Alamo Consumer Direct, LLC.

A Texas Fiscal Management Service Agency

CONSUMER'S EMPLOYEE PACKET

Introduction: Consumer Direct is a Fiscal Management Service Agency (FMSA). We are like the Consumer's accountant, payroll service or banker. We process payroll for the Consumer's employee(s), file taxes, pay for services provided by other businesses and agencies and bill the state program for services. Consumer Direct provides the Consumer with the necessary paperwork to become established as an employer. We also provide the paperwork for individuals to become enrolled as the Consumer's employees. Once employees are enrolled, we process all of the forms and pay employees as directed by the Consumer employer. Consumer Direct specializes in self-directed services and has more than thirteen years of experience in many different states assisting people to self-direct their supports and services.

As your employer, the Consumer's role is to:

- Assume the responsibilities of being an employer.
- Recruit, hire and dismiss all employees.
- Train all employees.
- Determine the schedule and schedule employees.
- Manage (supervise) employees.
- Submit time sheets only for the services approved on the Consumer's Individual Plan of Care.
- Approve and sign all time sheets.
- Make sure all signed time sheets are submitted to Consumer Direct on time.
- Treat employees consistently and fairly.
- Keep required records and receipts.

The purpose of this Employee Packet is to help you complete the required paperwork to become enrolled as the Consumer's employee. The Packet includes some forms you can fill out by yourself. Other forms require you and the Consumer to sign. There is also additional information that you will need as an employee in this packet as well.

Please complete the employee forms based on the instructions that are included. If you have questions about how to fill out any of the forms, please call Consumer Direct right away so we can help. Our toll free number is 1-877-903-0832

If you need additional help, you also can stop by the Consumer Direct office at 8701 Shoal Creek Blvd., Suite 303, Austin, TX 78757, during business hours Monday - Friday, 8:00 am - 5:00 pm.

After completing all of the forms, please mail or fax them to Consumer Direct at:

Alamo Consumer Direct
8701 Shoal Creek Blvd., Suite 303 Toll Free Fax: 1-866-409-5389
Austin, Texas 78757-6809

It is very important that you complete these forms and return them to Consumer Direct as quickly as possible. When all enrollment forms are correctly completed and submitted, each employee will receive an **Okay to Work Form**. You cannot start work until you receive an Okay to Work Form from Consumer Direct.

The forms in the Employee Packet are:

1) New Employee Checklist
2) Employee Job Application/Data Form
3) Pay Selection/Direct Deposit Form
4) Form I-9 Employment Eligibility Verification
5) Form W-4 Employee Withholding Allowance Certificate
6) Employment Relationship Disclosure Form
7) Employee Health Questionnaire

The directions for the forms are below:

1. <u>New Employee Checklist</u>: The New Employee Checklist lists all of the forms in the Employee Packet that <u>you need to complete</u>.

- ▶ Use this Checklist to keep track of which forms you have finished.
- ▶ As you complete each form, write the date on the line next to the form on
- ▶ The Consumer should initial next to the date to show that all paperwork was checked for accuracy and completeness.
- ▶ When you have completed all the required employee paperwork, have the Consumer sign the bottom of the form. When these steps are complete you can submit all paperwork to Consumer Direct.

2. <u>Employee Job Application/Data Form</u>: This form is designed to gather basic information about you and your work history so we can enroll you as an employee, set your file up in Consumer Direct's system and meet a state requirement that a job application be on file for every Consumer's employee. Please:

- ▶ Complete all of the blanks on the form as labeled (for example: name, mailing address, phone and so on).
- ▶ Let us know how you prefer Consumer Direct to contact you. Place a check(s) in the box in the lower left to show how you want us to contact you.
- ▶ Sign and date the bottom of the form to indicate all the information is correct.

Note: *You are an employee of the Consumer. You are not an employee of Consumer Direct or the State of Texas.*

3. Pay Selection Option Form: The purpose of this form is to give you an option about how you receive payment for the time you work. Consumer Direct offers two pay options: direct deposit to a bank/credit union account or direct deposit to a rapid! PayCard.

- ▶ Print your name on the line at the top of the form.
- ▶ Choose one of the two pay options by placing a check mark in the box that describes your choice.
- ▶ If you choose direct deposit to a bank or credit union account, provide the name of the institution on the line provided, and then check the appropriate box to indicate if it is a checking or savings account. Attach a voided check or other document with exact numbers for processing.
- ▶ Sign and date the lines at the bottom of the page.

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

5. IRS Form W-4: The W-4 form needs to be completed so that the correct amount of federal income tax can be withheld from your pay check. The directions are at the top of the form.

The "Personal Allowances Worksheet" in the middle of the page will help you determine how many allowances you claim in box 5 on the W-4 form. There are rules to follow in deciding how many allowances you can claim. The smaller the number of allowances you claim, the more taxes will be withheld from your pay check. This means you receive less take home pay. For example, if you claim "0" or "1", more taxes will be withheld from your income.

6. Employment Relationship Disclosure: This form is used to determine if your relationship to your employer exempts you from paying certain federal and state taxes on your earnings as described on the form.

7. Employee Health Questionnaire: This Questionnaire helps ensure that employees are able to perform the required tasks without injuring themselves or the Consumer. The information from the Questionnaire is kept confidential. However, if it is necessary to make a determination regarding an applicant's fitness for work, some information may be disclosed to the Consumer and Consumer Direct's Risk Manager.

STATE FORMS

The following forms are required by the Texas Dept. of Aging and Disability Services. Completed forms must be submitted and approved by Consumer Direct before an employee can be paid. Most of the forms listed also require the Consumer's signature.

1. New Employee Packet Coversheet (Form 1724)
2. Criminal Conviction History and Registry Checks (Form 1725)
3. Applicant Verification for Employees (Form 1729)
4. Service Provider and Employer Certification of Relationship Status for CDS (Form 1734)
5. Liability Acknowledgement (Form 1728) - Consumer Direct is one of the only providers in Texas that offers Workers Compensation. Workers Compensation pays for medical services if you are hurt on the job and will reimburse you for lost work for an injury. Because Consumer Direct offers workers compensation to all consumer' employees, the bottom section of Form 1728 has been populated with our carrier information. **The employer and employee must each sign the top AND bottom sections of this form**.
6. Acknowledgement of Workers' Compensation Network (page 8)
7. Wage and Benefit Plan Employee Compensation (Form 1730)
8. Employee Work Schedule and Assigned Tasks (Form 1731)
9. Employer and Employee Service Agreement (Form 1737)
10. Service Provider Agreement (Form 1739)
11. Occupational Exposure to Bloodborne Pathogens (Form 1727)
12. Employer and Employee Acknowledgement of Exemption from Nursing Licensure for Certain Services (Form 1733)
13. Management and Training of Service Provider (Form 1732)
14. Employee Misconduct Registry Notification (Form 1732-EMR)
15. Acknowledgement of Nursing Requirements (Form 1747, if applicable)
16. Licensed Vocational Nurse Supervision (Form 1747-LVN, if applicable)

The following forms are located in the Employer Binder that is issued to the Consumer. Please ask him/her for the form if you need to use it.

Status Change Form: This form is used to inform Consumer Direct if there is new information about a Consumer or an employee. It is important that you notify Consumer Direct of any changes right away in your name, address or phone number to make sure that you receive your paycheck or other information. Please complete and submit this form whenever you have any of the changes listed below:

- ▶ name, write both your "old" name and your "new" name.
- ▶ address, write in your new address.
- ▶ phone number, put a ✓ to show which number changed, then write in the new phone number.
- ▶ email address, write in your new email address

Sign and date the form to verify that this new information is correct. Please fax, scan or mail the form to the Consumer Direct office.

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

- Call the office (toll free 1-877-903-0832). Staff will listen to your feedback and respond to it quickly. We appreciate hearing about what is working well for you, because we want to keep doing these things! We also want to hear your ideas about how to improve things, because this will make our services better.
- Fill out the Feedback Form in the Employee Packet and mail it or fax it to the Consumer Direct office.
- If you have feedback regarding the Service Coordinator you are working with, contact the Program Manager directly (the toll free number is 1-877-903-0832).

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

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

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

The Time Sheet/Service Log is located in the Employer Binder. **DO NOT COPY THESE TIME SHEETS!** If you copy a time sheet, the bar-code at the bottom may not work, which will delay processing. When you need more time sheets, please call the Consumer Direct office at any time and we will send you more printed forms. They are also available online at Consumer Direct's website: http://alamoconsumerdirect.com.

Consumer Direct Time Sheet: Employees must complete and sign a time sheet before they can be paid. The time sheet will be processed if:

- Service dates are identified
- The employee has dated and signed
- The employer has reviewed, dated and signed
- The service and hours recorded matched authorized hours on the service plan
- The employee writes notes for each service, if applicable
- The hours worked must be for services that are outlined on the Employee Work Schedule and Assigned Tasks.

The time sheet is completed to report the employee's hours worked. An example of a completed time sheet and instructions for completing a time sheet is also located in the

Employer Binder. Please follow the example and instructions when filling out a time sheet. The example should help you avoid making mistakes. Mistakes on a time sheet can cause your pay to be late.

After the time sheet is finished, it should be returned to Consumer Direct by mail or fax. If you prefer, you can drop off time sheets at the Consumer Direct office Monday - Friday, 8:00 - 5:00 (during work hours) or use our drop box (mail slot) after hours.

Payroll Calendar: Time sheets are due to Consumer Direct by Monday at midnight after the week of service. This is the date time sheets must be mailed, faxed or dropped off at Consumer Direct EVERY Monday. The Payroll Calendar shows when time sheets are due and the date and day of pay. Pay day is every two weeks and is always on a Friday. Employees will be paid by paper check or direct deposit. The Payroll Calendar must be displayed, according to State regulations, in the place of work.

Late time sheets will result in late pay. **Remember, any time sheet received by Consumer Direct after the Payroll Calendar due date will be paid on the following pay date (the next pay date).**

Employee Injury Reporting – Consumer Direct offers workers compensation and liability to the Consumer's employees. This means, if you are injured on the job your medical costs will be paid and you may be paid for lost work. If you are injured on the job, PLEASE report the injury immediately. Please follow these steps:

1. **Get medical help if needed.**
    - If the injury is serious and life-threatening, someone should call 911.
    - If the injury needs medical treatment (but is not life-threatening), you should go to an urgent-care clinic or doctor's office. If you cannot get to a clinic or a doctor's office, go to the emergency room.

2. **Call the Consumer Direct Injury Hotline to report the injury/illness immediately. The employee must call as soon as the injury or illness happens, even if it does not seem serious.**
    - The Injury Hotline number is **1-888-541-1701.**
    - Injuries can be reported 24 hours a day, 7 days a week.

3. **Please tell the Consumer of the injury or illness before you leave work.**

The employee must also report injuries that occur away from the work place to the Injury Hotline. This is for your safety. Consumer Direct wants to make sure that the injury will not worsen by working. If an injury occurs away from work, please call the Hotline.

Abuse, Neglect and Exploitation – Because you are being paid to care for an older Texan or person with a disability you are a mandated reporter of abuse and neglect. If you are concerned about the treatment of an older Texan or someone

with a disability, PLEASE call **1-800-458-9858** to contact DADS Consumer Rights and Services**.**

Consumer Rights and Services employees take complaints about the treatment of people who receive services in long-term care facilities or in their homes.

