

Employee Contact Information

Name: _____
First Middle Last

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

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

Phone: Home _____ Work _____ Cell _____

Email: _____

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

Emergency Contact: _____
Name Phone Relationship

Age and Education Requirements

Are you at least 18 years old? ☐ Yes ☐ No

RN or LVN license is mandatory for Skilled Nursing Services. Licenses must be verified to be active and in good standing.

Criminal Background

Have you ever been convicted of a felony? ☐ 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

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.

Neither the acceptance of this application nor entry into any type of employment relationship or employment agreement with a consumer or their legally authorized representative for the consideration of employment shall serve to create an actual or implied contract of employment with Consumer Direct Care Network Texas (CDCN).

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

Signature of Applicant: _____ Date: _____



Employee Name	Estimated Start Date	Consumer Name

Please complete the forms in the lists below including this one. Consumer Direct Care Network Texas (CDCN) 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 CDCN and an “Okay to Work” approval form has been issued.

Payroll Related Forms (required for all new employees)

1. ☐ Employee Data Form
2. ☐ New Employee Checklist (this form)
3. ☐ Employment Relationship Disclosure
4. ☐ I-9 Form – Employment Eligibility Verification
Additional I-9 instructions are available on the CDCN Texas Website under the Resources tab
5. ☐ W-4 Form – Employee’s Withholding Allowance Certificate
6. ☐ Pay Selection Form (attachment may be required, see form instructions)
7. ☐ Wage and Benefits Plan (Form 1730)
Note: The Employer must use the most recent Budget to complete this form correctly
8. ☐ Employee Health Questionnaire

Texas Health and Human Services Forms (required for all new employees; some exceptions)

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
7. ☐ Employee Work Schedule and Assigned Tasks (Form 1731)
8. ☐ Employer and Employee Service Agreement (Form 1737)
9. ☐ Service Provider Agreement (Form 1739)
10. ☐ Occupational Exposure to Bloodborne Pathogens (Form 1727)
11. ☐ Exemption from Nursing Licensure (Form 1733, if applicable)
12. ☐ Management and Training of Service Provider (Form 1732)
13. ☐ Employee Misconduct Registry Notification (Form 1732-EMR)
14. ☐ Acknowledgement of Nursing Requirements (Form 1747, if applicable)
15. ☐ Licensed Vocational Nurse Supervision (Form 1747-LVN, if applicable)



Licensing/Training Verifications (as applicable, attach photocopy of documentation)

1. ☐ CPR certification. **Expiration date:** _____ (if applicable, only required for CLASS, DBMD, and MDCP waivers. CLASS and DBMD must be a hands-on course.
2. ☐ Driver's License (if applicable, only if transporting consumer)
3. ☐ Minimum Auto Insurance (if applicable, only if transporting consumer)
4. ☐ Professional licenses (if applicable, e.g. RN, LVN)

Distribution of training booklets (located in the Employer Binder)

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

Please review and verify that the above forms are complete and readable before submitting to CDCN. Illegible or missing forms will result in a delayed start date.



Employee Name	Consumer Name	Employer of Record (EOR) Name

Employee-Employer Relationship Determination

Background. Employees providing domestic services such as personal care may be exempt from some payroll taxes. This is based on the employee's age and relationship to the Employer of Record (EOR). The EOR is listed above and is either the Consumer or their designee. Consumer Direct Care Network (CDCN) will apply any exemptions based on the relationships identified below.

Instructions to Employee. CHOOSE ONLY ONE DESCRIPTION BELOW. Check the box that best describes your relationship to the Employer of Record (EOR) named above.

☐ **Child of EOR. I am less than 21 years old.** The EOR is my parent. I am the child (including adoptive child) of the EOR. I am also less than 21 years old.

☐ **Child of EOR. I am 21 years old or older.** The EOR is my parent. I am the child (including adoptive child) of the EOR. I am also 21 years old or older.

☐ **Spouse of EOR.** The EOR is my husband or wife.

☐ **Parent of EOR.** The EOR is my son or daughter (including adoptive child). Please answer additional questions below.

☐ Yes ☐ No The EOR (my son or daughter) has a child or step child that lives in the home.

