CONSUMER DIRECT CARE NETWORK

Date of enrollment:

Clear Form

FORMULARIO DE DATOS DEL EMPLEADO

Employer Name	Consumer Name	FMSA Representative Name

Información de Contacto del Empleado

Nombre: _____ _____ _____
Nombre Segundo nombre Apellido

Dirección física: _____
Calle # de Depto/Unidad Ciudad Estado Código postal

Dirección postal: _____
Calle/Apartado postal # de Depto/Unidad Ciudad Estado Código postal

Teléfono: Casa _____ Trabajo _____ Celular _____

Correo electrónico: _____

Fecha de nacimiento: ___/___/_____ Número del Seguro Social: _____ - ____ - _____

Contacto de emergencia: _____ _____ _____
Nombre Teléfono Parentesco

Requisitos de Edad y Educación

¿Tiene al menos 18 años? ☐ Sí ☐ No

Para prestar servicios de enfermería especializada, es necesario contar con una licencia de RN o LVN. Es necesario verificar que las licencias estén en vigor y que está al día con sus obligaciones.

Antecedentes penales

¿Alguna vez lo han condenado por un delito grave (felony)? ☐ Sí ☐ No

¿Alguna vez se le ha revocado o suspendido una licencia o certificado profesional o una licencia para conducir en cualquier estado? ¿Se le han aplicado medidas disciplinarias? ☐ Sí ☐ No

Acuse de recibo

Yo, el solicitante _____ (nombre en letra de molde), corroboro que la información proporcionada es fiel y exacta según mi leal saber y entender. También reconozco que es necesaria una verificación de antecedentes penales y una consulta de registros y que algunas condenas imposibilitan el empleo.

Ni la aceptación de esta solicitud ni el inicio de cualquier relación laboral o acuerdo de empleo con un consumidor o su representante autorizado legalmente para considerar el empleo representarán un contrato real o implícito de empleo con Consumer Direct Care Network Texas (CDCN).

Comprendo que no puedo prestar servicios a un cliente a cambio de un pago hasta recibir el formulario de "Luz verde para trabajar" de CDCN. Haber recibido este formulario significa que los resultados requeridos de la verificación de antecedentes penales se han aprobado. También comprendo que los resultados de la verificación de antecedentes podrían compartirse con la entidad aprobatoria (Departamento de Salud y Servicios Humanos de Texas) y/o con el consumidor para el que trabajo. Los resultados de la verificación de antecedentes se archivarán en mi carpeta de personal.

Firma del solicitante: _____ Fecha: _____

CONSUMER DIRECT CARE NETWORK

FORMULARIO DE SELECCIÓN DE PAGO

Nombre del empleado: _____ Fecha de nacimiento: ___/___/_____

Los pagos de Consumer Direct Care Network (CDCN) se realizan mediante depósito directo a una cuenta bancaria o tarjeta de pago. Los comprobantes de pago (talones) se le enviarán por correo a la dirección que tiene registrada con nosotros.

Marque una de las siguientes opciones de pago.

Nota: Se le inscribirá en la opción de tarjeta Wisely Pay si (1) no hace ninguna selección a continuación, o (2) selecciona el depósito directo a una cuenta bancaria pero proporciona información de cuenta no válida o su cuenta.

☐ **Depósito directo a una cuenta de Wisely Pay Card.** Autorizo a CDCN a emitirme una tarjeta Wisely Pay. La tarjeta estará vinculada a mi identificación en el archivo. CDCN hará depósitos de nómina en la cuenta de mi tarjeta. Recibiré la tarjeta en 7 a 10 días hábiles después del procesamiento inicial.

☐ **Depósito directo a una cuenta de cheques, ahorros o tarjeta de pago existente.** Autorizo a CDCN a iniciar depósitos de nómina en mi banco o institución financiera.

El nombre de mi banco es: _____

El tipo de cuenta es: (marque una opción) ☐ Cheques ☐ Ahorros ☐ Tarjeta de pago

SE REQUIERE UN ANEXO.

Para una cuenta de cheques. Adjunte un cheque anulado. Este es el preferido. Un formulario de depósito directo emitido por un banco o una carta bancaria también son aceptables

Para una cuenta de ahorros o tarjeta de pagos. Adjunte un formulario de depósito directo emitido por el banco o una carta bancaria.

* *No envíe una boleta de depósito. Los códigos bancarios (números de ruta) difieren de los números de ruta de depósito directo.*

Reconocimiento. Autorizo a CDCN a procesar mi método de pago seleccionado. Entiendo que:

- CDCN se reserva el derecho de rechazar cualquier solicitud de depósito directo.
- Soy responsable de confirmar que se haya realizado cada depósito. Debo pagar cualquier cargo causado por sobregiros en mi cuenta.
- Todos los depósitos directos se realizan a través de una Cámara de Compensación Automatizada (CCA). El procesamiento está sujeto a los términos de la CCA. También se aplicarán las condiciones y los términos de mi banco.
- Si se llegaran a realizar depósitos en mi cuenta por error, autorizo a CDCN a debitar mi cuenta para corregir el error. Si no se puede debitar mi cuenta debido al cierre o al saldo insuficiente, entonces CDCN podrá retener pagos futuros hasta que se paguen las cantidades depositadas erróneamente.
- Es posible que reciba un cheque en papel mientras se configura el método de pago que seleccioné.
- Debo enviar un nuevo formulario de selección de pago a CDCN si deseo cambiar mi opción de depósito directo.

_____ _____

Firma del Empleado *Fecha*

wisely by ADP

Control financiero: ¡Ahora es posible!

Controle su dinero con una cuenta digital de Wisely®[1].