Consumer Rights and Services employees also can answer your questions about DADS programs and services.

How can I contact Consumer Rights and Services? – The Consumer Rights and Services toll-free line — **1-800-458-9858** — is answered Monday through Friday from 8 a.m. to 5 p.m., Central time. Voice mail is available 24 hours a day, seven days a week. Voice mail messages are monitored between 8 a.m. and 5 p.m., Central time, including weekends and holidays. Calls are returned on or before the next work day.

When leaving a voice mail, please:

- state and spell your name;
- provide a daytime phone number, with area code; and
- leave a brief message.

There is a handout that you will be given by your Employer that gives more information about abuse, neglect and exploitation.

Conclusion and Contact Information – We look forward to enrolling you as the Consumer's employee. Be sure to complete the required forms and return them to us right away. **Remember, required forms need to be completed before you can begin work.** When you have finished all the required employee forms, please return them to Consumer Direct as soon as possible. The Consumer must receive the Okay to Work Form before you can begin to work.

Thanks for your willingness to provide services to a Consumer (person receiving services) to help him/her stay in his/her home and community. You also are helping the State of Texas meet the goal of giving people with disabilities and the elderly more choice and control over their services.

Please feel free to contact us at 1-877-903-0832 with any questions about forms, employment or if you need additional information to complete the required forms.

The mail address is:

Alamo Consumer Direct
8701 Shoal Creek Blvd., Suite 303
Austin, TX 78757-6809

The fax numbers are:

Toll Free Fax: 1-866-409-5389

TEXAS FMSA
NEW EMPLOYEE CHECKLIST

Welcome to Consumer Direct!

Please complete the forms in the lists below including this one. Consumer Direct must receive either originals or copies of each prior to the start of employment (those labeled "if applicable" may be an exception). The employee is not approved to begin work until all forms are completed and received at Consumer Direct and an "Okay to Work" approval form has been issued.

Employee Name	Estimated Start Date	Consumer Name

The Consumer or Legally Authorized Representative should date and initial each item below as they are completed.

Consumer Direct forms, tax forms and licensing verifications required for all new employees:

	Date	Initial	
1.	_____	_____	New Employee Checklist (this form)
2.	_____	_____	Job Application/Employee Data Form
3.	_____	_____	Pay Selection Form
4.	_____	_____	I-9 Form – Employment Eligibility Verification
5.	_____	_____	W-4 Form – Employee's Withholding Allowance Certificate
6.	_____	_____	Employment Relationship Disclosure Form
7.	_____	_____	Employee Health Questionnaire
8.	_____	_____	Photocopy of Social Security card (payroll).
9.	_____	_____	Photocopy of CPR certification. **Expiration date:** _____ **Note:** If applicable, only required for CLASS, DBMD, and MDCP waivers. CLASS and DBMD must be a hands-on course; MDCP can be either a hands-on or online course.
10.	_____	_____	Photocopy of Driver's License (if applicable, only if transporting consumer)
11.	_____	_____	Photocopy of Minimum Auto Insurance (if applicable, only if transporting consumer)
12.	_____	_____	Photocopy of professional licenses (e.g. RN, LVN, if applicable)

Texas Dept. of Aging and Disability Services forms required for all new employees:

1.	_____	_____	New Employee Packet Cover Sheet (Form 1724)
2.	_____	_____	Criminal Conviction History and Registry Checks (Form 1725)
3.	_____	_____	Applicant Verification for Employees (Form 1729)
4.	_____	_____	Service Provider and Employer Certification of Relationship Status for CDS (Form 1734)
5.	_____	_____	Liability Acknowledgement (Form 1728)
6.	_____	_____	Acknowledgement of Workers' Compensation Network (page 8)
7.	_____	_____	Wage and Benefits Plan (From 1730)
8.	_____	_____	Employee Work Schedule and Assigned Tasks (Form 1731)
9.	_____	_____	Employer and Employee Service Agreement (Form 1737)
10.	_____	_____	Service Provider Agreement (Form 1739)
11.	_____	_____	Occupational Exposure to Bloodborne Pathogens (Form 1727)
12.	_____	_____	Exemption from Nursing Licensure (Form 1733, if applicable)
13.	_____	_____	Management and Training of Service Provider (Form 1732)
14.	_____	_____	Employee Misconduct Registry Notification (Form 1732-EMR)
15.	_____	_____	Acknowledgement of Nursing Requirements (Form 1747, if applicable)
16.	_____	_____	Licensed Vocational Nurse Supervision (Form 1747-LVN, if applicable)

Distribution of training booklets (located in the Employer Binder):

1.	_____	_____	HIPAA Employee Training Guide, Infection Control, Lifting and Moving Patients, Fraud Prevention

I have reviewed and verified the above forms for completeness and all forms are readable.

_____ _____ _____

Consumer Signature Date Print Name

02041

JOB APPLICATION/EMPLOYEE DATA FORM

Applicant Information

Last Name: _____ First Name: _____ MI: ____

Mailing Address: _____
Street

_____
City State Zip County

Phone: Home _____ Work _____

Cell _____ Fax _____

Email Address: _____

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

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

Are you 18-years-old or older: ☐ Yes ☐ No

Position: Caregiver Other: _____

Employment Desired: ☐ Full-Time ☐ Part-Time Hours/week: _____

Emergency Contact: _____ Phone: _____

Name of Consumer with whom you want to work: _____

Education

Type of School	Name of School	Location (Complete Address)	Circle Last Grade Completed	Major and Degree
High School			9 10 11 12	
College			1 2 3 4	

Certificates/Licenses (e.g. CPR, First Aid, LVN, RN)

Type	Issuing Authority	Expiration Date

02059

This Consumer is an equal opportunity employer

JOB APPLICATION/EMPLOYEE DATA FORM

Work Experience

Name of Employer: _____ Phone: _____

Address: _____
Street City State Zip

Last Supervisor: _____ Your Last Job Title: _____

May I contact this employer? ☐ Yes ☐ No

Employment Dates: _____ to _____ Pay: Start _____ Final: _____

Reason for leaving (please be specific): _____

_____

_____

List the jobs you held, duties performed, skills used or learned, advancements or promotions achieved while you worked at this company.

_____

_____

_____

_____

_____

Work Experience

Name of Employer: _____ Phone: _____

Address: _____
Street City State Zip

Last Supervisor: _____ Your Last Job Title: _____

May I contact this employer? ☐ Yes ☐ No

Employment Dates: _____ to _____ Pay: Start _____ Final: _____

Reason for leaving (please be specific): _____

_____

_____

List the jobs you held, duties performed, skills used or learned, advancements or promotions achieved while you worked at this company.

_____

_____

_____

_____

_____

JOB APPLICATION/EMPLOYEE DATA FORM

Criminal Background

Have you ever been convicted of a crime, plead guilty or no contest to a crime, or received deferred adjudication for any offense? ☐ Yes ☐ No

Have you ever had a professional license, certificate, or driver's license in any state revoked, suspended, or had disciplinary action applied? ☐ Yes ☐ No

In the past three (3) years, have you had any moving violations or motor vehicle accidents? ☐ Yes ☐ No

Please explain any "Yes" answers: _____

_____

_____

Aliases

Please list any aliases or previously held names: _____

References

Please list three references:

1. _____
   Name Address Phone Number

2. _____
   Name Address Phone Number

3. _____
   Name Address Phone Number

Applicant Acknowledgement: I, _____ (print name), the applicant, verify that the information provided is true and correct to the best of my knowledge. I also acknowledge that a criminal conviction check and registry check are required and that some convictions prevent employment.

Please read carefully: Neither the acceptance of this application nor entry into any type of employment relationship or employment agreement with a Consumer or LAR for the consideration and employment shall serve to create an actual or implied contract of employment with Alamo Consumer Direct, LLC.

I understand that I may not provide services for payment for a consumer until I receive an "Okay to Work Form" from Consumer Direct. The receipt of this form means that the required results of the criminal background check have been received and approved. I also understand that the results of the background check may be shared with the approving entity (DADS) and/or the Consumer with whom I work. The results of the background check will be filed in my personnel file.

Applicant's Signature: _____ **Date:** _____

CONSUMER DIRECT

PAY SELECTION FORM

Name: _____
(please print)

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

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

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

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

Account Type (check one): ☐ Checking ☐ Savings

For Checking Accounts:

Attach (tape) a voided check here

Do not attach a deposit slip.

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

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

_____ _____

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.

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

Consumer Direct

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

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

focus

Getting Started

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

Follow the activation instructions that accompany your card.

Features

Cash Back Rewards

For purchases at certain retail and restaurant locations.

Savings Account

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

Cash Reload Networks[5]

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

Text and Email Alerts[4]

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

Mobile Banking App[4]

Quickly see your account balance and transaction history.

Track Spending

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

Fee Schedule

Activity		Cost		
Monthly Account Maintenance		Free		
Purchases at Point-of-Sale (Domestic)		Free		
Cash Back with Purchases (Domestic)		Free		
ATM Transactions		Cash Withdrawal	Declined Withdrawal	Balance Inquiry
The owner of any Non-U.S. Bank or Non-MoneyPass ATM may assess an additional surcharge fee for any ATM transaction that you complete.	U.S. Bank ATM	Free	Free	Free
	MoneyPass® ATM	Free	Free	Free
	Allpoint® ATM	Free	Free	Free
	Other ATM	$2.00	$0.50	$1.00
	International ATM	$3.00	$0.50	$1.00
Teller Cash Withdrawal		Free		
Teller Cash Withdrawal Decline		$0.00		
Customer Service Automated Phone Service, Online, Live Phone Representative		Free		
Text or Email Alerts[4]		Free		
Inactivity After 90 consecutive days. Not assessed if balance is $0.00.		$2.00 Per Month		
Monthly Paper Statement		If requested – $2.00		
Card Replacement Non-Personalized Issued by employer (If applicable to your program) 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.

Instructions for Completing Form I-9 Section 1

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

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

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

Employee (steps 1-9)

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

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

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

④ Print your Social Security Number.