☐ Yes ☐ No The EOR is (1) a widow or widower; (2) divorced; or (3) married and lives with a spouse but the spouse can't care for their child or step child due to a mental or physical condition. The spouse is unable to provide care for at least 4 straight weeks in 3 months.

☐ Yes ☐ No The EOR's child or stepchild is less than 18 years old or needs personal care from an adult. Care is needed for at least 4 straight weeks in 3 months due to a mental or physical condition.

☐ **Mother-in-Law/Father-in-Law of EOR.** The EOR is my son-in-law or daughter-in-law.

☐ **Relative not described above.** The EOR is my aunt, uncle, sibling, grandparent, grandchild or other relative not specifically listed above.

Please describe the relationship: _____.

☐ **Not related to the EOR.** I am not related by blood, marriage or adoption to the EOR.





EMPLOYEE-EMPLOYER RELATIONSHIP DISCLOSURE

Important Notes:

- If employee and EOR qualify for tax exemptions, they must be taken. Exemptions cannot be waived.
- If employee's earnings are exempt from these taxes, they may not qualify for related benefits. An example is unemployment insurance.
- Exemptions are based on the relationship between the employee and EOR. The Consumer may or may not be the EOR.

Employee-Consumer Live-in Determination

Background. Employees that live under the same roof as the Consumer receiving services may be exempt from federal minimum wage and overtime regulations.

Instructions to Employee. Do you live under the same roof as the Consumer receiving services? Check Yes or No below.

☐ Yes ☐ No Employee resides at the same residence as the Consumer receiving services.

Acknowledgements

Employee and EOR attest the relationships defined above are accurate. This may show that the employee and EOR are exempt from some taxes. Explanations of exemptions are provided below. If these relationships change, employee must notify CDCN within 5 days. If CDCN is not notified of changes, employee may have to pay back money that should have been withheld from pay.

If Employee checked "Yes" above indicating they live at the same residence as the Consumer receiving services, they understand and declare they are not subject to overtime requirements of the Fair Labor Standards Act for Domestic Care Workers (Title 29, Subtitle B, Chapter V, Subchapter A, Part 552).

Employee Signature

Date

Employer of Record Signature

Date

Explanation of Employee Exemptions

Relationship to EIN Holder (Employer of Record)	FICA	FUTA	SUTA
Spouse	Exempt	Exempt	Exempt
Parent (including adoptive and step parent)	*Exempt **Subject to Tax	Exempt	Exempt
Mother-in-Law/Father-in-Law	Subject to Tax	Subject to Tax	Exempt
Child age 18-20	Exempt	Exempt	Exempt
All other Relationships	Subject to Tax	Subject to Tax	Subject to Tax
No Relationship	Subject to Tax	Subject to Tax	Subject to Tax

*Exempt if answered "No" to any of the 3 questions on page 1 regarding care for the EOR's child.

**Subject to Tax if answered "Yes" to all 3 questions on page 1 regarding care for the EOR's child.



Instructions for Completing Form I-9 Section 1

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

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

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

Employee (steps 1-9)

- ① Print your full legal name: Last, First and Middle Initial. Provide any other names used, such as maiden name. Enter "N/A" if you have never had another name.
- ② Print your physical address. Entering a PO Box is not allowed. Enter "N/A" if you have no apartment number.
- ③ Print your date of birth (mm/dd/yyyy).
- ④ Print your Social Security Number.
- ⑤ Print your email address or print "N/A" if you choose to not provide it.
- ⑥ Print your telephone number or print "N/A" if you choose to not provide it.
- ⑦ Check the one box that best describes your citizenship or immigration status in the United States.
- ⑧ Sign and print the date you completed the form. **No later than first day of work for pay.**
- ⑨ Check the box that indicates whether or not you were assisted by a preparer or translator.