Reciba pagos con anticipación[2].

Ya sea que quiera pagar una factura u obtener dinero para planes de último momento, Wisely le permite obtener el dinero con hasta 2 días de anticipación[2].

Ahorre y organice su dinero como quiera.

Realice un seguimiento de su saldo y sus gastos las 24 horas del día, los 7 días de la semana, y obtenga importantes ahorros[3].

Realice compras con confianza.

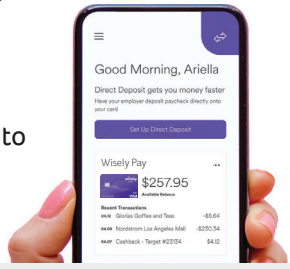
Pague en línea, en la tienda, en la aplicación o por teléfono dondequiera que se acepten tarjetas de débito Visa® o Mastercard®.

Evite los cargos del cajero automático.

Acceda a una red de 90 000 cajeros automáticos sin cargo a nivel nacional[4].

¡Aproveche todos los beneficios de Wisely hoy mismo!

Hable con su departamento de Nóminas.



Administre su dinero como quiera.

Afford yourself every advantage™.

[1] La tarjeta Wisely es una tarjeta prepagada. La cuenta digital se requiere para la administración y el mantenimiento de su tarjeta prepaga en línea de forma digital o mediante una aplicación móvil. La tarjeta Wisely no es una tarjeta de crédito, por cual no otorga crédito.

[2] Debe iniciar sesión en la aplicación myWisely o en su cuenta de mywisely.com para inscribirse en el depósito directo anticipado. No se garantiza el depósito directo anticipado de los fondos y queda sujeto a los plazos de la orden de pago del pagador. La referencia acerca del plazo de financiación más rápido se establece al comparar nuestra política de extender los fondos al recibir la orden de pago con la práctica bancaria habitual de otorgar los fondos al momento de la liquidación. Consulte las reglas completas en mywisely.com o en la aplicación myWisely. Si tiene una tarjeta Wisely Pay o Wisely Cash (vea el reverso), se requiere una actualización que es posible que no esté disponible para todos los tarjetahabientes. Permita que pase un plazo de hasta 3 semanas después de la configuración inicial del depósito directo para que su pago se cargue a su tarjeta.

[3] Los montos transferidos a su sobre de ahorros ya no aparecerán en su saldo disponible. Puede restituirlos a su saldo disponible en cualquier momento con la aplicación myWisely o desde su cuenta de mywisely.com.

[4] El número de transacciones en cajero automático sin cargo podría estar limitado. Inicie sesión en la aplicación myWisely o en mywisely.com para consultar el acuerdo del tarjetahabiente y la lista de todos los cargos a fin de obtener más información.

Instrucciones para completar el formulario I-9 Sección 1

(El primer día de trabajo remunerado del empleado o antes)

Empleado: Complete la Sección 1 del Formulario I-9 a más tardar el primer día de trabajo remunerado. Escriba con letra de imprenta clara. Firme y feche cuando haya terminado. Las explicaciones numeradas a continuación se muestran en el ejemplo de la imagen.

① Escriba su nombre completo: apellido, nombre, e inicial del segundo nombre. Proporcione cualquier otro nombre utilizado, como su apellido de soltera. Escriba "N/A" si nunca ha tenido otro nombre.

② Escriba su dirección física. No se permite ingresar un apartado postal. Escriba "N/A" si no tiene número de apartamento.

③ Escriba su fecha de nacimiento (mm/dd/aaaa).

④ Escriba su número de Seguro Social.

⑤ Escriba su dirección de correo electrónico o escriba "N/A" si decide no proporcionarla.

⑥ Escriba su número de teléfono o escriba "N/A" si decide no proporcionarla.

⑦ Marque una casilla que describe su estatus migratorio o ciudadanía en Estados Unidos. Escriba información adicional si marca la casilla 3 ó 4.

⑧ Firme e ⑨ Imprima la fecha en que complete el formulario. **A más tardar el primer día de trabajo remunerado.**

⑩ Presente el Suplemento A (Certificación de preparador y/o traductor) si le ha ayudado un preparador o traductor.

Empleador: Revise la Sección 1, asegurarse de que su empleado la haya completado correctamente.

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 (if any)	Other Last Names Used (if any)
① Doe	Jane	Q	N/A

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code
② 123 Main St.	N/A	Anytown	TX	75032

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number
③ 03/13/1964	④ 1 2 3 4 5 6 7 8 9	⑤ employee@email.com	⑥ 555-123-4567

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

⑦ Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- [X] 1. A citizen of the United States
- [ ] 2. A noncitizen national of the United States (See Instructions)
- [ ] 3. A lawful permanent resident (Enter USCIS or A-Number.)
- [ ] 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

Ejemplo

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

Signature of Employee	Today's Date (mm/dd/yyyy)
⑧ Jane Doe	⑨ 09/15/2023

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Nota: Consulte a las instrucciones del formulario I-9 para información más detallada.

Instrucciones para completar el formulario I-9 Sección 2

(Después de que el empleado haya aceptado la oferta de trabajo, pero a más tardar 3 días después del primer día de trabajo del empleado)

Empleado: Presente documentos originales y vigentes a su empleador para verificar su identidad y autorización para trabajar en Estados Unidos. Consulte la LISTA DE DOCUMENTOS ACEPTABLES.

Empleador: Examine y registra los documentos que le proporciona su empleado. El empleado debe estar presente mientras los examina. Las explicaciones numeradas a continuación se muestran en el ejemplo de la imagen.

