ Transportation TSS (hourly) ☐ Learning LSS ☐ Emotional ESS ☐ Skilled Nursing SNS ☐ Relationship RSS ☐ Transportation Mileage Reimbursement (MR)		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**		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
	☐ 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:						$

04888

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

_____

_____

_____

_____

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

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

☐ The CSW meets the above age criteria.

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

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

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

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

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

PARTICIPANT Date

LEGAL GUARDIAN (IF APPLICABLE) Date

CSW Date

04889

IDAHO DEPARTMENT OF HEALTH & WELFARE

Family-Directed Community Supports Option

MEDICAID – COMMUNITY SUPPORT WORKER AGREEMENT

This agreement is hereby made between the Family-Directed Community Supports (FDCS) Option, a Medicaid Option administered by the Department of Health and Welfare (Department), and

_____,
a Community Support Worker (CSW).

This CSW is associated with an Agency. ☐ Yes ☐ No.

The CSW acknowledges that even though he/she is the employee of a participant in the FDCS Option, the Department, through the Fiscal Employer Agent (FEA) is the source of payment for the CSW's wages for services performed under the FDCS Option. Because of the unique relationships of the participant, the Department, and the FEA the CSW acknowledges and agrees to the following:

1. Services provided to any participant under the FDCS Option will be provided in compliance with the rules contained in IDAPA 16.03.13, "Consumer Directed Services."

2. Payment will not be requested through the FEA or the Department for any service not performed in accordance with the FDCS rules, the employment agreement with the participant of the participant's Support and Spending Plan. It is understood that neither the FEA nor the Department is liable to pay for any service performed that is not in conformance with the FDCS rules, the employment agreement with the participant, and the participant's Support and Spending Plan.

3. The CSW acknowledges that even though he/she is the employee of the Participant, they are also a Medicaid provider under the FDCS Option. As a provider the CSW agrees to accept payment received by the FEA as payment in full for services rendered under the FDCS Option.

4. The CSW acknowledges they are an employee of the participant and not an employee of the Department or the Fiscal/Employer Agent (F/EA) and agrees that the CSW is not entitled to nor will make claim for any employee benefits from the Department of the FEA, including but not limited to, workers' compensation, disability life and/or health insurance.

5. To protect the confidentiality of personal and health information relating to the participant and his participation in the Medicaid Option, and to release that information only on request of the participant or as otherwise allowed by law.

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

_____

Printed name of CSW

_____

Signature of CSW Date

Note: Each CSW must sign personally.

IDAHO DEPARTMENT OF
HEALTH & WELFARE

Criminal History Check
Waiver of Liability - Assumption of Risk

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

Waiver: I do not want (name of community support worker) _____ to be subject to

Criminal History Check requirements.

Relationship to the Participant: _____

Description of Service: _____

Reason:

_____

_____

_____

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

_____

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

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

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

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

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

Comments:

_____

_____
Signature of Support Broker Date

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

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

Relationship to the Participant: _____

Description of Service: _____

Reason: _____

_____

_____

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

_____

_____

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

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

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

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

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

Comments:

_____

_____
Signature of Support Broker Date

CONSUMER DIRECT CARE NETWORK IDAHO

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

In the My Voice, My Choice and Family Directed Services programs, Idaho Medicaid prohibits employees from working more than 40 hours per week unless they are specifically exempted from Fair Labor Standard Act (FSLA) regulations (see page two of your Participant-CSW Employment Agreement).

Because of this restriction, Consumer Direct Care Network (CDCN) cannot pay an employee for any hours worked beyond 40 in a work week unless they qualify for an exemption – and an exemption form, signed by both employer and employee, is on file:

- **If CDCN has an exemption form on file…**Employee is eligible to work more than 40 hours in a work week - Hours worked beyond 40 are paid at the regular hourly rate.
- **If CDCN does not have an exemption form on file…** Employee is not eligible to work more than 40 hours in a work week - Hours worked beyond 40 will not be paid.

The two FSLA exemptions for domestic service employees are:

Companionship Services Exemption - Congress exempted minimum wage and overtime provisions to domestic service employees who provide "companionship services" to the elderly or to people with illness, injuries, or disabilities who require assistance in caring for themselves.

Criteria: Employee must perform at least 80% of their work on one or both or the following:

- Fellowship – engages participant in social, physical, and mental activities, such as conversation, reading, games and crafts; and /or accompanying participant on walks, errands, appointments and social events.
- Protection – be present with participant in home or accompany participant when outside of home, and monitor participant's safety and well-being.

Live-in Exemption - Congress exempted overtime provisions to domestic service employees who have a "live-in relationship" with their employer. That is, they reside in the household in which they provide services.

Criteria: The employee resides in the participant's home permanently OR resides in participant's home for extended periods of time (120 hours or more per week). No family relationship needs to exist.

Guidance on these exemptions is available from the Department of Labor's website at https://www.dol.gov/whd/homecare/homecare_guide.htm and on the CDCN website under the resources tab (Look for the link titled: Guide to DOL Home Care Rule).

Exemption forms are available on the CDCN website at http://consumerdirectid.com/forms/, or can be obtained by calling the CDCN Meridian office.

New Health Insurance Marketplace Coverage
Options and Your Health Coverage

FEA Marketplace Notice - ID 2018

Dear Community Support Worker,

The following is information regarding the 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 1st each year for coverage starting January 1st of the following 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
Consumer Direct Care Network

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 tax credit that lowers your monthly premium.

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 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