Employment Eligibility Verification		USCIS Form I-9 OMB No. 1615-0047 Expires 08/31/2019	
Department of Homeland Security U.S. Citizenship and Immigration Services			
▶ START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.			
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.			
Section 1. Employee Information and Attestation (Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)			
Last Name (Family Name) ① Doe		First Name (Given Name) Jane	Middle Initial Q
Other Last Names Used (if any) N/A			
Address (Street Number and Name) ② 123 Main St.		Apt. Number N/A	City or Town Anytown
State TX		ZIP Code 78000	
Date of Birth (mm/dd/yyyy) ③ 03/13/1964	U.S. Social Security Number ④ 123-45-6789	Employee's E-mail Address ⑤ employee@email.com	Employee's Telephone Number ⑥ 555-123-4567
I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.			
I attest, under penalty of perjury, that I am (check one of the following boxes):			
<input checked="" type="checkbox"/> 1. A citizen of the United States			
<input type="checkbox"/> 2. A noncitizen national of the United States (See instructions)			
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number):			
<input type="checkbox"/> 4. An alien authorized to work until (expiration date of approval mm/dd/yyyy) Some aliens may write "N/A" in the expiration date field. (See instructions)			
Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.			
1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____			
Signature of Employee ⑧ Jane Doe		Today's Date (mm/dd/yyyy) 02/05/2017	
Preparer and/or Translator Certification (check one):			
<input checked="" type="checkbox"/> I did not use a preparer or translator. <input type="checkbox"/> A preparer(s) and/or translator(s) assisted the employee in completing Section 1. (Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)			
I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.			
Signature of Preparer or Translator		Today's Date (mm/dd/yyyy)	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State ZIP Code
Employer Completes Next Page			
Form I-9 11/14/2016 N			
Page 1 of 3			

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

Instructions for Completing Form I-9 Section 2

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

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

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

Employer (steps 1-10)

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

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

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

one document from List A

OR

one from List B and one from List C

Only accept unexpired, original documents (no photocopies).

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

⑤ Sign the form.

⑥ Print the date you signed the form.

Must be completed and signed within 3 days of employee's first day of work.

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

⑧ Print your last then first name.

⑨ Print your first and last name.

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

Section 2. Employer or Authorized Representative Review and Verification				
<small>(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")</small>				
Employee Info from Section 1		Last Name (Family Name)	First Name (Given Name)	M.I.
		① Doe	Jane	
List A Identity and Employment Authorization		OR	List B Identity	AND List C Employment Authorization
Document Title	③ Driver's License	Document Title	Social Security Card	
Issuing Authority	Texas Dept. of Public Safety	Issuing Authority	SSA	
Document Number	0123456789abcde	Document Number	123-45-6789	
Expiration Date (if any)(mm/dd/yyyy)	08/17/2020	Expiration Date (if any)(mm/dd/yyyy)	N/A	
Document Title	Additional Information			
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				
Document Title	OR Code - Sections 2 & 3 Do Not Write In This Space			
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				
Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.				
The employee's first day of employment (mm/dd/yyyy): ④ 02/05/2017 (See instructions for exemptions)				
Signature of Employer or Authorized Representative		Today's Date(mm/dd/yyyy)	Title of Employer or Authorized Representative	
⑤ Ronald Smith		⑥ 02/05/2017	⑦ Employer	
Last Name of Employer or Authorized Representative		First Name of Employer or Authorized Representative	Employer's Business or Organization Name	
⑧ Smith		Ronald	⑨ Ronald Smith	
Employer's Business or Organization Address (Street Number and Name)		City or Town	State	ZIP Code
⑩ 500 Fictional St.		Anytown	TX	78000

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

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



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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

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

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

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

Last Name (Family Name)		First Name (Given Name)		Middle Initial	Other Last Names Used (if any)	
Address (Street Number and Name)		Apt. Number	City or Town		State	ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number [][][] - [][] - [][][][]		Employee's E-mail Address		Employee's Telephone Number	

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

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

<input type="checkbox"/> 1. A citizen of the United States	
<input type="checkbox"/> 2. A noncitizen national of the United States <i>(See instructions)</i>	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ Some aliens may write "N/A" in the expiration date field. <i>(See instructions)</i>	
<p><i>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</i></p> <p>1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____</p>	<p>QR Code - Section 1 Do Not Write In This Space</p>

Signature of Employee	Today's Date (mm/dd/yyyy)
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Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

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



Employer Completes Next Page



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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

Section 2. Employer or Authorized Representative Review and Verification

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

Employee Info from Section 1	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date (if any) (mm/dd/yyyy)		Expiration Date (if any) (mm/dd/yyyy)		Expiration Date (if any) (mm/dd/yyyy)
Document Title		<div>Additional Information</div> <div>QR Code - Sections 2 & 3 Do Not Write In This Space</div>		
Issuing Authority				
Document Number				
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)				

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

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

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

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

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

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

Document Title	Document Number	Expiration Date (if any) (mm/dd/yyyy)
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I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Name of Employer or Authorized Representative
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LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

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

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

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

Refer to the instructions for more information about acceptable receipts.