① Examine cada documento. Escriba los detalles en la(s) columna(s) adecuada(s) de la Lista. Solo acepte documentos originales y vigentes (no fotocopias).

Puede aceptar un documento de la Lista A **O** uno de la Lista B y uno de la Lista C.

② Escriba la fecha del primer día de trabajo del empleado.

③ Escriba su apellido, nombre, y título. El título es "Employer".

④ Firme e ⑤ Imprima la fecha. **Debe completarse y firmarse dentro de los 3 días posteriores al primer día de trabajo del empleado.**

⑥ Escriba su nombre y apellido.

⑦ Escriba la dirección física donde se prestan los servicios, (el domicilio del Consumidor).

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign **Section 2** within three business days after the employee's first day of employment, and must physically examine, **or examine consistent with an alternative procedure authorized by the Secretary of DHS**, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1		①	*Driver's License*		*Social Security Card*
Issuing Authority			*State of Residence*		*SSA*
Document Number (if any)			*0123456789abcde*		*123-45-6789*
Expiration Date (if any)			*08/17/2027*		*N/A*
Document Title 2 (if any)			**Additional Information**		
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Ejemplo

No marque. Debe examinar físicamente los documentos.

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears 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.

First Day of Employment (mm/dd/yyyy): ② *09/15/2023*

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)
③ *Smith, Ronald Employer*	④ *Ronald Smith*	⑤ *09/15/2023*

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
⑥ *Ronald Smith*	⑦ *500 Fictional Street, Anytown TX 75018*

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

Nota: Consulte a las instrucciones del formulario I-9 para información más detallada.

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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 (if any)	Other Last Names Used (if any)

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

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number
/ /			

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

Signature of Employee	Today's Date (mm/dd/yyyy)

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears 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.

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

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 an individual temporarily authorized to work for a specific employer because of his or her status or parole: **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 individual's status or parole 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 For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		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				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	**OR**	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

Supplement A,
Preparer and/or Translator Certification for Section 1

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

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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.

OMB No. 1545-0074

2024

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) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **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, and when to use the estimator at *www.irs.gov/W4App*.

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). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **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 generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

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 Dependent and Other Credits

If your total 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 for qualifying children and other dependents. You may add to this the amount of any other credits. 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)

General Instructions

Section references are to the Internal Revenue Code.

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, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2024 if you meet both of the following conditions: you had no federal income tax liability in 2023 **and** you expect to have no federal income tax liability in 2024. You had no federal income tax liability in 2023 if (1) your total tax on line 24 on your 2023 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), 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 2024 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 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2025.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

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. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

3. 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.

Instead, if you (and your spouse) have a total of only two jobs, you may 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 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. This step 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. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. 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 2024 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. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

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 2024 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $

2 Enter:
- $29,200 if you're married filing jointly or a qualifying surviving spouse
- $21,900 if you're head of household
- $14,600 if you're single or married filing separately

. . . . . **2** $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. 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 Part II of Schedule 1 (Form 1040)). 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 territories 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.

Married Filing Jointly or Qualifying Surviving Spouse

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	$0	$780	$850	$940	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,370
$10,000 - 19,999	0	780	1,780	1,940	2,140	2,220	2,220	2,220	2,220	2,220	2,570	3,570
$20,000 - 29,999	780	1,780	2,870	3,140	3,340	3,420	3,420	3,420	3,420	3,770	4,770	5,770
$30,000 - 39,999	850	1,940	3,140	3,410	3,610	3,690	3,690	3,690	4,040	5,040	6,040	7,040
$40,000 - 49,999	940	2,140	3,340	3,610	3,810	3,890	3,890	4,240	5,240	6,240	7,240	8,240
$50,000 - 59,999	1,020	2,220	3,420	3,690	3,890	3,970	4,320	5,320	6,320	7,320	8,320	9,320
$60,000 - 69,999	1,020	2,220	3,420	3,690	3,890	4,320	5,320	6,320	7,320	8,320	9,320	10,320
$70,000 - 79,999	1,020	2,220	3,420	3,690	4,240	5,320	6,320	7,320	8,320	9,320	10,320	11,320
$80,000 - 99,999	1,020	2,220	3,620	4,890	6,090	7,170	8,170	9,170	10,170	11,170	12,170	13,170
$100,000 - 149,999	1,870	4,070	6,270	7,540	8,740	9,820	10,820	11,820	12,830	14,030	15,230	16,430
$150,000 - 239,999	1,960	4,360	6,760	8,230	9,630	10,910	12,110	13,310	14,510	15,710	16,910	18,110
$240,000 - 259,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$260,000 - 279,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$280,000 - 299,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,380
$300,000 - 319,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,980	17,980	19,980
$320,000 - 364,999	2,040	4,440	6,840	8,310	9,710	11,280	13,280	15,280	17,280	19,280	21,280	23,280
$365,000 - 524,999	2,720	6,010	9,510	12,080	14,580	16,950	19,250	21,550	23,850	26,150	28,450	30,750
$525,000 and over	3,140	6,840	10,540	13,310	16,010	18,590	21,090	23,590	26,090	28,590	31,090	33,590