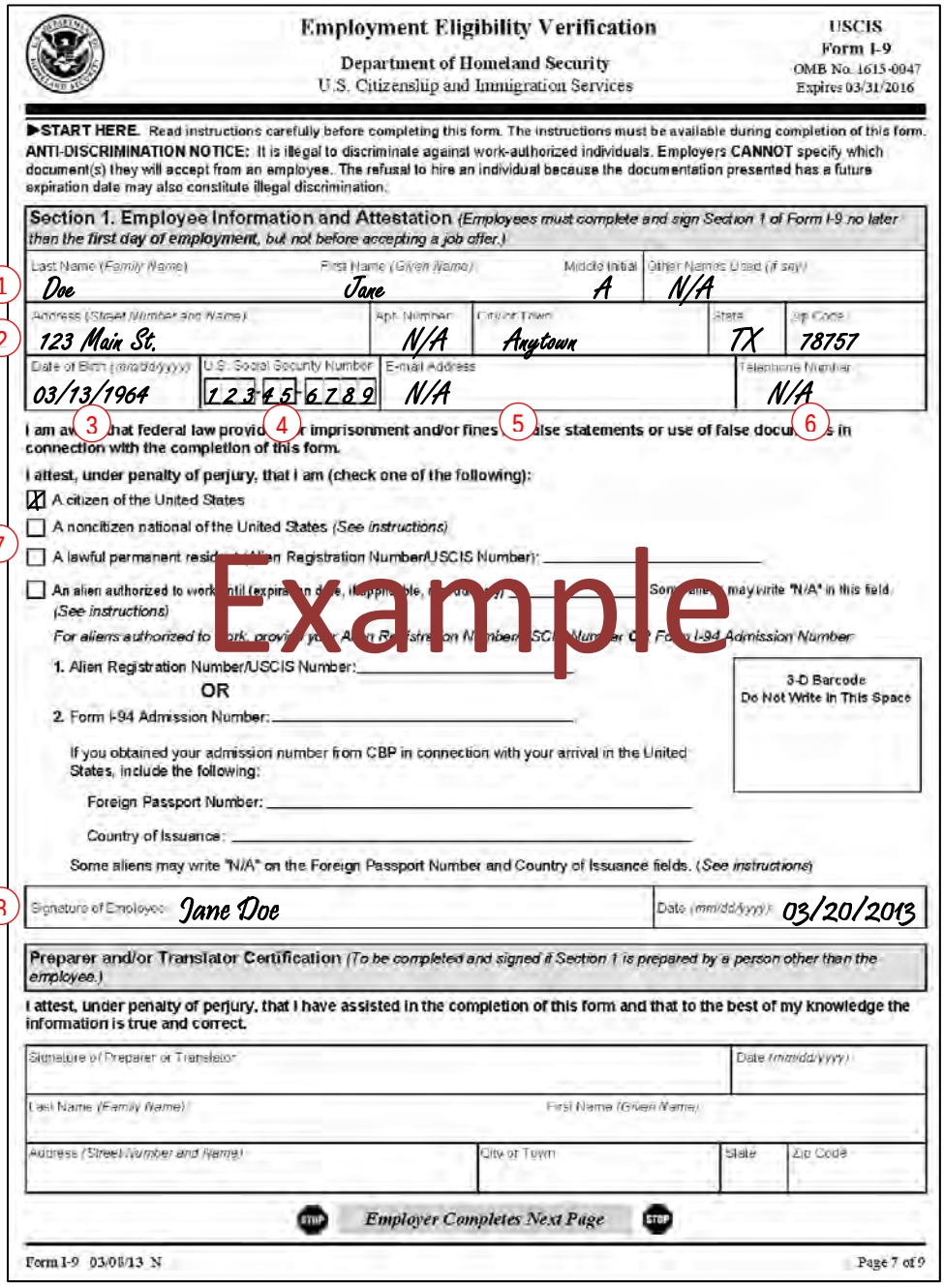
⑤ Print your email address or print "N/A" if you choose not to provide it.

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

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

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

⑨ Provide documents to your employer to complete Section 2.



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

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

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

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

Last Name (Family Name)	First Name (Given Name)	Middle Initial	Other Names Used (if any)
① Doe	Jane	A	N/A

Address (Street Number and Name)	Apt. Number	City or Town	State	Zip Code
② 123 Main St.	N/A	Anytown	TX	78757

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	E-mail Address	Telephone Number
③ 03/13/1964	④ 123-45-6789	⑤ N/A	⑥ N/A

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

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

☒ A citizen of the United States
☐ A noncitizen national of the United States (See instructions)
⑦ ☐ A lawful permanent resident (Alien Registration Number/USCIS Number): _____
☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____ Some aliens may write "N/A" in this field. (See instructions)

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

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

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

Foreign Passport Number: _____

Country of Issuance: _____

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

2-D Barcode
Do Not Write In This Space

⑧ Signature of Employee: Jane Doe	Date (mm/dd/yyyy): 03/20/2013

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

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

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

STOP Employer Completes Next Page STOP

Form I-9 03/08/13 N Page 1 of 9

Example

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

Instructions for Completing Form I-9 Section 2

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

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

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

Employer (steps 1-10)

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

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

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

OR

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

Only accept unexpired, original documents (no photocopies).

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

④ Sign the form.

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

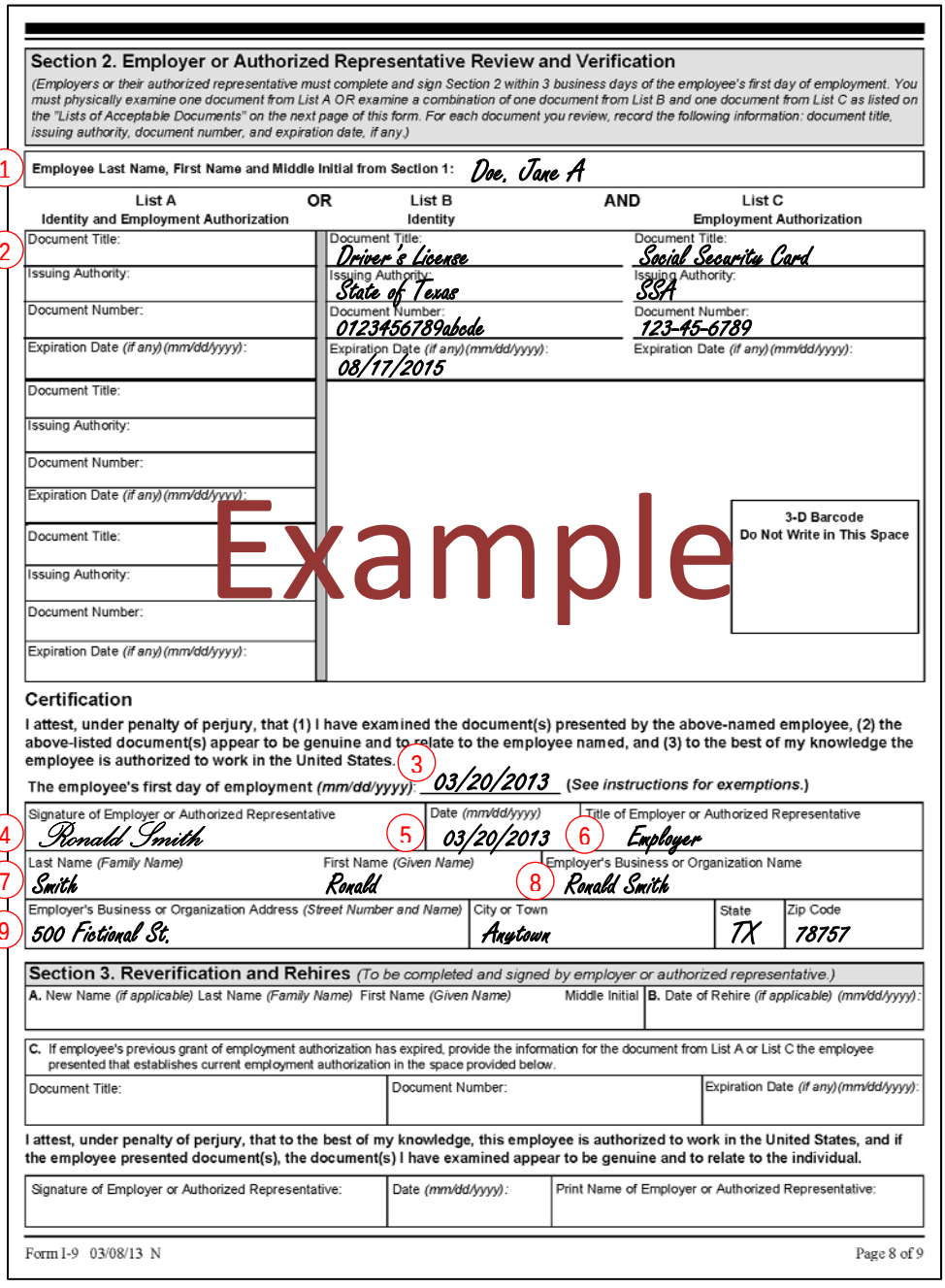
⑥ If not pre-populated, print your title as "Employer."

⑦ Print your last and first name.

⑧ Print your first and last name.

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

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



Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

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

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
2 Document Title:		Driver's License		Social Security Card
Issuing Authority:		State of Texas		SSA
Document Number:		0123456789abcde		123-45-6789
Expiration Date (if any) (mm/dd/yyyy):		08/17/2015		
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date (if any) (mm/dd/yyyy):				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date (if any) (mm/dd/yyyy):				

Example

3-D Barcode Do Not Write in This Space

Certification

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

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

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

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

9 Employer's Business or Organization Address (Street Number and Name)	City or Town	State	Zip Code
500 Fictional St.	Anytown	TX	78757

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

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

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

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

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

Signature of Employer or Authorized Representative:	Date (mm/dd/yyyy):	Print Name of Employer or Authorized Representative:

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

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

Instructions for Employment Eligibility Verification

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

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

Read all instructions carefully before completing this form.

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

What Is the Purpose of This Form?

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

General Instructions

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

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

Section 1. Employee Information and Attestation

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

Provide the following information to complete Section 1:

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

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

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

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

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

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

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

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

   If you check this box:

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

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

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

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

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

Preparer and/or Translator Certification

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

Minors and Certain Employees with Disabilities (Special Placement)

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

Section 2. Employer or Authorized Representative Review and Verification

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

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

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

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

Employers or their authorized representative must:

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

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

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

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

Unexpired Documents

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

Receipts

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

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

There are three types of acceptable receipts:

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

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

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

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

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

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

Section 3. Reverification and Rehires

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

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

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

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

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

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

Reverification does not apply to List B documents.

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

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

To complete Section 3, employers should follow these instructions:

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

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

3. Complete Block C if:

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

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

   To complete Block C:

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

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

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

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

What Is the Filing Fee?

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

USCIS Forms and Information

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

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

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

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

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

Photocopying and Retaining Form I-9

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

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

USCIS Privacy Act Statement

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

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

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

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

Paperwork Reduction Act

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

Employment Eligibility Verification

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

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

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

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

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

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

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

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

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

☐ A citizen of the United States

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

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

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

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

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

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

Foreign Passport Number: _____

Country of Issuance: _____

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

3-D Barcode
Do Not Write in This Space

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

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

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

Signature of Preparer or Translator:	Date *(mm/dd/yyyy):*

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

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

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

03149

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

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

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

3-D Barcode
Do Not Write in This Space

Certification

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

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

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

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

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

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

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

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

Signature of Employer or Authorized Representative:	Date *(mm/dd/yyyy):*	Print Name of Employer or Authorized Representative:

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

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

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

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

00540 - Delete

Form W-4 (2015)

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

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2015 expires February 16, 2016. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

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

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

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

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

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

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

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

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

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

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2015. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

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

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	**A**	
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	**B**	
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	**C**	
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	**D**	
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	**E**	
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	**F**	
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $65,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $65,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child	**G**	
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ►	**H**	

For accuracy, complete all worksheets that apply.