Employee's Withholding Certificate

OMB No. 1545-0074

- **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
 ► **Give Form W-4 to your employer.**
 ► **Your withholding is subject to review by the IRS.**

2020**Step 1:
Enter
Personal
Information**

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

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

**Step 2:
Multiple Jobs
or Spouse
Works**

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

Do **only one** of the following.

- (a) Use the estimator at www.irs.gov/W4App for most accurate withholding for this step (and Steps 3–4); **or**
 (b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**
 (c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld ► ☐

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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

**Step 3:
Claim
Dependents**

If your income will be \$200,000 or less (\$400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by \$2,000 ► \$ _____

Multiply the number of other dependents by \$500 ► \$ _____

Add the amounts above and enter the total here **3** \$ _____

**Step 4
(optional):
Other
Adjustments**

(a) **Other income (not from jobs).** If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income **4(a)** \$ _____

(b) **Deductions.** If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here **4(b)** \$ _____

(c) **Extra withholding.** Enter any additional tax you want withheld each pay period . . . **4(c)** \$ _____

**Step 5:
Sign
Here**

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

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

**Employers
Only**

Employer's name and address	First date of employment	Employer identification number (EIN)
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02227



General Instructions

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2020 if you meet both of the following conditions: you had no federal income tax liability in 2019 **and** you expect to have no federal income tax liability in 2020. You had no federal income tax liability in 2019 if (1) your total tax on line 16 on your 2019 Form 1040 or 1040-SR is zero (or less than the sum of lines 18a, 18b, and 18c), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2020 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1a, 1b, and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2021.

Your privacy. If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

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

1. Expect to work only part of the year;
2. Have dividend or capital gain income, or are subject to additional taxes, such as the additional Medicare tax;
3. Have self-employment income (see below); or
4. Prefer the most accurate withholding for multiple job situations.

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

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

Specific Instructions

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

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

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

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



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

Step 3. Step 3 of Form W-4 provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2020 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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



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

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

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

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

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

- 1** Enter an estimate of your 2020 itemized deductions (from Schedule A (Form 1040 or 1040-SR)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 10% of your income **1** \$ _____
- 2** Enter: $\left\{ \begin{array}{l} \bullet \$24,800 \text{ if you're married filing jointly or qualifying widow(er)} \\ \bullet \$18,650 \text{ if you're head of household} \\ \bullet \$12,400 \text{ if you're single or married filing separately} \end{array} \right\}$ **2** \$ _____
- 3** If line 1 is greater than line 2, subtract line 2 from line 1. If line 2 is greater than line 1, enter "-0-" . . . **3** \$ _____
- 4** Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Schedule 1 (Form 1040 or 1040-SR)). See Pub. 505 for more information . . . **4** \$ _____
- 5 Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 **5** \$ _____

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and 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



Married Filing Jointly or Qualifying Widow(er)