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	$240	$870	$1,020	$1,020	$1,020	$1,540	$1,870	$1,870	$1,870	$1,870	$1,910	$2,040
$10,000 - 19,999	870	1,680	1,830	1,830	2,350	3,350	3,680	3,680	3,680	3,720	3,920	4,050
$20,000 - 29,999	1,020	1,830	1,980	2,510	3,510	4,510	4,830	4,830	4,870	5,070	5,270	5,400
$30,000 - 39,999	1,020	1,830	2,510	3,510	4,510	5,510	5,830	5,870	6,070	6,270	6,470	6,600
$40,000 - 59,999	1,390	3,200	4,360	5,360	6,360	7,370	7,890	8,090	8,290	8,490	8,690	8,820
$60,000 - 79,999	1,870	3,680	4,830	5,840	7,040	8,240	8,770	8,970	9,170	9,370	9,570	9,700
$80,000 - 99,999	1,870	3,690	5,040	6,240	7,440	8,640	9,170	9,370	9,570	9,770	9,970	10,810
$100,000 - 124,999	2,040	4,050	5,400	6,600	7,800	9,000	9,530	9,730	10,180	11,180	12,180	13,120
$125,000 - 149,999	2,040	4,050	5,400	6,600	7,800	9,000	10,180	11,180	12,180	13,180	14,180	15,310
$150,000 - 174,999	2,040	4,050	5,400	6,860	8,860	10,860	12,180	13,180	14,230	15,530	16,830	18,060
$175,000 - 199,999	2,040	4,710	6,860	8,860	10,860	12,860	14,380	15,680	16,980	18,280	19,580	20,810
$200,000 - 249,999	2,720	5,610	8,060	10,360	12,660	14,960	16,590	17,890	19,190	20,490	21,790	23,020
$250,000 - 399,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$400,000 - 449,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$450,000 and over	3,140	6,450	9,110	11,610	14,110	16,610	18,430	19,930	21,430	22,930	24,430	25,870

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	$510	$850	$1,020	$1,020	$1,020	$1,020	$1,220	$1,870	$1,870	$1,870	$1,960
$10,000 - 19,999	510	1,510	2,020	2,220	2,220	2,220	2,420	3,420	4,070	4,070	4,160	4,360
$20,000 - 29,999	850	2,020	2,560	2,760	2,760	2,960	3,960	4,960	5,610	5,700	5,900	6,100
$30,000 - 39,999	1,020	2,220	2,760	2,960	3,160	4,160	5,160	6,160	6,900	7,100	7,300	7,500
$40,000 - 59,999	1,020	2,220	2,810	4,010	5,010	6,010	7,070	8,270	9,120	9,320	9,520	9,720
$60,000 - 79,999	1,070	3,270	4,810	6,010	7,070	8,270	9,470	10,670	11,520	11,720	11,920	12,120
$80,000 - 99,999	1,870	4,070	5,670	7,070	8,270	9,470	10,670	11,870	12,720	12,920	13,120	13,450
$100,000 - 124,999	2,020	4,420	6,160	7,560	8,760	9,960	11,160	12,360	13,210	13,880	14,880	15,880
$125,000 - 149,999	2,040	4,440	6,180	7,580	8,780	9,980	11,250	13,250	14,900	15,900	16,900	17,900
$150,000 - 174,999	2,040	4,440	6,180	7,580	9,250	11,250	13,250	15,250	16,900	18,030	19,330	20,630
$175,000 - 199,999	2,040	4,510	7,050	9,250	11,250	13,250	15,250	17,530	19,480	20,780	22,080	23,380
$200,000 - 249,999	2,720	5,920	8,620	11,120	13,420	15,720	18,020	20,320	22,270	23,570	24,870	26,170
$250,000 - 449,999	2,970	6,470	9,310	11,810	14,110	16,410	18,710	21,010	22,960	24,260	25,560	26,860
$450,000 and over	3,140	6,840	9,880	12,580	15,080	17,580	20,080	22,580	24,730	26,230	27,730	29,230

CONSUMER DIRECT CARE NETWORK

DETERMINACIÓN DE RELACIÓN ENTRE EMPLEADOR Y EMPLEADO

(Determina si el empleado está exento de algunos impuestos sobre la nómina)

Nombre del Empleado	Nombre del Empleador Registrado	Nombre del Consumidor

Antecedentes: Los Empleados que presten servicios domésticos podrían estar exentos de algunos impuestos sobre la nómina. Esto se basa en la edad del Empleado y su relación con el Empleador Registrado (Empleador) Consumer Direct Care Network (CDCN) aplicará toda exención con base en las relaciones que se identifiquen a continuación. **Llenar incorrectamente este formulario podría dar pie a retenciones de impuestos incorrectas.**

Nota: Si el Empleado y el Empleador califican para exenciones de impuestos, estas tienen que realizarse. Las exenciones no pueden dispensarse. Si los ingresos del Empleado están exentos de estos impuestos, podrían no calificar para recibir los beneficios asociados. Un ejemplo es el seguro de desempleo.

Relación entre Empleador y Empleado

*El Empleado debe seleccionar **una** relación de las descritas a continuación.*

☐ **Soy el cónyuge del Empleador** (esto incluye matrimonios por convivencia).
Exento de FICA[1], FUTA[2] y SUTA[3].

☐ **Soy el padre del Empleador** (esto incluye padres adoptivos o padrastros). En caso de ser uno de los padres, marque todas las opciones que apliquen de la lista que se encuentra a continuación:

- ☐ Proporciono atención para el hijo o hijastro del Empleador que vive en la residencia.
- ☐ El hijo o hijastro del Empleador tiene menos de 18 años o requiere cuidado personal de un adulto por al menos 4 semanas consecutivas en 3 meses.
- ☐ El Empleador es viudo, está divorciado o está casado y vive con un cónyuge, pero dicho cónyuge tiene un padecimiento médico o limitante física que evita que cuide del niño al menos 4 semanas consecutivas en 3 meses.

Exento de FUTA y SUTA. Sujeto a FICA si las tres casillas previas se marcaron; de lo contrario, exento de FICA.