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

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

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

Employee's Withholding Allowance Certificate

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

OMB No. 1545-0074

2015

1 Your first name and middle initial	Last name	**2 Your social security number**	
Home address (number and street or rural route)		**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code		**4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ► ☐	

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	**5**	
6	Additional amount, if any, you want withheld from each paycheck	**6**	$
7	I claim exemption from withholding for 2015, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ►	**7**	

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

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

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

01858

Deductions and Adjustments Worksheet

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

1	Enter an estimate of your 2015 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1951) of your income, and miscellaneous deductions. For 2015, you may have to reduce your itemized deductions if your income is over $309,900 and you are married filing jointly or are a qualifying widow(er); $284,050 if you are head of household; $258,250 if you are single and not head of household or a qualifying widow(er); or $154,950 if you are married filing separately. See Pub. 505 for details	1	$
2	Enter: { $12,600 if married filing jointly or qualifying widow(er); $9,250 if head of household; $6,300 if single or married filing separately }	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2015 adjustments to income and any additional standard deduction (see Pub. 505)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2015 Form W-4* worksheet in Pub. 505.)	5	$
6	Enter an estimate of your 2015 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero or less, enter "-0-"	7	$
8	**Divide** the amount on line 7 by $4,000 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

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

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

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

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

4	Enter the number from line 2 of this worksheet	4	
5	Enter the number from line 1 of this worksheet	5	
6	**Subtract** line 5 from line 4	6	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here	7	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	$
9	Divide line 8 by the number of pay periods remaining in 2015. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2015. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	$

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $6,000	0	$0 - $8,000	0
6,001 - 13,000	1	8,001 - 17,000	1
13,001 - 24,000	2	17,001 - 26,000	2
24,001 - 26,000	3	26,001 - 34,000	3
26,001 - 34,000	4	34,001 - 44,000	4
34,001 - 44,000	5	44,001 - 75,000	5
44,001 - 50,000	6	75,001 - 85,000	6
50,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 100,000	10	140,001 and over	10
100,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $75,000	$600	$0 - $38,000	$600
75,001 - 135,000	1,000	38,001 - 83,000	1,000
135,001 - 205,000	1,120	83,001 - 180,000	1,120
205,001 - 360,000	1,320	180,001 - 395,000	1,320
360,001 - 405,000	1,400	395,001 and over	1,580
405,001 and over	1,580		

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

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

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

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

00540

CONSUMER DIRECT

TEXAS FMSA
EMPLOYMENT RELATIONSHIP DISCLOSURE

Employee Name	FEIN holder Name

INSTRUCTIONS: Each Employee must provide the following information about his or her relationship with the FEIN Holder before employment begins. You must review, complete all the sections below, and sign and date at the bottom of the form. This information is required to begin employment.

1) RELATIONSHIP DISCLOSURE:

Before employment, my existing relationship with the above-named **FEIN Holder (please check one)**:

- ☐ Parent (Exempt)
- ☐ Step Parent (Exempt)
- ☐ Spouse (Exempt)
- ☐ Child under age 21 (Exempt)
- ☐ Other, please describe: _____
- ☐ No Relationship
- ☐ Paid Guardian/Conservator
- ☐ Sibling
- ☐ Legal Representative

2) RELATIONSHIP AND EMPLOYMENT ACKNOWLEDGMENTS:

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

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

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

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

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

_____ _____

Employee Signature *Date*

_____ _____ _____

Employer/Consumer Signature *Date* *Consumer Name*

02577

CONSUMER DIRECT

EMPLOYEE HEALTH QUESTIONNAIRE

Employee Printed Name

Background: At this point in the employment process, you have been conditionally hired by a Consumer/Member/ Representative/Individual ("Employer") as an Employee. Your position involves delivering hands-on care for the Employer. Your duties will vary according to the needs and authorized services of the Employer, but will require you to perform tasks of a physical nature, which have physical demand requirements. The purpose of this Health Questionnaire is to obtain information about your ability to perform the authorized tasks. The information provided on this Questionnaire will be used to help manage your employment in a safe manner. Your responses are considered *Confidential*.

Instructions: Please respond to each item as to whether you have a medical or physical activity restriction or limitation to physical activity. Only list permanent restrictions or restrictions incurred within the last five (5) years. **Please explain each "Yes" answer on the reverse of this form, and attach additional information as necessary.**

Return this completed form, with the other employment forms, to the Consumer Direct office.

	Do you have a Physical Activity Restriction for:	**NO**	**YES**
1	Sitting		
2	Stationary Standing		
3	Walking		
4	Ability to be Mobile		
5	Crouching (bending at knee)		
6	Kneeling/Crawling		
7	Stooping (bending at waist)		
8	Twisting (knees/waist/neck)		
9	Turning/Pivoting		
10	Climbing		
11	Balancing		
12	Reaching overhead		
13	Reaching extension		
14	Grasping		
15	Pushing/Pulling		
16	Lifting/Carrying		
17	Whole/Partial Loss of Hearing		
18	Blindness (partial or complete) or Eye Problems		
19	Have you ever been advised by a health care professional to restrict your physical activities in any way?		

	Personal Medical History **Have you ever had or been treated for:**	**NO**	**YES**
20	Epilepsy		
21	Fainting/Dizzy Spells		
22	Hernia		
23	Muscular Strain		
24	Neck or Back Strain or Injury		
25	Ruptured Intervertebral Disc		
26	Joint Injury or Pain		
27	Fractures		
28	Tuberculosis or Non-Negative TB Test		
29	Lung Problems/Disease		
30	Head Injury		
31	Allergies		
32	Other Current Problems, Diseases, Conditions		
33	Have you ever been hospitalized or undergone surgery, other than for childbirth?		
34	Have you ever refused a recommended surgical procedure?		
35	Are you currently taking any medication or drugs, whether by prescription or not, that could impair your judgment?		

CONSUMER DIRECT

EMPLOYEE HEALTH QUESTIONNAIRE

_____

Employee Printed Name

Do you currently have, or have you ever been told by a health care professional that you have, any physical limitations in reference to the list below?							
		NO	**YES**			**NO**	**YES**
A	Back			H	Arm		
B	Shoulder			I	Hip		
C	Neck			J	Knee		
D	Elbow			K	Ankle		
E	Wrist			L	Foot		
F	Hand			M	Leg		
G	Finger			N	Other		

Consumer Direct does not discriminate in hiring, promotion, or retention policies or practices against persons who have, in good faith, filed a claim for or received benefits pursuant to State Workers' Compensation Laws.

Please explain any "Yes" answers from page 1 and 2 in detail below and note the associated number or letter. Also, include the dates of injuries & surgeries. Use additional pages if necessary:

I hereby certify that I have answered the above questions to the best of my knowledge, and that my answers are true and complete. I understand that misrepresentation or omission of facts is cause for dismissal and may result in denial of workers' compensation benefits.

Employee Signature: _____ Date: _____/_____/_____

Office Use Only

Reviewed by: [_____] Date _____/_____/_____ Date sent to Risk Mgr: _____/_____/_____

State Office/Location: Alamo CD/Austin, TX Risk Mgr: [_____] Date _____/_____/_____

02770

TEXAS Department of Aging and Disability Services

Form 1724
August 2015-E

Consumer Directed Services

New Employee Packet Cover Sheet

Name of Individual Receiving Services	Employer Name
Employee Name	
Date of Hire	First Day of Work

Employer	Agency	FMSA	Document Description / Form Information
Before Hire: (1) Original or Copy for Employer's Personnel Files and (2) Original or Copy to FMSA			
☐	**DADS**	☐	**DADS Form 1725,** Criminal Conviction History and Registry Checks
☐	**DADS**	☐	**DADS Form 1729,** Applicant Verification for Employees; **DADS Form 1734,** Service Provider and Employer Certification of Relationship Status for CDS
☐	**USCIS**	☐	**USCIS Form I-9,** Employment Eligibility Verification
☐	**DADS**	☐	**DADS Form 1728,** Liability Acknowledgement
☐	**DADS**	☐	**Professional license verification** (nursing, professional therapies)
At Time of Hire: (1) Original or Copy for Employer's Personnel Files and (2) Original or Copy to FMSA			
☐	**IRS**	☐	**IRS Form W-4,** Employee's Withholding Allowance Certificate — Due before first payroll check is calculated; provide to the Financial Management Services Agency (FMSA) on date of hire.
☐	**OAG**	☐	**Texas Employer New Hiring Reporting Form** (www.employer.texasattorneygeneral.gov)
☐	**DADS**	☐	**DADS Form 1730,** Wage and Benefits Plan Employee Compensation, and any court-ordered garnishment(s); **DADS Form 1731,** Employee Work Schedule and Assigned Tasks; **DADS Form 1737,** Employer and Employee Service Agreement; **DADS Form 1739,** Service Provider Agreement
☐	**DADS**	☐	***CLASS, DBMD and MDCP only:*** **Cardiopulmonary resuscitation (CPR) certification** — Effective at time of service delivery initiation, and maintained. *Verify again before expiration date.*
☐	**DADS**	■	**Texas Department of Public Safety driver's license** (if transporting client) — *Verify again before expiration date.*
☐	**DADS**	■	**Proof of minimum auto insurance** (if transporting client)
☐	**CDC OSHA**	■	**DADS Form 1727,** Occupational Exposure to Bloodborne Pathogens (Acknowledgement: Hepatitis B Vaccination and Universal Precautions)
☐	**TWCC**	■	**Notice to Employees Concerning Workers' Compensation in Texas** (TWC Notice 5)
☐	**DADS**	☐	***If hiring a nurse:*** **DADS Form 1747,** Acknowledgment of Nursing Requirements
☐	**CDS DADS**	☐	***If applicable:*** **DADS Form 1733,** Employer and Employee Acknowledgement of Exemption from Nursing Licensure for Certain Services Delivered through Consumer Directed Services
☐	**DADS**	☐	**DADS Form 1732,** Management and Training of Service Provider — Initial training must be conducted within 30 days of hire.
Ongoing: (1) Original or Copy for Employer's Personnel Files and (2) Original or Copy to FMSA			
☐	**DADS**	☐	**DADS Form 1732,** Management and Training of Service Provider — Evaluation, employment status changes, documentation of training, documentation of conflict and job performance issues. (The employer must send the original or a copy to the FMSA within 30 calendar days of an initial orientation or annual evaluation and when an action affects the service provider's continued status with the employer, e.g., termination, change in payment.)
☐	**DADS**	■	**DADS Form 1732-EMR,** Management and Training of Service Provider Addendum — Must be signed by the employee within five days of hire.
☐	**DADS**	☐	**Time sheets/service logs** — **DADS Form 1745,** Service Delivery Log with Written Narrative/Written Summary, **or** facsimile approved by the FMSA
☐	**Vendors**	☐	**Receipts and invoices**

Code	Action
☑	Employer checks off each item for the **personnel file** and retains original or copy.
☑	Employer checks each required item when completed and sends original or copy to the FMSA as indicated. Employer retains original or copy.
■	Items the employer is **not** required to send to the FMSA, but which the employer **must** maintain on file in the employee's **personnel file**.

Code	Agency
CDC	Centers for Disease Control and Prevention
CDS	Consumer Directed Services
DADS	Texas Department of Aging and Disability Services
IRS	Internal Revenue Service
OAG	Office of the Attorney General, State of Texas
OSHA	Occupational Safety and Health Administration
TWCC	Texas Workers' Compensation Commission
USCIS	U.S. Citizenship and Immigration Services (formerly the **INS**, Immigration and Naturalization Services)

TEXAS Department of Aging and Disability Services

Consumer Directed Services

Criminal Conviction History and Registry Checks

Applicant is a person being considered as a service provider (employee or independent contractor [when required]).