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$220	\$850	\$900	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,210	\$1,870	\$1,870
\$10,000 - 19,999	220	1,220	1,900	2,100	2,220	2,220	2,220	2,220	2,410	3,410	4,070	4,070
\$20,000 - 29,999	850	1,900	2,730	2,930	3,050	3,050	3,050	3,240	4,240	5,240	5,900	5,900
\$30,000 - 39,999	900	2,100	2,930	3,130	3,250	3,250	3,440	4,440	5,440	6,440	7,100	7,100
\$40,000 - 49,999	1,020	2,220	3,050	3,250	3,370	3,570	4,570	5,570	6,570	7,570	8,220	8,220
\$50,000 - 59,999	1,020	2,220	3,050	3,250	3,570	4,570	5,570	6,570	7,570	8,570	9,220	9,220
\$60,000 - 69,999	1,020	2,220	3,050	3,440	4,570	5,570	6,570	7,570	8,570	9,570	10,220	10,220
\$70,000 - 79,999	1,020	2,220	3,240	4,440	5,570	6,570	7,570	8,570	9,570	10,570	11,220	11,240
\$80,000 - 99,999	1,060	3,260	5,090	6,290	7,420	8,420	9,420	10,420	11,420	12,420	13,260	13,460
\$100,000 - 149,999	1,870	4,070	5,900	7,100	8,220	9,320	10,520	11,720	12,920	14,120	14,980	15,180
\$150,000 - 239,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,190	16,050	16,250
\$240,000 - 259,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,520	17,170	18,170
\$260,000 - 279,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	13,120	15,120	17,120	18,770	19,770
\$280,000 - 299,999	2,040	4,440	6,470	7,870	9,190	10,720	12,720	14,720	16,720	18,720	20,370	21,370
\$300,000 - 319,999	2,040	4,440	6,470	8,200	10,320	12,320	14,320	16,320	18,320	20,320	21,970	22,970
\$320,000 - 364,999	2,720	5,920	8,750	10,950	13,070	15,070	17,070	19,070	21,290	23,590	25,540	26,840
\$365,000 - 524,999	2,970	6,470	9,600	12,100	14,530	16,830	19,130	21,430	23,730	26,030	27,980	29,280
\$525,000 and over	3,140	6,840	10,170	12,870	15,500	18,000	20,500	23,000	25,500	28,000	30,150	31,650

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$460	\$940	\$1,020	\$1,020	\$1,470	\$1,870	\$1,870	\$1,870	\$1,870	\$2,040	\$2,040	\$2,040
\$10,000 - 19,999	940	1,530	1,610	2,060	3,060	3,460	3,460	3,460	3,640	3,830	3,830	3,830
\$20,000 - 29,999	1,020	1,610	2,130	3,130	4,130	4,540	4,540	4,720	4,920	5,110	5,110	5,110
\$30,000 - 39,999	1,020	2,060	3,130	4,130	5,130	5,540	5,720	5,920	6,120	6,310	6,310	6,310
\$40,000 - 59,999	1,870	3,460	4,540	5,540	6,690	7,290	7,490	7,690	7,890	8,080	8,080	8,080
\$60,000 - 79,999	1,870	3,460	4,690	5,890	7,090	7,690	7,890	8,090	8,290	8,480	9,260	10,060
\$80,000 - 99,999	2,020	3,810	5,090	6,290	7,490	8,090	8,290	8,490	9,470	10,460	11,260	12,060
\$100,000 - 124,999	2,040	3,830	5,110	6,310	7,510	8,430	9,430	10,430	11,430	12,420	13,520	14,620
\$125,000 - 149,999	2,040	3,830	5,110	7,030	9,030	10,430	11,430	12,580	13,880	15,170	16,270	17,370
\$150,000 - 174,999	2,360	4,950	7,030	9,030	11,030	12,730	14,030	15,330	16,630	17,920	19,020	20,120
\$175,000 - 199,999	2,720	5,310	7,540	9,840	12,140	13,840	15,140	16,440	17,740	19,030	20,130	21,230
\$200,000 - 249,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
\$250,000 - 399,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
\$400,000 - 449,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,450	19,940	21,240	22,540
\$450,000 and over	3,140	6,230	8,810	11,310	13,810	15,710	17,210	18,710	20,210	21,700	23,000	24,300