☐ **Soy el suegro o suegra del Empleador.**
Exento de SUTA. Sujeto a FICA y FUTA.

☐ **Soy hijo del Empleador.** En ese caso, marque una opción de las que se encuentran a continuación:

- ☐ Soy mayor de 21 años. *Sujeto a FICA, FUTA y SUTA.*
- ☐ Soy menor de 21 años. *Exento de FICA, FUTA y SUTA.*

☐ **No tengo parentesco con el Empleador o ninguna de las opciones previas describe mi parentesco.**
Sujeto a FICA, FUTA y SUTA.

Reconocimiento: El Empleado y el Empleador acuerdan que la relación seleccionada previamente es correcta. En caso de que esta información cambie, el Empleador debe notificar a CDCN. Si no se notifica a CDCN de los cambios, el Empleado podría tener que devolver dinero que debió haberse retenido del pago.

Firma del Empleado	*Fecha*	*Firma del Empleador Registrado*	*Fecha*

[1]FICA – Ley Federal de Aportaciones al Seguro (Seguro Social y Medicare)
[2]FUTA – Ley Federal del Impuesto para el Desempleo
[3]SUTA – Impuesto Estatal para el Desempleo

CONSUMER DIRECT CARE NETWORK

DETERMINACIÓN DE ESTANCIA DE PLANTA DEL EMPLEADO CON EL CONSUMIDOR *(Determina si el empleado está exento de paga de horas extra e impuesto sobre la renta)*

Nombre del Empleado	Nombre del Empleador Registrado	Nombre del Consumidor

Los trabajadores de servicio doméstico podrían estar exentos de requisitos de paga de horas extra, así como del pago de impuestos sobre la renta. Consumer Direct Care Network (CDCN) aplicará exenciones con base en las respuestas que proporcione a continuación.

Estado de Estancia Planta del Empleado con el Consumidor

El Empleado deberá responder a lo siguiente con "sí" o "no"

☐ Sí ☐ No – **¿Vive permanentemente en la misma residencia que el Consumidor antes mencionado, o de forma temporal por periodos extendidos de tiempo (al menos 120 horas por semana o 5 días o noches consecutivas por semana)?**

Si respondió SÍ:

- *Las horas extra que trabaje se pagarán a la tarifa de paga regular.*
- *Estado de exención de impuesto sobre la renta por Dificultad de Cuidado.*

  ☐ Sí ☐ No – **Declaro bajo pena de perjurio que soy un proveedor de cuidados individual que recibe pagos bajo el programa estatal de exención de Medicaid conforme a lo definido en la Notificación 2014-7 del IRS.**
  Brindo cuidados al Consumidor mencionado arriba. El Consumidor reside en mi hogar. Bajo este programa de Medicaid no se requiere que reporte los ingresos obtenidos. No se deben retener impuestos federales y estatales de mi paga. Si CDCN reportó salarios no gravables en el recuadro 1 de mi formulario W-2, puedo deducir los salarios no gravables de mis ingresos gravables al presentar mi declaración de impuestos. Notificaré a CDCN en caso de dejar de calificar para la Notificación 2014-7 del IRS. En ese momento reiniciará la retención de impuestos federales y estatales. Si el IRS determina que no era elegible para 2014-7 y que no se pagaron impuestos, acepto que seré responsable por cualquier impuesto atrasado.

  Nota: *La Notificación 2014-7 del IRS indica que los pagos recibidos bajo un programa de Exención de Medicaid Comunitario o de Residencia para la prestación de servicios de Habilitación o Cuidado Personal se consideran pagos de "Dificultas de cuidado" que pueden excluirse de la tributación sobre la renta cuando el receptor de Medicaid vive en la residencia del proveedor de cuidados. Los servicios paliativos y especializados no califican. Para mayor información, por favor consulte https://www.irs.gov/pub/irs-drop/n-14-07.pdf.*

Si respondió NO:

- *Las horas de tiempo extra se pagarán a un costo de 1.5 veces la tarifa de paga regular.*

Reconocimiento: El Empleado y el Empleador acuerdan que las declaraciones previas son correctas. En caso de que cambie la situación de vivienda, el Empleado deberá informar a CDCN. Independientemente del estado en cuanto a horas extra que se haya identificado previamente, el trabajo de horas extra requiere aprobación previa.

Firma del Empleado _____ *Fecha* _____ *Firma del Empleador Registrado* _____ *Fecha* _____

Consumer Directed Services (CDS)

Service Provider and Employer Certification of Relationship Status for CDS

Section 1: Basic Information

Service Provider Applicant Name	Maiden Name — if applicable
Applicant Street Address	City, State and ZIP Code
Person Receiving Services	CDS Employer Name (if different than person receiving services)
Person Receiving Services Street Address	City, State and ZIP Code
Applicant's Relationship to Person Receiving Services	Designated Representative (DR) — if applicable
Applicant's Relationship to CDS Employer	Applicant's Relationship to DR

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

Section 2: All Programs

The applicant must answer the following questions.

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

*** Spouse** is defined as either a legal marriage or a marriage without formalities (common law marriage) in accordance with the Texas Family Code. Page 8

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

Section 3: Medically Dependent Children Program (MDCP)

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

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

Section 4: Home and Community-based Services (HCS) and Texas Home Living (TxHmL)

If providing Community First Choice Personal Assistance Services or Habilitation (CFC PAS/HAB), respite, adaptive aids or behavioral support services in the HCS or TxHmL program, please answer the following additional questions, as applicable. (Mark these items NA if the individual is not receiving an applicable HCS or TxHmL service.)