Section I - Applicant Authorization/Acknowledgment (Applicant must complete this section.)

I, (applicant's printed name) _____, give my permission to check for a criminal conviction history, to check the required registries annually, and to check the state and federal lists of individuals and entities excluded from participation in Medicaid (LEIE) monthly as part of my application as a service provider through the Consumer Directed Services (CDS) option. I also understand that a criminal conviction or a registry listing that prohibits a person from employment in a health care setting in the state of Texas may prohibit my employment.

I understand that I must not provide services for payment until the required criminal history and registry checks are conducted, the employer and Financial Management Services Agency (FMSA) review the results and determine that I can be paid for services, and this form is signed by the FMSA.

_____ _____

Signature - Applicant | Date

Applicant Information Required by the Texas Department of Public Safety (DPS) (Applicant must print.)

Individual's Name (Last, First, Middle)	Alias	Maiden Name

Date of Birth (mm/dd/yyyy)	Social Security No.

Section II - Criminal Conviction History Check and Registry Verification Process (Employer must complete this section.)

Individual's Name	Employer Name

Criminal Conviction History Check (Check each box to certify agreement):

- ☐ I request that my FMSA obtain a **current** Criminal Conviction History Check of the applicant from DPS. I authorize the FMSA to be reimbursed for the cost of obtaining the DPS Criminal Conviction History Check and if I request the report, the cost of sending the report from my budgeted funds.
- ☐ I understand that if I request the report, the FMSA must send it to me through a secure method, DPS approved encrypted software or certified mail.
- ☐ I understand that all criminal records and reports obtained by my FMSA, and the information they contain, are confidential information.
- ☐ I understand all DPS criminal history information reports must be destroyed five days after I make the hiring decision. Paper records need to be shredded, pulped or burned. For electronic records, destroying the media or using specialized software to copy over the data are acceptable methods.
- ☐ I understand that sharing of criminal history information with any person or agency may be prosecuted as a Class A Misdemeanor.

_____ _____

Signature - Employer | Date

Registry Check

- ☐ I request that my FMSA obtain the applicant's status with the Employee Misconduct Registry and the Nurse Aide Registry initially and annually.
- ☐ I understand that the FMSA will screen the applicant initially and monthly using both the state and federal lists of excluded individuals and entities (LEIE).
- ☐ I also understand that the applicant cannot provide services and cannot be paid with program funds until the criminal history and registry checks are completed and my FMSA has notified me that the applicant meets the qualifications.

_____ _____

Signature - Employer | Date

I request that the FMSA provide the criminal history to me:

- ☐ Verbally
- ☐ Encrypted email
- ☐ Certified mail

_____
Date

Section III - Criminal Conviction History and Registry Check Results

DPS Criminal Conviction Criminal History Check

Date of DPS Check	Time (specify a.m. or p.m.)
Obtained By	Convictions: ☐ **Yes** ☐ **No**
DPS approved dissemination method used to inform employer of results: ☐ Verbally ☐ Encrypted email ☐ Certified mail ☐ Did not request report – sent Form 1725	Date FMSA staff notified employer: _____ FMSA staff:

Date disseminated by FMSA: _____

If yes, does the conviction(s) prohibit service delivery in compliance with Health and Safety Code Chapter 250, §250.006(a), or §250.006(b)? ..... ☐ Yes ☐ No

Within five calendar days after the hiring decision, the FMSA must destroy the criminal history record information obtained from DPS whether or not hired or retained by the employer or designated representative.

Date report was destroyed: _____

Date employer notified FMSA of hiring decision: _____

Registry Checks (Conduct search at https://emr.dads.state.tx.us/DadsEMRWeb/)

Date of Registry Checks	Time (specify a.m. or p.m.)	Obtained By	☐ Employer ☐ FMSA Representative

Employee Misconduct Registry: ☐ No Record ☐ Record (must not be hired or retained)

Nurse Aide Registry: ☐ No Record ☐ Record (must not be hired or retained)

Medicaid Exclusion List: ☐ No Record ☐ Record (must not be hired)

Certification - I acknowledge that the applicant's DPS criminal conviction history and registry record were checked.

The applicant ☐ **is** ☐ **is not** eligible for hire, to be retained for service delivery based on the checks above.

_____
Signature - FMSA Representative

_____
Date FMSA notified the employer or Designated Representative

FMSA and Employer Must Each Keep Original or Copy of This Form

TEXAS
Department of Aging and Disability Services

Form 1729
August 2015-E

Consumer Directed Services

Applicant Verification for Employees

Individual's Name

Employer Name

Applicant Name

Applicant Social Security Number

The employer must verify the applicant meets each criterion. The employer must ensure the following forms and/or copies of documentation used to verify the criteria are valid and kept in the employee's personnel file. This form and supporting documentation **must** be sent to the Financial Management Services Agency (FMSA) for verification before the employer can hire the applicant.

Employment Qualifications

- ☐ The applicant is at least age 18.
- ☐ The applicant is not disqualified based on Form 1734, Service Provider and Employer Certification of Relationship Status for CDS.
- ☐ The applicant is not barred from employment based on the results of the Texas Department of Public Safety (DPS) criminal conviction history check, the Texas Health and Safety Code Chapter 250 registry checks, or the Medicaid exclusion list (Form 1725, Criminal Conviction History and Registry Checks).
- ☐ The applicant has completed Form 1728, Liability Acknowledgement.
- ☐ The applicant has read *Notice Concerning Workers' Compensation in Texas* (TWC Notice 5).
- ☐ The applicant has current cardiopulmonary resuscitation (CPR) and first aid certification for Medically Dependent Children Program (MDCP) flexible family support and respite services.
- ☐ The applicant has current hands-on CPR, first aid and choking prevention certification, if providing services in the Deaf Blind with Multiple Disabilities (DBMD) Program.
- ☐ The applicant has the following educational qualifications, if providing services for DBMD, Home and Community-based Services (HCS), MDCP, Texas Home Living (TxHmL) or Community First Choice (CFC):
  - has a high school diploma or a certificate recognized by a state as the equivalent of a high school diploma; or
    - documentation of a proficiency evaluation of the employee's experience and competence to perform job tasks, including an ability to provide the services needed by the individual, as demonstrated through a written competency-based assessment; and
    - at least three personal references from people not related by blood that evidence the person's ability to provide a safe and healthy environment for the individual.
- ☐ The applicant has the following qualifications, if providing services for DBMD:
  - is fluent in the communication methods used by the individual (for example, American Sign Language, tactile symbols, communication boards, pictures and gestures) or has the ability to become fluent in the communication methods used by the individual within three months after beginning to work with the individual.

FMSA Certification

The applicant ☐ **does** ☐ **does not** meet qualifications for employment.

Only applicants who meet all qualifications may be employed.

Acknowledgement

The applicant and employer acknowledge that the applicant meets the qualifications for employment and that a copy of this form must be submitted to the FMSA. The FMSA must verify the applicant's qualifications before the employer offers employment to the applicant.

Signature — Employer

Date

Signature — FMSA

01767 Date

TEXAS
Department of Aging and Disability Services

Form 1734
June 2015-E

Consumer Directed Services (CDS)

Service Provider and Employer Certification of Relationship Status for CDS

Service Provider Name	Maiden Name — if applicable
Individual Receiving Services	Employer Name
Service Provider's Relationship to Individual	Designated Representative (DR) — if applicable
Service Provider's Relationship to Employer	Service Provider's Relationship to DR

Service Provider: Place a check mark in the column that describes your status and relationship.

Section 1: All Programs

All service providers must answer the following questions.

	Service Provider Status and Relationship	Yes	No	N/A
1.	Are you under age 18?	☐	☐	
2.	Are you the individual's legally authorized representative (LAR)? (That is, the individual's natural parent, legal/adopted parent, stepparent or managing conservator if the individual is under age 18 [a minor], or the court-appointed guardian of an individual of any age.)	☐	☐	
3.	Are you the spouse* of the individual's LAR? (That is, the spouse of the individual's natural parent, legal/adopted parent, stepparent or managing conservator if the individual is under age 18 [a minor], or the spouse of the court-appointed guardian of an individual of any age.)	☐	☐	
4.	Are you the spouse* of the individual? (Consumer Managed Personal Attendant Services (CMPAS) service providers mark this item Not Applicable (N/A).)**	☐	☐	☐
5.	Are you the spouse* of the employer? (CMPAS service providers mark this item N/A.)**	☐	☐	☐
6.	If the individual is a Texas Department of Family and Protective Services (DFPS) foster child or adult, are you the individual's foster parent? (If the individual is not a DFPS foster child/adult, mark this item N/A.)	☐	☐	☐
7.	If the individual is a DFPS foster child or adult, are you the spouse* of the individual's foster parent? (If the individual is not a DFPS foster child/adult, mark this item N/A.)	☐	☐	☐
8.	Are you the power of attorney (attorney in fact or agent) for financial responsibilities on behalf of the individual?	☐	☐	
9.	Are you the DR or the CDS employer for the individual?	☐	☐	
10.	Are you the spouse* of the employer's DR?	☐	☐	

*** Spouse** is defined as either a legal marriage or a marriage without formalities (common law marriage) in accordance with the Texas Family Code.

** The spousal relationship in questions 4 and 5 is not applicable for CMPAS. (The spouse may be employed.)

Section 2: Medically Dependent Children Program (MDCP)

If providing services in the MDCP program, please answer the following additional questions. (Mark these items N/A if the individual is not enrolled in MDCP.)

	Service Provider Status and Relationship	Yes	No	N/A
1.	Are you the parent or primary caregiver of the individual?	☐	☐	☐
2.	Are you the spouse* of the parent or primary caregiver?	☐	☐	☐

Section 3: Home and Community-based Services (HCS) and Texas Home Living (TxHmL)

If providing respite, adaptive aids or behavioral support services in the HCS or TxHmL program, please answer the following additional questions, as applicable. (Mark these items N/A if the individual is not receiving an applicable HCS or TxHmL service.)

	Service Provider Status and Relationship	Yes	No	N/A
1.	Are you a person living in the same household as the individual? (Applies to respite services.)	☐	☐	☐
2.	Are you the spouse* of a person living in the same household as the individual? (Applies to respite services.)	☐	☐	☐
3.	Are you a person related to the individual within the fourth degree of consanguinity or within the second degree of affinity? (Applies to adaptive aids and behavioral support services.)	☐	☐	☐

Section 4: Community Living Assistance and Support Services (CLASS) — Respite Service Providers Only

If providing respite services in the CLASS program **and the primary caregiver is the Community First Choice (CFC) Personal Assistance Services/Habilitation (PAS/HAB) service provider**, please answer the following additional question. (Mark this item N/A if the individual is not receiving CLASS respite services. Also mark this item N/A if the individual is receiving CLASS respite services, but the primary caregiver is not the CFC PAS/HAB service provider.)

	Service Provider Status and Relationship	Yes	No	N/A
1.	Do you live in the same household as the individual?	☐	☐	☐

Section 5: Primary Home Care (PHC), Community Attendant Services (CAS) and Family Care (FC)

If providing PHC, CAS or FC, please answer the following additional questions. (Mark these items N/A if the individual is not enrolled in PHC, CAS or FC.)