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$830	\$930	\$1,020	\$1,020	\$1,020	\$1,480	\$1,870	\$1,870	\$1,930	\$2,040	\$2,040
\$10,000 - 19,999	830	1,920	2,130	2,220	2,220	2,680	3,680	4,070	4,130	4,330	4,440	4,440
\$20,000 - 29,999	930	2,130	2,350	2,430	2,900	3,900	4,900	5,340	5,540	5,740	5,850	5,850
\$30,000 - 39,999	1,020	2,220	2,430	2,980	3,980	4,980	6,040	6,630	6,830	7,030	7,140	7,140
\$40,000 - 59,999	1,020	2,530	3,750	4,830	5,860	7,060	8,260	8,850	9,050	9,250	9,360	9,360
\$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,780	10,980	11,180	11,580	12,380
\$80,000 - 99,999	1,900	4,300	5,710	7,000	8,200	9,400	10,600	11,180	11,670	12,670	13,580	14,380
\$100,000 - 124,999	2,040	4,440	5,850	7,140	8,340	9,540	11,360	12,750	13,750	14,750	15,770	16,870
\$125,000 - 149,999	2,040	4,440	5,850	7,360	9,360	11,360	13,360	14,750	16,010	17,310	18,520	19,620
\$150,000 - 174,999	2,040	5,060	7,280	9,360	11,360	13,480	15,780	17,460	18,760	20,060	21,270	22,370
\$175,000 - 199,999	2,720	5,920	8,130	10,480	12,780	15,080	17,380	19,070	20,370	21,670	22,880	23,980
\$200,000 - 249,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
\$250,000 - 349,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
\$350,000 - 449,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,900	25,200
\$450,000 and over	3,140	6,840	9,560	12,140	14,640	17,140	19,640	21,530	23,030	24,530	25,940	27,240





PAY SELECTION FORM

Employee Name: _____
(please print)

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

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

- ☐ **US Bank Focus Card Direct Deposit** – I authorize CDCN to issue me a US Bank Focus Card using my Social Security Number and other identification on file and to initiate payroll deposits to my card account. You should receive your debit card in approximately two weeks.
- ☐ **Bank or Credit Union Direct Deposit** – I authorize CDCN to initiate payroll deposits to
(name of bank or financial institution): _____
- Account Type (check one): ☐ Checking ☐ Savings

For Checking Accounts:

Attach (tape) a voided check here
Do not attach a deposit slip.

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

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

Signature

Date



With the
U.S. Bank Focus Card™ ...

life just got easy.



The U.S. Bank Focus Card

is a Visa® or Mastercard® prepaid debit card and a convenient alternative to receiving paper checks.



SAFE

- Your pay will be **deposited onto a prepaid Visa or Mastercard** each payday.
- **Funds are protected**¹ if lost or stolen.
- Keep track of purchases and loads with **text**² and **email alerts**.



CONVENIENT

- Your card can be **used anywhere Visa and Mastercard debit cards are accepted worldwide**.
- **Access to cash when you need it most** with over thousands of in-network ATMs nationwide.



PORTABLE

- Your card can **stay with you for life**.
- Add tax refunds, pay from a second employer, and even cash deposits!

Visit prepaidmaterials.com/usbankfocus

to learn more about the features and benefits of the U.S. Bank Focus Card.

¹ You are generally protected from all liability for unauthorized transactions with Zero Liability. You must call the number on the back of your Card immediately to report any unauthorized use. Certain conditions and limitations may apply. See your Cardholder Agreement for details.

² For text messages, standard messaging charges apply through your mobile carrier and message frequency depends on account settings.

The Focus Card is issued by U.S. Bank National Association pursuant to a license from Visa U.S.A. Inc. or Mastercard International. Mastercard is a registered trademark and the circles design is a trademark of Mastercard International Incorporated. ©2019 U.S. Bank. Member FDIC.



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 Networks⁵

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



Text and Email Alerts⁴

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



Mobile Banking App⁴

Quickly see your account balance and transaction history.



Track Spending

Online | Phone | Email | Text⁴ | 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 <u>Withdrawal</u>	Declined <u>Withdrawal</u>	Balance <u>Inquiry</u>
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.

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

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

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	<input type="checkbox"/> Initial Wage and Benefit Plan <input type="checkbox"/> 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: _____

Paychecks are distributed by (method): _____ at least twice a month on _____

or every other week starting _____.

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 _____



Signature - Employee _____

Date _____

Employee Name: _____
(please print)

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 services 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 safely 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: Respond to each item as to whether you have a medical or physical activity restriction or limitation to physical activity. **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 Care Network (CDCN) office.

Do you currently 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 In the past 5 years, have you had or been treated for:		NO	YES
20	Epilepsy		
21	Fainting/Dizzy Spells		
22	Hernia		
23	Muscular Strain		
24	Neck or Back 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	Other Current Problems, Diseases, Conditions		
32	Have you been hospitalized or undergone surgery, other than for childbirth?		
33	Have you refused a recommended surgical procedure?		
34	Are you currently taking any medication or drugs, whether by prescription or not, that could impair your judgment?		