	Applicant Status and Relationship	Yes	No	NA
1.	Are you a person living in the same household as the individual? (Applies to CFC PAS/HAB and respite services.)	☐	☐	☐
2.	Are you a person related to the individual within the fourth degree of consanguinity or within the second degree of affinity? (Applies to adaptive aids and behavioral support services.)	☐	☐	☐

Section 5: 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 CFC PAS/HAB applicant**, answer the following additional question. (Mark this item NA if the individual is not receiving CLASS respite services. Also mark this item NA if the individual is receiving CLASS respite services, but the primary caregiver is not the CFC PAS/HAB service provider.)

	Applicant Status and Relationship	Yes	No	NA
1.	Do you live in the same household as the individual?	☐	☐	☐

Section 6: 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 NA if the individual is not enrolled in PHC, CAS or FC.)

	Applicant Status and Relationship	Yes	No	NA
1.	Are you the primary caregiver for the individual?	☐	☐	☐
2.	Are you the spouse* of the primary caregiver for the individual?	☐	☐	☐

Employer and Service Provider Applicant Verification

If any item above is marked Yes, the applicant 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 NA, the applicant meets relationship eligibility for employment in the CDS option for this individual, unless contraindicated by requirements of the individual's program. (NA only applies where indicated.) The employer and the applicant certify that the responses are accurate.

Employer confirmation and acknowledgement: As the CDS employer, I confirm that the information provided on this form is true and correct to the best of my knowledge. I understand that an applicant cannot be paid for providing services if they are not eligible for employment.

Printed Employer Name	Signature — Employer	Date

Applicant confirmation and acknowledgement: As the applicant, I confirm that the information provided on this form is true and correct to the best of my knowledge. I understand that I cannot be paid for providing services if I am not eligible for employment.

Printed Service Provider Applicant Name	Signature — Service Provider Applicant	Date

Consumer Directed Services

Wage and Benefits Plan
Employee Compensation

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

Name of Program Service Being Provided:

Compensation:

Regular Hourly Wage

☐ Employee = $

☐ Respite = $

Calculation of Overtime Hourly Wage (No aprovado)

Hourly $ N/A + $ N/A (50%) = $ N/A

Hourly $ N/A + $ N/A (50%) = $ N/A

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): Workers Compensation

Acknowledgement/Agreement:

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

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

Paychecks are distributed by (method): direct deposit at least twice a month on N/A

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

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

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Signature - Employer or Designated Representative

Date

Signature - Employee

Date

CONSUMER DIRECT CARE NETWORK

LISTA DE VERIFICACIÓN DEL PAQUETE PARA NUEVOS EMPLEADOS

Nombre del empleado	Fecha de inicio estimada	Nombre del consumidor

Por favor complete los formularios de las listas que se encuentran a continuación, incluida esta. Consumer Direct Care Network Texas (CDCN) debe recibir originales o copias de cada una antes del inicio del empleo (las designadas "de ser el caso" pueden ser una excepción). El empleado no tiene aprobación para comenzar a trabajar hasta que todos los formularios se hayan completado y CDCN los haya recibido y se haya emitido un formulario de aprobación para trabajar.

Formularios relacionados con la nómina (requerido de todos los nuevos empleados)

1. ☐ Formulario de Datos del Empleado
2. ☐ Lista de verificación de nuevos empleados (este formulario)
3. ☐ Determinación de relación entre empleador y empleado
4. ☐ Determinación de estancia de planta del empleado con el consumidor
5. ☐ Formulario I-9 - Verificación de elegibilidad para el empleo
   Hay instrucciones adicionales sobre el formulario I-9 disponibles en el sitio web de CDCN Texas bajo la pestaña de recursos
6. ☐ Formulario W-4 – Certificado de Deducción en la Retención del Empleado
7. ☐ Formulario de selección de paga (puede ser necesario un anexo, consulte las instrucciones del formulario)
8. ☐ Plan de salarios y beneficios (Formulario 1730)
   Nota: El empleador debe contar con el presupuesto más reciente para completar este formulario correctamente
9. ☐ Cuestionario de salud para empleados

Formularios del Departamento de Salud y Servicios Humanos de Texas (requerido de todos los nuevos empleados; hay algunas excepciones)

1. ☐ Página de cubierta del Paquete para nuevos empleados (Formulario 1724)
2. ☐ Verificaciones de registros y antecedentes de condenas penales (Formulario 1725)
3. ☐ Verificación de solicitantes para empleados (Formulario 1729)
4. ☐ Certificado de estado de parentesco entre el proveedor de servicio y el empleador para CDS (Formulario 1734)
5. ☐ Reconocimiento de responsabilidad (Formulario 1728)
6. ☐ Reconocimiento de la red de indemnización laboral
7. ☐ Calendario de trabajo y tareas asignadas al empleado (Formulario 1731)
8. ☐ Acuerdo de Servicio de Empleado y el empleador (Formulario 1737)
9. ☐ Acuerdo de proveedor de servicios (Formulario 1739)
10. ☐ Exposición ocupacional a patógenos de transmisión sanguínea (Formulario 1727)

CONSUMER DIRECT CARE NETWORK

LISTA DE VERIFICACIÓN DEL PAQUETE PARA NUEVOS EMPLEADOS

11. ☐ Exención de licencia de enfermería (Formulario 1733, de ser el caso)
12. ☐ Gestión y capacitación de Proveedores de Servicio (Formulario 1732)
13. ☐ Notificación de registro de conducta indebida del empleado (Formulario 1732-EMR)
14. ☐ Reconocimiento de Requisitos de Enfermería (Formulario 1747, de ser el caso)
15. ☐ Supervisión de personal de enfermería vocacional con licencia (Formulario 1747-LVN, de ser el caso)