	Service Provider Status and Relationship	Yes	No	N/A
1.	Are you the primary caregiver for the individual?	☐	☐	☐
2.	Are you the spouse* of the primary caregiver for the individual?	☐	☐	☐

Employer and Service Provider Certification

Employer: Place a check mark to determine eligibility for employment in CDS. ☐

If any item above is marked Yes, the service provider is not eligible to be a paid service provider (employee, contractor or vendor) in the CDS option for this individual. If every item above is marked No or N/A, the service provider meets relationship eligibility for employment in CDS for this individual unless contraindicated by requirements of the individual's program. (N/A only applies where indicated.) The employer and the service provider certify that the responses are accurate.

Employer check one: The service provider ☐ *is* or ☐ *is not* eligible for employment in CDS for this individual.

Printed Employer Name	Signature — Employer	Date
Printed Service Provider Name	Signature — Service Provider	Date

Consumer Directed Services

Liability Acknowledgement

Liability Acknowledgement Between the Employer and the Applicant for Employment

The individual receiving services or the individual's legally authorized representative (LAR) is the employer in the Consumer Directed Services (CDS) option.

The **employer** employs (hires, manages and terminates) employees. The **employer** is solely responsible and liable for any negligent acts or omissions by the employer; the employee; other employee(s) or service provider(s); the individual receiving services; or, if applicable, the employer's designated representative.

Employees or service providers are **not** employed or retained by the Texas Department of Aging and Disability Services (DADS); any other state or federal governmental agency; or by the Financial Management Services Agency (FMSA).

As an applicant for employment through the CDS option, I acknowledge that I have read and that I understand the above information regarding the employer and employee liability.

Signature – Employer (Must be signed by the employer)	Date	Signature – Applicant for Employment	Date

Liability Notice to Applicants for Employment

Section I:

The employer:

☐ **is** a subscriber of Texas Workers' Compensation through the Texas Department of Insurance, Division of Workers' Compensation.

☑ **is not** a subscriber of Texas Workers' Compensation through the Texas Department of Insurance, Division of Workers' Compensation. (Employer completes Section II below if this option applies.)

Section II:

Employer indicates the correct option in this section if the employer **is not** a subscriber to Texas Workers' Compensation.

☑ I have made the following arrangement(s) for employee work-related injuries/illnesses:

- ☐ self-insurance;
- ☐ homeowner's personal liability insurance;
- ☐ renter's personal liability insurance;
- ☐ medical coverage insurance;
- ☐ risk pool insurance;
- ☑ other: The Hartford's Texas Worker' Compensation Health Care Network-FH

☐ I have **no** insurance or other protection against employee work-related injuries/illnesses for my employee(s).

Acknowledgement by Employer and Applicant for Employment

I acknowledge that I have read and that I understand the above information in Section I and in Section II.

Signature – Employer (Must be signed by the employer)	Date	Signature – Applicant for Employment	Date

Notice of Network Requirements
Employee Information; Responsibilities

Dear Texas Employee:

As of July 1st, 2013 Alamo Consumer Direct is using The Hartford's Texas Workers' Compensation Health Care Network (FH). This is a certified workers' compensation network for providing healthcare service that you can use. We call it a "healthcare network" because it includes different kinds of healthcare services. This network will be offered through your employer starting on July 1, 2013. This network has been certified by the Health and Workers' Compensation Networks & Quality Assurance Division. If you live in the area that is serviced by the network (called a Geographic
Service Area, or simply "Service Area"), and if you are injured at work, you must get medical treatment through this network. Your employer must tell you about what you need to do so that you will be able to use the network if you are injured. Not all of the doctors in your area are part of this network. Your employer must also give you a list of the names of the doctors that you can use in your area. This list of network treating doctors includes:

- The names and addresses of the doctors and whether they are treating doctors (the kind of doctor that you contact yourself) or specialists (doctors that the treating doctor recommends); network doctors are listed by the kind of service they provide; treating doctors are listed separately from specialists;
- The names of the doctors who are able to determine whether your work related medical condition has reached maximum medical improvement and provide impairment ratings associated with your work related injury; and
- Information about doctors who are accepting new patients.

This list of network providers will be updated at least four times each year. If you would like a printed copy, please contact us at 1-800-327-3636, Option 4 and we will be happy to mail one to you. If you have Internet access, the electronic directory is updated more frequently.

Visit: www.talispoint.com/htfd/external

Alamo Consumer Direct utilizes a Risk Manager to help assist with workers' compensation claims and questions.

If you are injured please contact the Risk Manager at the Injury Hotline at 1-888-541-1701.

THE HARTFORD

Workers' Compensation Network Acknowledgement Form

I have received information that tells me how to get health care under workers' compensation insurance.

If I am hurt on the job and live in the service area described in this information, I understand that:

1. I must choose a treating doctor from the list of doctors in the network. OR, I may ask my HMO primary care physician to agree to serve as my treating doctor.
2. I must go to my treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me. If I need emergency care, I may go anywhere.
3. The insurance carrier will pay the treating doctor and other network providers.
4. I might have to pay the bill if I get healthcare from someone other than a network doctor without network approval.

_____ _____
(Signature) (Date)

_____
(Printed Name)

I live at: _____
(Street Address)

_____ _____ _____
(City) (State) (Zip Code)

Employer Printed Name: _____

Employer Signature: _____ Date: _____

Name of Network: The Hartford's Texas Workers' Compensation Health Care Network-FH

THE HARTFORD

03681

Consumer Directed Services

Wage and Benefits Plan
Employee Compensation

Employee Name (Last, First, Middle Initial)		Social Security No.
Date of Hire	First Date of Work	☐ Initial Wage and Benefit Plan ☐ Plan Change – Effective Date:

Name of Program Service Being Provided: _____

Compensation:

Regular Hourly Wage

☐ Employee = $ _____

☐ Respite = $ _____

Calculation of Overtime Hourly Wage

Hourly $ _____ + $ _____ (50%) = $ _____

Hourly $ _____ + $ _____ (50%) = $ _____

Benefits: ***Optional***

☐ **Hepatitis B Vaccination** (Attach completed Form 1727 if vaccination is requested by the employee.)

Employer: List other optional benefits here. (Attach additional sheet, if required.)

Withholdings:

☐ **W-4 Employee's Withholding Allowance Certificate** (Attach completed Form W-4.)

☐ **Required Garnishments**

Type:	Amount:
Frequency:	Payment To:

☐ **Voluntary Withholdings** (not related to W-4)

Type:	Amount:
Frequency:	Payment To:

☐ **Other** (specify): _____

Acknowledgement/Agreement:

Time Sheets/Service Delivery Logs must be completed accurately each work shift/day. Payment for services delivered is made from state and/or federal funds. Falsification of a time sheet is considered fraud and is punishable under the law.

Accurate, signed time sheets are due: every Monday by midnight

Paychecks are distributed by (method): USPS mail or direct deposit at least twice a month on n/a

or every other week starting two weeks after employee turns in first time sheet

Employee and employer mutually agree to the compensation, benefits, withholdings and all information above and agree that any changes or revisions must be documented and provided to the employee, the employer and the Financial Management Services Agency.

Signature - Employer or Designated Representative	Date	Signature - Employee	Date

01768

Name of Employer:

Name of Individual Receiving Services:

Texas Department of Aging
and Disability Services

Form 1731
January 2007

Consumer Directed Services

Employee Work Schedule and Assigned Tasks

Employee Name: _____

Purpose of Form:
- ☐ Initial
- ☐ Change

Activity Involved:
- ☐ Tasks
- ☐ Schedule

Effective Date: _____

Schedule I _____

Day	Time In	Time Out	Time In	Time Out	Time In	Time Out	Total Hours
Sunday							
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							
						Weekly Total Hours	

Schedule I – Tasks

Schedule II _____

Day	Time In	Time Out	Time In	Time Out	Time In	Time Out	Total Hours
Sunday							
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							
						Weekly Total Hours	

Schedule II – Tasks

Acknowledgment of Work Schedule and Assigned Tasks – Sign and Date:

Signature – Employer	Date	Signature – Employee	Date

01769

Consumer Directed Services

Employer and Employee Service Agreement

The name of individual receiving services, hereafter referred to as the "**Individual**," is:

_____ .

The Individual's program, _____ , hereafter referred to as the "**program**," is funded and administered by the Texas Department of Aging and Disability Services (DADS).

The name of the employer, hereafter referred to as "**Employer**" is: _____ .

The Employer is the ☐ Individual, ☐ parent of a minor or ☐ court-appointed guardian of the Individual.

This agreement is between the Employer and _____ hereafter referred to as "**Employee**."

The Employer Agrees:

1. **To give notice to the Employee as soon as possible of any change(s) in the work schedule, the tasks to be performed or the number of hours the Employee will work.**
2. To adhere to all federal, state, and local employment-related laws and regulations.
3. To assume responsibility for:
   a. liability for any negligent acts or omissions by the Employer, his/her Employee(s) and service provider(s), the Designated Representative (if applicable), the Individual or others in the work place; and
   b. managing the risk and liability of any incidence(s) of Employee work-related injury/injuries or illnesses.
4. To provide orientation and training to the Employee of tasks and activities to be performed.
5. To provide the Employee with written notice of compensation for services delivered.

The Employee Agrees:

1. I, _____ the Employee, am willing and able to perform the tasks as outlined by, and at the direction of, the Employer, the Individual or the Designated Representative, if applicable.
2. To provide information and documents to the Employer, as required, to maintain current, up-to-date personnel records. The information and documents include at least changes in address and/or telephone numbers, criminal convictions and evidence of employment status and qualifications.
3. To not use the personal property of the Employer or the Individual without prior approval. The Employee will reimburse the Employer for any expense incurred related to his/her personal use of the personal property.
4. To respect the rights and dignity of the Individual and to follow safety procedures for the benefit of the Individual and the Employee.
5. To notify the Employer as soon as possible when the Employee will be late for work or is not able to work, as well as not report to work when illness or another condition may jeopardize the health and safety of the Individual.

Both the Employer and the Employee Agree:

1. That this document serves as an agreement, not an employment contract.
2. That the Employer employs the Employee. The Employee is not an independent contractor. The Employer controls the training and management, evaluation and firing/termination of the Employee.
3. That the Employee is not barred by relationship to the Individual, Employer or Designated Representative, if applicable, from being an Employee.
4. That a Financial Management Services Agency (FMSA) is responsible for the administration of program funds on behalf of the Employer, including payroll functions.
5. That funds for services to pay the Employee is from public sources, and financial accountability and liability applies to the use of the funds. Both the Employer and the Employee have an individual and joint responsibility to be accountable for the public funds spent through the Consumer Directed Services (CDS) option and understand that submitting false or fraudulent time sheets, submitting a time sheet of an unqualified service provider, submitting a time sheet for tasks other than those approved on the service plan or implementation plan will be reported to the appropriate authorities for investigation and possible prosecution as Medicaid fraud.