EMPLOYEE HEALTH QUESTIONNAIRE



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			
<input type="checkbox"/>	HHSC	<input type="checkbox"/>	HHSC Form 1725, Criminal Conviction History and Registry Checks
<input type="checkbox"/>	HHSC	<input type="checkbox"/>	HHSC Form 1729, Applicant Verification for Employees; HHSC Form 1734, Service Provider and Employer Certification of Relationship Status for CDS
<input type="checkbox"/>	USCIS	<input type="checkbox"/>	USCIS Form I-9, Employment Eligibility Verification
<input type="checkbox"/>	HHSC	<input type="checkbox"/>	HHSC Form 1728, Liability Acknowledgement
<input type="checkbox"/>	HHSC	<input type="checkbox"/>	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			
<input type="checkbox"/>	IRS	<input type="checkbox"/>	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.
<input type="checkbox"/>	OAG	<input type="checkbox"/>	Texas Employer New Hiring Reporting Form (www.employer.texasattorneygeneral.gov)
<input type="checkbox"/>	HHSC	<input type="checkbox"/>	HHSC Form 1730, Wage and Benefits Plan Employee Compensation, and any court-ordered garnishment(s); HHSC Form 1731, Employee Work Schedule and Assigned Tasks; HHSC Form 1737, Employer and Employee Service Agreement; HHSC Form 1739, Service Provider Agreement
<input type="checkbox"/>	HHSC	<input type="checkbox"/>	CLASS, DBMD and MDCP only: Cardiopulmonary resuscitation (CPR) certification — Effective at time of service delivery initiation, and maintained. <i>Verify again before expiration date.</i>
<input type="checkbox"/>	HHSC	<input type="checkbox"/>	Texas Department of Public Safety driver's license (if transporting client) — <i>Verify again before expiration date.</i>
<input type="checkbox"/>	HHSC	<input type="checkbox"/>	Proof of minimum auto insurance (if transporting client)
<input type="checkbox"/>	CDC OSHA	<input type="checkbox"/>	HHSC Form 1727, Occupational Exposure to Bloodborne Pathogens (Acknowledgement: Hepatitis B Vaccination and Universal Precautions)
<input type="checkbox"/>	TWCC	<input type="checkbox"/>	Notice to Employees Concerning Workers' Compensation in Texas (TWC Notice 5)
<input type="checkbox"/>	HHSC	<input type="checkbox"/>	If hiring a nurse: HHSC Form 1747, Acknowledgment of Nursing Requirements
<input type="checkbox"/>	CDS HHSC	<input type="checkbox"/>	If applicable: HHSC Form 1733, Employer and Employee Acknowledgement of Exemption from Nursing Licensure for Certain Services Delivered through Consumer Directed Services
<input type="checkbox"/>	HHSC	<input type="checkbox"/>	HHSC 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			
<input type="checkbox"/>	HHSC	<input type="checkbox"/>	HHSC 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.)
<input type="checkbox"/>	HHSC	<input type="checkbox"/>	HHSC Form 1732-EMR, Management and Training of Service Provider Addendum — Must be signed by the employee within five days of hire.
<input type="checkbox"/>	HHSC	<input type="checkbox"/>	Time sheets/service logs — HHSC Form 1745, Service Delivery Log with Written Narrative/Written Summary, or facsimile approved by the FMSA
<input type="checkbox"/>	Vendors	<input type="checkbox"/>	Receipts and invoices

Code	Action
<input checked="" type="checkbox"/>	Employer checks off each item for the personnel file and retains original or copy.
<input checked="" type="checkbox"/>	Employer checks each required item when completed and sends original or copy to the FMSA as indicated. Employer retains original or copy.
<input type="checkbox"/>	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
HHSC	Texas Health and Human Services Commission
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 known as the INS, Immigration and Naturalization 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