Verificaciones de capacitación/licencias (según corresponda, adjunte una fotocopia del documento)

1. ☐ Certificación de RCP **Fecha de vencimiento:** _____ (según corresponda, requerido únicamente para exenciones de MDCP, CLASS, DBMD, StarKids y StarPlus Respite). CLASS y DBMD deben ser cursos activos.
2. ☐ Licencia de conducir (según corresponda, únicamente si se transportará al cliente)
3. ☐ Seguro de auto mínimo (según corresponda, únicamente si se transportará al cliente)
4. ☐ Licencias profesionales (de ser el caso, p.ej., RN, LVN)

Distribución de folletos de capacitación (se encuentra en la carpeta del empleador)

1. ☐ Guía de capacitación de HIPAA, control de infección, levantar y mover a pacientes, prevención de fraudes

Por favor revise y verifique que los formularios previos estén completos y puedan leerse antes de enviarlos a CDCN. Formularios faltantes o ilegibles provocarán un retraso en la fecha de inicio.

CONSUMER DIRECT CARE NETWORK

CUESTIONARIO DE SALUD PARA EMPLEADOS

Nombre del empleado: _____

Antecedentes: Se le ha contratado condicionalmente para brindar servicios para el destinatario del servicio de conformidad con su plan de atención autorizado. Es posible que se le requiera realizar tareas físicas. El propósito de este cuestionario de salud es evaluar su capacidad de realizar las tareas autorizadas de forma segura. La información que proporcione en este cuestionario se utilizará para ayudar a gestionar su empleo de forma segura. Sus respuestas se consideran *Confidenciales*.

Instrucciones: Responda a cada artículo sobre si tiene una restricción o limitante médica o a su actividad física. **Por favor explique cualquier respuesta afirmativa en el reverso de este formulario y adjunte la información adicional que sea necesaria.** Devuelva este formulario completado y otros formularios de empleo a la oficina de Consumer Direct Care Network (CDCN).

	Actualmente tiene una restricción a la actividad física que involucre:	**NO**	**SÍ**
1	Estar sentado		
2	Estar de pie sin moverse		
3	Caminar		
4	Capacidad de movilidad		
5	Ponerse en cuclillas (doblar las rodillas)		
6	Hincarse/gatear		
7	Agacharse (doblar la cintura)		
8	Girar (rodillas/cintura/cuello)		
9	Dar la vuelta, pivotear		
10	Escalar		
11	Equilibrarse		
12	Extenderse hacia arriba		
13	Extenderse horizontalmente		
14	Sujetar		
15	Empujar/Jalar		
16	Alzar/Cargar		
17	Pérdida total o parcial de la audición		
18	Ceguera (parcial o completa) o problemas oculares		
19	¿Un profesionales del cuidado de la salud le ha indicado restringir sus actividades físicas de cualquier manera?		
	Historial médico personal - En los últimos cinco años ha sufrido o recibido tratamiento por:	**NO**	**SÍ**
20	Epilepsia		
21	Desmayos/mareos		
22	Hernias		
23	Distensión muscular		
24	Lesiones de cuello o espalda		
25	Ruptura de discos intervertebrales		
26	Dolor o lesiones articulares		
27	Fracturas		
28	Tuberculosis o una prueba de tuberculosis con un resultado que no sea negativo		
29	Enfermedades o problemas pulmonares		
30	Lesiones de cabeza		
31	Otros problemas, enfermedades o padecimientos en curso		
32	¿Lo han hospitalizado o se ha sometido a una cirugía, excluyendo partos?		
33	¿Ha rechazado un procedimiento quirúrgico recomendado?		
34	¿Actualmente toma algún fármaco o medicamento, ya sea de venta o libre o con receta, que pueda mermar su toma de decisiones?		

CONSUMER DIRECT CARE NETWORK

CUESTIONARIO DE SALUD PARA EMPLEADOS

¿Actualmente tiene, o un profesionales del cuidado de la salud le dicho que tiene, una limitante física relacionada con la lista que se encuentra a continuación?							
		NO	**SÍ**			**NO**	**SÍ**
A	Regresar			H	Brazo		
B	Hombro			I	Cadera		
C	Cuello			J	Rodilla		
D	Codo			K	Tobillo		
E	Muñeca			L	Pie		
F	Mano			M	Pierna		
G	Dedo			N	Otro		

CDCN no discrimina en la contratación, ascenso u otros términos y condiciones del empleo. De igual manera, CDCN no discrimina contra personas que, de buena fe, han interpuesto una reclamación o han recibido beneficios bajo las Leyes de Compensación para Trabajadores del estado. Las solicitudes de adecuaciones para permitir a los empleados desempeñar las funciones esenciales necesarias deben realizarse por escrito y se proporcionarán en caso de no causar dificultades excesivas.

Por favor explique cualquier repuesta afirmativa en las páginas 1 y 2 a mayor detalle a continuación y anote el número o letra correspondiente. También debe incluir las fechas de lesiones y cirugías. Utilice páginas adicionales, de ser necesario:

Afirmo que he respondido a las preguntas previas según mi leal saber y entender. Mis respuestas son verdaderas y completas. Comprendo que proporcionar información falsa deliberadamente es causal de despido y puede dar pie a que se nieguen los beneficios de compensación para trabajadores.