6. To provide an accurate accounting of services delivered by the Employee, and to submit accurate time sheets and documentation for reimbursement to the FMSA.
7. To bill only for actual time worked, allowable benefits and CDS-related expenses (billing for services and items not allowed or budgeted results in non-payment by the FMSA).
8. The Employer must not charge any fee to the Employee. The Employee must not make any payment to the Employer related to the Employee's employment. Any corrections to payroll are made by the FMSA.
9. That neither the FMSA or DADS is responsible or liable for any negligent acts, work-related injuries or omissions by the Employer, Individual, Employee, other Employees and service providers and/or the Designated Representative, if applicable.
10. That personal medical and personal information and data about the Individual and the Employee is confidential. This information is not to be discussed, directly or indirectly, with others outside of the work environment at any time, currently or in the future.

Duration and Modification of Service Agreement

1. This service agreement will be in effect as of the date this agreement is signed by the Employer and Employee. This service agreement must not precede the date the Individual is eligible to participate in the program or in CDS
2. This service agreement can be modified by agreement of both parties, unless prohibited by DADS rules or policy, or by applicable state, federal and/or local regulations.
3. This service agreement will terminate when:
   a. the Individual's participation in CDS ends voluntarily or involuntarily;
   b. the individual is no longer eligible for the DADS program or for CDS participation;
   c. the Employee is convicted of a crime or listed on a registry that forbids employment by law;
   d. a relationship change occurs and continued employment is prohibited; or
   e. the Employee fails to maintain and provide documentation of eligibility or qualifications for continued employment.
4. This service agreement may be terminated, without cause, by either party with 14-calendar days written notice. A different time frame may be used if both parties agree in writing.

The following required documents are incorporated by reference:

Document	Date of Signature
DADS Form 1725, Criminal Conviction History and Registry Checks	
DADS Form 1729, Applicant Verification for Employees	
DADS Form 1733, Employer and Employee Acknowledgement of Exemption from Nursing Licensure for Certain Services Delivered through Consumer Directed Services, if applicable	
DADS Form 1734, Applicant and Employer Certification of Relationship for Employment	

Acknowledgement of service agreement, including documents incorporated by reference:

Employer:

Printed Name

Signature

Date

Employee:

Printed Name

Signature

Date

Texas Department of Aging and Disability Services

Consumer Directed Services

Service Provider Agreement

Form 1739
October 2013-E

This agreement is between the **Texas Health and Human Services Commission** (HHSC), the state Medicaid agency; the **Texas Department of Aging and Disability Services** (DADS), the state operating agency; a **Financial Management Services Agency** (FMSA); and a **service provider** providing services to one or more individuals through the Consumer Directed Services (CDS) Option.

The **service provider,** _____ ☐ an individual or

☐ an entity, located at (Address) _____,

_____; Telephone _____ Fax _____

The service provider agrees to:

- provide services, items or goods that are authorized prior to purchase to individuals in home and community support programs in accordance with program rules and policy;
- keep records of purchased services, items and goods in accordance with program rules and policy;
- accept checks from the FMSA as full and complete payment for authorized services, items or goods purchased for individuals served through home and community-based programs;
- neither impose on or accept from individuals any additional charges for the services, items or goods paid for by the check; and
- provide records and other information upon request to the individual, the FMSA, HHSC, DADS or their representative.

The FMSA, HHSC and DADS agree:

- that the FMSA will pay the service provider for services, items or goods provided to the individual in accordance with this agreement and program rules and policy; and
- to allow the service provider to charge the individual for approved upgrades or purchases not authorized or paid for in accordance with this agreement, program rules and policy.

The service provider, FMSA, HHSC and DADS mutually agree that:

- the FMSA Alamo Consumer Direct, LLC, doing business in Austin, TX, provides financial management services (FMS) to the individual receiving services for purchases from the service provider;
- the FMSA is responsible for acquiring the completed agreement and retaining the original on behalf of HHSC and DADS;
- payment from the FMSA will not be issued prior to the receipt of this agreement by the FMSA;
- payment from the FMSA is funded by HHSC and DADS with government funds; and
- the FMSA is not a Texas or federal government agency.

This agreement is effective _____, and terminates when the service provider is no longer providing services to individuals through the FMSA.

Service Provider or Representative* (Print)	Service Provider or Representative* (Signature)	Date

FMSA Representative* (Print)	FMSA Representative* (Signature)	Date

** If the service provider is an entity, a representative from the entity with authorization to negotiate this agreement on behalf of the entity must sign.*

01780

Consumer Directed Services

Occupational Exposure to Bloodborne Pathogens

Universal Precautions

Blood has long been recognized as a potential source of pathogenic microorganisms that may present a risk to individuals who are exposed during the performance of their duties. Universal precautions is the method of control required by the Occupational Safety and Health Administration (OSHA) to protect employees from exposure to all human blood and body fluids. **Universal precautions** refers to a concept of bloodborne disease control, which requires that all human blood and certain human body fluids be treated as if known to be infectious for HIV (the virus that causes AIDS), the Hepatitis B virus and other bloodborne pathogens.

Protective barriers reduce the risk of exposure to blood, body fluids containing visible blood and other fluids to which universal precautions apply. Examples of protective barriers include gloves, gowns, masks and protective eyewear. Universal precautions are intended to supplement rather than replace recommendations for routine infection control, such as hand-washing and using gloves to prevent gross microbial contamination of hands. Universal precautions will be used during the provision of services as applicable and appropriate.

Employee Initials: _____ Date: _____

Hepatitis B

Hepatitis B is a serious infection involving the liver. Hepatitis B virus (HBV) can cause lifelong infection, cirrhosis (scarring) of the liver, liver cancer, liver failure and death. Hepatitis B is spread when blood or body fluids from an infected person enters the body of a person who is not infected. HBV is a major infectious occupational hazard for health care. Any health-care worker may be at risk for HBV exposure depending on the tasks that he or she performs. Workers should be vaccinated if their tasks involve contact with blood or blood-contaminated body fluids.

Employee Initials: _____ Date: _____

Hepatitis B Vaccination

OSHA standards effective June 4, 1992, require that employers make available the Hepatitis B vaccine and vaccination series to all employees who have occupational exposure. The Hepatitis B vaccine is available at no cost to the employee. The cost to provide vaccinations is an administrative expense to the employer and is reimbursable through the consumer's program budget.

The vaccine is administered in a prescribed series of three injections over a six-month period:

Dose 2 is administered 30 days after Dose 1.

Dose 3 is administered five months following Dose 2.

The employee is responsible for requesting from the healthcare provider administering the vaccination additional information specific to the efficiency, safety, benefits, method of administration and potential side effects of the Hepatitis B vaccination.

The employee may elect to **receive** or **decline** the Hepatitis B vaccination.

Employee Initials: _____ Date: _____

Informed Choice Related to Hepatitis B Vaccination

Employee Statement — Check one statement below.

☐ I **agree** to receive the Hepatitis B vaccination and will be reimbursed by my employer within 30 days of presenting a paid receipt for each dose. I understand that I will only be reimbursed for doses received while employed by the employer.

☐ I **agree** to receive the Hepatitis B vaccination and the employer and I have agreed to the following arrangement(s) related to covering the cost of the vaccination:

_____

_____

☐ I **decline** the Hepatitis B vaccination at this time because I have previously received the Hepatitis B vaccination.

☐ I **decline** the Hepatitis B vaccination.

* **I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine at this time. However, I decline the Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.**

Federal Register: 61 FR 5507, February 13, 1996
*OSHA 1910.1030 App A – *Mandatory Declination Statement*

Certification by Employee:

I, _____ , the **employee**, acknowledge and certify that I have received information on occupational exposure to bloodborne pathogens, universal precautions, Hepatitis B and Hepatitis B vaccination. I have been provided the opportunity to ask questions and to seek additional information. I have made my choice (as documented above) related to the Hepatitis B vaccination based on informed choice.

* I may decide in the future to request and accept the vaccination at no charge to me.

Employee:	**Employer:**
Printed Name	Printed Name
Signature	Signature
Date	Date

01765

Employer and Employee Acknowledgement of Exemption from Nursing Licensure for Certain Services Delivered through Consumer Directed Services

The employer in the Consumer Directed Services (CDS) option is the individual receiving services or the individual's legally authorized representative (LAR). The employer may choose to have certain nursing services provided by an unlicensed person employed in the CDS option. The individual or the LAR must be capable of training the unlicensed employee in the performance of the task(s) and train and supervise the employee performing the task(s). The employee who delivers the service must not have been denied a license under Chapter 301, Occupations Code or have a license under Chapter 301, Occupations Code that is revoked or suspended.

When the employee is trained and supervised by the LAR, the employee delivers the service when the LAR is present or is immediately accessible to the employee. If the employee will perform the service when the LAR is not present, the LAR must observe the person performing the service at least once to assure the LAR that the employee performs the service correctly.

Government Code, Title 4, Subtitle I, Chapter 531, Subchapter B, §531.051, Consumer Direction for certain services for persons with disabilities, states the employee must not perform those service that are expressly prohibited from delegation by the **Texas Board of Nursing (Texas Administrative Code, *§225.12,Tasks Prohibited From Delegation), including:***

(1) physical, psychological, and social assessment, which requires professional nursing judgment, intervention, referral, or follow-up;

(2) formulation of the nursing care plan and evaluation of the client's response to the care rendered;

(3) specific tasks involved in the implementation of the care plan that require professional nursing judgment or intervention;

(4) the responsibility and accountability for client or client's responsible adult health teaching and health counseling which promotes client or client's responsible adult education and involves the client's responsible adult in accomplishing health goals; and

(5) the following tasks related to medication administration:

(A) calculation of any medication doses except for measuring a prescribed amount of liquid medication and breaking a tablet for administration, provided the RN has calculated the dose;

(B) administration of medications by an injectable route except for subcutaneous injectable insulin as permitted by §225.11(b) of this title (relating to Delegation of Administration of Medications From Pill Reminder Container and Administration of Insulin);

(C) administration of medications by way of a tube inserted in a cavity of the body except as permitted by §225.10(10) of this title (relating to Task That May Be Delegated);

(D) responsibility for receiving or requesting verbal or telephone orders from a physician, dentist, or podiatrist; and

(E) administration of the initial dose of a medication that has not been previously administered to the client.

Examples of services that may be exempt from nursing licensure and can be included in the Individual Service Plan for the CDS option if all the qualifying conditions are met include:

(1) bathing, including feminine hygiene;

(2) grooming, including nail care, except for consumers with medical conditions like diabetes;

(3) feeding, including feeding through a permanently placed feeding tube;

(4) routine skin care, including decubitus Stage 1;

(5) transferring, ambulation or positioning;

(6) exercising and range of motion; and digital stimulation;

(7) the administering of a bowel and bladder program, including suppositories, catheterization, enemas, manual evacuation and digital stimulation;

(8) administering oral medications that are normally self-administered, including administration through a gastrostomy tube; and

(9) non-invasive and non-sterile treatments with low risk of infection.

Employee:

Printed Name

Signature

Date

Employer:

Printed Name

Signature

Date

Certification - We, the employee and the employer, certify that the employer has trained and supervised the employee in the delivery of the services listed below. We understand that those services that cannot be provided by anybody except a licensed nurse, according to Texas Administrative Code, §225.12, **Tasks Prohibited** From **Delegation**, must not be provided by the employee. Checked tasks indicate the employee may perform those tasks when the LAR is not present to supervise.