02650



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: <input type="checkbox"/> Yes <input type="checkbox"/> No
DPS approved dissemination method used to inform employer of results: <input type="checkbox"/> Verbally <input type="checkbox"/> Encrypted email <input type="checkbox"/> Certified mail <input type="checkbox"/> Did not request report – sent Form 1725	Date FMSA staff notified employer: _____ FMSA staff: <div style="border: 1px solid black; height: 50px; margin-top: 5px;"></div>
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)? <input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Employer <input type="checkbox"/> 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

02651





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

Date



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?	<input type="checkbox"/>	<input type="checkbox"/>	
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.)	<input type="checkbox"/>	<input type="checkbox"/>	
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.)	<input type="checkbox"/>	<input type="checkbox"/>	
4.	Are you the spouse* of the individual? (Consumer Managed Personal Attendant Services (CMPAS) service providers mark this item Not Applicable (N/A).)**	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Are you the spouse* of the employer? (CMPAS service providers mark this item N/A).)**	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Are you the power of attorney (attorney in fact or agent) for financial responsibilities on behalf of the individual?	<input type="checkbox"/>	<input type="checkbox"/>	
9.	Are you the DR or the CDS employer for the individual?	<input type="checkbox"/>	<input type="checkbox"/>	
10.	Are you the spouse* of the employer's DR?	<input type="checkbox"/>	<input type="checkbox"/>	

* **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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Are you the spouse* of the parent or primary caregiver?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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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.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Are you the spouse* of a person living in the same household as the individual? (Applies to respite services.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Are you the spouse* of the primary caregiver for the individual?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

04293



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 Health and Human Services Commission (HHSC); 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: _____

- ☐ 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:

Consumer Direct Care Network Texas (CDCN) 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 is offered through your employer. 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.talispaint.com/htfd/external

CDCN 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.





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





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



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 Health and Human Services Commission (HHSC).

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 HHSC 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 HHSC 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 HHSC 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
HHSC Form 1725, Criminal Conviction History and Registry Checks	
HHSC Form 1729, Applicant Verification for Employees	
HHSC Form 1733, Employer and Employee Acknowledgement of Exemption from Nursing Licensure for Certain Services Delivered through Consumer Directed Services, if applicable	
HHSC 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



This agreement is between the **Texas Health and Human Services Commission (HHSC)**, the state Medicaid 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, or their representative.

The FMSA and HHSC 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 and HHSC mutually agree that:

- the FMSA _____,
doing business in _____, 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;
- 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 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

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 individuals'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: _____



01764



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, §225.13, 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 individuals 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:

Employer:

Printed Name

Printed Name

Signature

Signature

Date

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, §225.13, **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.

<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____





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

Date sent to FMSA: _____

Date received by FMSA: _____





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 Texas Health and Human Services Commission (HHSC) 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, Chapter 711, Subchapter O.

Rules regarding the EMR can be found on the Secretary of State's website at:

[http://texreg.sos.state.tx.us/public/readtac\\$ext.ViewTAC?tac_view=5&ti=40&pt=19&ch=711&sch=O&rl=Y](http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=40&pt=19&ch=711&sch=O&rl=Y).

Questions may be directed to HHSC 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



04253



A registered nurse (RN) or a licensed vocational nurse (LVN) 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). §301.353 requires an LVN to practice under the supervisor of a registered nurse (RN), advanced practice registered nurse (APRN), physician or a physician's assistant. The Texas Board of Nursing (BON) rules at Texas Administrative Code, Title 22, Part 11, Chapter 217, §217.11 and the BON Interpretive Guidelines 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), STAR+PLUS Home and Community Based Services (HCBS) program, STAR Kids Medically Dependent Children Program (MDCP) 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, STAR Kids MDCP, STAR+PLUS HCBS program 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.

Registered Nurse's Signature_____
Date_____
LVN Signature_____
Individual's 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 No.: _____

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

Supervisor's Area Code and Telephone No.: _____

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 to the FMSA before the LVN can deliver nursing services.

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



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.

An LVN 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 (except MDCP);
- 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; and
- 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.

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



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 Care Network Texas (CDCN) 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 only 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 CDCN 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.

Note: If an employee does not work for 6 months they will become **inactive** in the CDCN payroll system. Once inactive, employees must re-apply to work with a consumer and be issued another Okay to Work form to be eligible to work again. **This is especially important to keep in mind for backup employees.**

Please contact the CDCN 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