☐ _____	☐ _____	☐ _____
☐ _____	☐ _____	☐ _____
☐ _____	☐ _____	☐ _____
☐ _____	☐ _____	☐ _____
☐ _____	☐ _____	☐ _____

Employee:

Signature

Date

Employer:

Signature

Date

TEXAS Department of Aging and Disability Services

Form 1732
October 2015-E

Consumer Directed Services

Management and Training of Service Provider

Service Provider Name (Employee)	First Day of Work	Annual Evaluation Due Date
Name of Individual Receiving Services	Program	Services Delivered
Name of Consumer Directed Services Employer		

I. Purpose

☐ Initial Orientation ☐ Ongoing Training

☐ Evaluation

☐ 30-Day ☐ 3-Month ☐ 6-Month ☐ Annual ☐ Other _____

☐ Supervision

☐ Verbal Warning: ☐ First ☐ Second ☐ Third ☐ Other _____

☐ Written Warning: ☐ First ☐ Second ☐ Third ☐ Other _____

☐ Conflict Resolution ☐ Other _____

II. Documentation of Topics Covered at Initial Orientation or Ongoing Training: *(Initial orientation must include training related to the individual's condition and the tasks the service provider will perform as well as any required training described in an applicable addendum to Form 1735, Employer and Financial Management Services Agency Service Agreement.)*

III. Documentation of Abuse, Neglect and Exploitation Training: *(Initial orientation must include training on acts that constitute abuse, neglect or exploitation of an individual.)*

IV. Evaluation/Performance Review:

V. Corrective Action Plan (if applicable):

Date for follow-up on corrective action plan: _____

VI. Service Provider Comments:

_____ Signature of Service Provider

_____ Date

This document has been reviewed with the service provider listed above.

_____ Signature of Employer

_____ Date

_____ Signature of Witness

_____ Date

01770

Date sent to FMSA: _____

Date received by FMSA: _____

TEXAS
Department of Aging and Disability Services

Form 1732-EMR
October 2014-E

Consumer Directed Services (CDS)

Management and Training of Service Provider Addendum

Employee Misconduct Registry Notification

Employee Name: _____ Date of Hire: _____

Position: _____ Employer Name: _____

Long-term care employers, including Consumer Directed Service (CDS) employers, in Texas are required under 40, Texas Administrative Code (TAC), Part 1, Chapter 93, and Texas Health and Safety Code, Chapter 253 and to inform new unlicensed employees about the Employee Misconduct Registry (EMR).

The purpose of the EMR is to ensure that an unlicensed person who commits an act of abuse, neglect, or exploitation that meets the definition of reportable conduct against a consumer receiving services from a facility or against an individual receiving services in the CDS option is not employed in the Department of Aging and Disability Services (DADS)-regulated facilities and in certain programs including CDS. The EMR applies to employees who provide personal care services, treatment, or any other personal services and are not licensed by the state to perform the services.

A person listed in the EMR is not employable by a facility, agency, or individual employer. The EMR is governed by 40, Texas Administrative Code, Part 1, Chapter 93, and Texas Health and Safety Code, Chapter 253. Regarding a CDS employee, the Department of Family and Protective Services (DFPS) conducts EMR investigations and makes findings in accordance with DFPS rules at 40 TAC, Part 19, Chaper 711, Subchapter O.

Rules regarding the EMR can be found on the Secretary of State's website at:
http://info.sos.state.tx.us/pls/pub/readtac$ext.ViewTAC?tac_view=4&ti=40&pt=1&ch=93&rl=Y .

Questions may be directed to DADS Professional Credentialing Enforcement Unit at 512-438-5495.

The employer must provide the employee with a copy of this notice.

I, _____, have read and understand the above notification.

_____ _____
Signature Date

TEXAS Department of Aging and Disability Services

Form 1747
September 2014-E

Consumer Directed Services (CDS) Option

Acknowledgement of Nursing Requirements

A nurse hired by a CDS employer must complete this form before providing nursing services. Texas Occupations Code, Title 3, Subtitle E, Chapter 301, §301.002 defines professional nursing as services provided by registered nurses (RNs) and licensed vocational nurses (LVNs). The Texas Board of Nursing (BON) rules at Texas Administrative Code, Title 22, Part 11, Chapter 217, §217.11 require nurses to know and conform to the Texas Nursing Practice Act and the BON's rules and regulations, as well as all federal, state or local laws, rules or regulations affecting the nurse's current area of nursing practice.

Requirements — Community Living Assistance and Support Services (CLASS), Home and Community-based Services (HCS), and Texas Home Living (TxHmL)

A nurse hired by the CDS employer must have the following documentation in the home:

- Nursing assessment and nursing plan of care developed by the CDS RN
- Doctor's orders for any skilled care, tasks, medications and treatments, including a signed plan of care
- Nursing notes as required by the BON to document the individual's status, including signs and symptoms, nursing care rendered, and physician, dentist or podiatrist orders
- Documentation of medication administration or treatment, nursing interventions completed according to the practitioner's orders, and nursing assessments completed at the beginning of each shift

Certification by nurse hired by a CLASS, HCS or TxHmL CDS employer:

I, _____ (print name), acknowledge and certify that I have received information regarding documents that must be obtained, completed and kept in the home of the individual.

_____ _____
Nurse's Signature Date

Requirements — Medically Dependent Children Program (MDCP)

A nurse hired by the CDS employer must have the following documentation in the home:

- Doctor's orders for any skilled care, tasks, medications and treatments, signed within the preceding 12 months (if applicable)
- Nursing notes as required by the BON to document the individual's status, including signs and symptoms, medication administration or treatment, nursing interventions completed according to the practitioner's orders, and nursing assessments completed at the beginning of each shift

Certification by nurse hired by an MDCP CDS employer:

I, _____ (print name), acknowledge and certify that I have received information regarding documents that must be obtained, completed and kept in the home of the individual.

_____ _____
Nurse's Signature Date

TEXAS Department of Aging and Disability Services

Form 1747-LVN
September 2014-E

Consumer Directed Services (CDS) Option

Licensed Vocational Nurse (LVN) Supervision

An LVN must complete this form if hired by a CDS employer:

- to provide skilled nursing in the following programs:
  - Community Living Assistance and Support Services (CLASS),
  - Home and Community-based Services (HCS), or
  - Texas Home Living (TxHmL); or
- to provide respite or flexible family support services in the Medically Dependent Children Program (MDCP).

The LVN must complete this form before providing nursing services.

Texas Occupations Code, Title 3, Subtitle E, Chapter 301, §301.353 requires an LVN to practice under the supervision of a registered nurse (RN), advanced practice registered nurse (APRN), physician or a physician's assistant. This requirement is further explained in the Texas Board of Nursing (BON) rules at Texas Administrative Code (TAC), Title 22, Part 11, Chapter 217, §217.11 and the BON Interpretive Guidelines. The BON rules at 22 TAC §217.11 require nurses to know and conform to the Texas Nursing Practice Act and the BON's rules and regulations, as well as all federal, state or local laws, rules or regulations affecting the nurse's current area of nursing practice.

_____ Printed Name of LVN

_____ Individual or Employer's Name/Program

I, the LVN named above, meet this requirement.

I am supervised by: ☐ **Licensed Physician** ☐ **RN** ☐ **APRN** ☐ **Physician's Assistant**

Supervisor's Name: _____ Supervisor's License Number: _____

Supervisor's Address (Street, City, State, ZIP Code): _____

Supervisor's Area Code and Telephone Number: _____

_____ Signature — LVN

_____ Date

_____ Signature — Physician, RN, APRN or Physician's Assistant

_____ Date

_____ License Number

_____ Signature — Financial Management Services Agency (FMSA)

_____ Date Received

The CDS employer must send a copy of the completed Form 1747-LVN to the FMSA before the LVN can deliver nursing services.

The CDS employer must maintain a copy of the completed Form 1747-LVN in the home of the individual.

04208

Dear Caregiver,

The following is information regarding the new Affordable Care Act related Health Insurance Marketplace. Key parts of the health care law took effect in 2014; as a result, there is a new way to buy health insurance: **the Health Insurance Marketplace**.

The annual Open Enrollment Period for the Health Insurance Marketplace is usually scheduled to begin on November 15th each year for coverage starting January 1st of each year. This is the ***one*** time of year where you can apply for private health insurance coverage through the marketplace. To confirm Open Enrollment Period dates for this year, please contact www.HealthCare.gov. ***NOTE****: You can apply for Medicaid or CHIP (Children's Health Insurance Program) any time of year.*

To assist you as you evaluate options for you and your family, this information sheet provides some basic information about the new Marketplace.

If you have any questions about healthcare reform or the online application process, please contact the Health Insurance Marketplace Call Center at 1-800-318-2596 or visit www.HealthCare.gov.

Thank you,
Human Resources Department
for Consumer Direct and the Consumer Direct Family of Companies

Health Care Marketplace

PART A: General Information

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit [1].

1 An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

How Can I Get More Information?

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please call 1-800-318-2596 or visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

In the Texas consumer-directed service option, the Client is the employer of record and the managing employer. **Health insurance is not being offered by your employer.** You and your family may be able to obtain health coverage through the Marketplace, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.

Medicaid Coverage

In all states, Medicaid provides health coverage for some low-income people, families and children, pregnant women, the elderly, and people with disabilities. Texas 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 Texas 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 Texas:

- Contact your state Medicaid agency online at www.yourtexasbenefits.com or call their Customer Service Center at 1-800-252-8263.

- Fill out an application for coverage in the Health Insurance Marketplace at www.healthcare.gov/marketplace.

If you live in Texas, you'll use www.HealthCare.gov to apply and enroll in health coverage. For more information on resources available in your state, visit www.yourtexasbenefits.com

TEXAS FMSA
OKAY TO WORK

Employee Name (please print) _____

Consumer Name (please print) _____

APPROVAL TO BEGIN WORK:

Thank you for your interest in working as an Employee in the Texas Consumer-Directed Services program. Consumer Direct has reviewed and approved your enrollment paperwork and has confirmed that your criminal conviction history and registry checks comply with requirements. We are pleased to authorize you to start work.

This notice authorizes you to begin working on: _____

PROGRAM REQUIREMENTS - Please remember that as an Employee you are responsible for:

- Working on the tasks approved on your Work Schedule and Assigned Tasks (Form 1731) and working within the hours approved by the Case Manager.
- Accurately document the hours that you work on the timesheet.
- Notifying the Consumer Direct office of changes in your information (see Status Change Form)
- Maintaining your automobile insurance if driving the Consumer is part of your tasks.
- Remain in compliance with the Texas Department of Aging and Disability Services' regulations concerning maintaining professional standards or any program specific training requirements.
- Submit timesheets postmarked, emailed or faxed by Monday midnight each week.

If an Employee does not work for 6 months they will become inactive. Once inactive, employees must re-apply and be issued another Okay to Work form to be eligible to work a scheduled shift. **This is especially important to keep in mind for backup Employees.**

Please contact the office if you have any questions about the application process or an Employee's employment status. ***Thank You!***

Phone: 512-420-0832 Toll Free: 1-877-903-0832

_____ _____

Consumer Direct Representative Signature Date

_____

Printed Name

02047

Rev. 09/29/2013