Firma del empleado: _____ Fecha: _____/_____/_____

Uso en la oficina únicamente

Revisado por: [_____] Fecha _____/_____/_____ Fecha de envío a Gestor de Riesgo: _____/_____/_____

Ubicación/oficina de estado: _____ Revisión de Gestor de Riesgos: [_____] Fecha

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TEXAS Health and Human Services

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			
☐	**HHSC**	☐	**HHSC Form 1725,** Criminal Conviction History and Registry Checks
☐	**HHSC**	☐	**HHSC Form 1729,** Applicant Verification for Employees; **HHSC Form 1734,** Service Provider and Employer Certification of Relationship Status for CDS
☐	**USCIS**	☐	**USCIS Form I-9,** Employment Eligibility Verification
☐	**HHSC**	☐	**HHSC Form 1728,** Liability Acknowledgement
☐	**HHSC**	☐	**Professional license verification** (nursing, professional therapies)
At Time of Hire: (1) Original or Copy for Employer's Personnel Files and (2) Original or Copy to FMSA			
☐	**IRS**	☐	**IRS Form W-4,** Employee's Withholding Allowance Certificate — Due before first payroll check is calculated; provide to the Financial Management Services Agency (FMSA) on date of hire.
☐	**OAG**	☐	**Texas Employer New Hiring Reporting Form** (www.employer.texasattorneygeneral.gov)
☐	**HHSC**	☐	**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
☐	**HHSC**	☐	***CLASS, DBMD and MDCP only:*** **Cardiopulmonary resuscitation (CPR) certification** — Effective at time of service delivery initiation, and maintained. *Verify again before expiration date.*
☐	**HHSC**	■	**Texas Department of Public Safety driver's license** (if transporting client) — *Verify again before expiration date.*
☐	**HHSC**	■	**Proof of minimum auto insurance** (if transporting client)
☐	**CDC OSHA**	■	**HHSC Form 1727,** Occupational Exposure to Bloodborne Pathogens (Acknowledgement: Hepatitis B Vaccination and Universal Precautions)
☐	**TWCC**	■	**Notice to Employees Concerning Workers' Compensation in Texas** (TWC Notice 5)
☐	**HHSC**	☐	***If hiring a nurse:*** **HHSC Form 1747,** Acknowledgment of Nursing Requirements
☐	**CDS HHSC**	☐	***If applicable:*** **HHSC Form 1733,** Employer and Employee Acknowledgement of Exemption from Nursing Licensure for Certain Services Delivered through Consumer Directed Services
☐	**HHSC**	☐	**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			
☐	**HHSC**	☐	**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.)
☐	**HHSC**	■	**HHSC Form 1732-EMR,** Management and Training of Service Provider Addendum — Must be signed by the employee within five days of hire.
☐	**HHSC**	☐	**Time sheets/service logs** — **HHSC Form 1745,** Service Delivery Log with Written Narrative/Written Summary, **or** facsimile approved by the FMSA
☐	**Vendors**	☐	**Receipts and invoices**

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

Code	Agency
CDC	Centers for Disease Control and Prevention
CDS	Consumer Directed Services
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)

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TEXAS Health and Human Services

Consumer Directed Services

Criminal Conviction History and Registry Checks

The applicant is a person under consideration for hire as a service provider in the CDS option (employee or independent contractor [when required]). This form covers only criminal history conviction history and registry checks.

Note: An applicant may not be hired by the CDS employer, and must not start providing services for payment, until and unless the required criminal history and registry checks are conducted, in addition to other employee qualification checks. The CDS employer and Financial Management Services Agency (FMSA) review the results of all required qualification checks to determine that an applicant can be hired. This form is signed by the FMSA.

Section I - Applicant Authorization and 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 people 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 I may not begin delivering services until the FMSA and Employer confirm that I meet all qualifications to be hired.

Applicant Information Required by the Texas Department of Public Safety (DPS) (Applicant must complete this section.)

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

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

_____ _____

Signature - Applicant Date

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.
- ☐ I understand I may not allow the applicant to begin delivering services until the FMSA and I confirm the applicant meets all qualifications to be hired.

_____ _____

Signature - Employer Date

Registry Check

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

_____ _____

Signature - Employer Date

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

- ☐ Verbally
- ☐ Encrypted email
- ☐ Certified mail

_____
Date of Employer Request

Section III - Criminal Conviction History and Registry Check Results (FMSA must complete this section.)

DPS Criminal Conviction Criminal History Check

Date FMSA received Form 1725 with employer selection for criminal history results:

Date of DPS Check	Time (specify a.m. or p.m.)
Obtained By	Convictions: ☐ **Yes** ☐ **No**

DPS approved dissemination method used to inform employer of results:

- ☐ Verbally
- ☐ Encrypted email
- ☐ Certified mail
- ☐ Did not specify method

Date FMSA staff notified employer: _____

FMSA staff:

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

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

Date report was destroyed: _____

Date employer notified FMSA of hiring decision: _____

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

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

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

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

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

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

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

_____
Signature - FMSA Representative

_____
Date FMSA notified the employer or Designated Representative

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

Consumer Directed Services

Applicant Verification for Employees

Individual's Name	Employer Name

Applicant Name	Applicant Social Security No.

The employer must verify the applicant meets each criterion. The employer must ensure the following forms 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

Boxes 1-5 must be check by Employer; Boxes 6-9 are checked if applicable.

1. ☐ The applicant is at least 18.
2. ☐ The applicant is not disqualified based on a "Yes" response on Form 1734, Service Provider and Employer Certification of Relationship Status for CDS.
3. ☐ 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).
4. ☐ The applicant has completed Form 1728, Liability Acknowledgement.
5. ☐ The applicant has read Notice Concerning Workers' Compensation in Texas (TWC Notice 5).
6. ☐ The applicant has current cardiopulmonary resuscitation (CPR) and first aid certification for Medically Dependent Children Program (MDCP) flexible family support and respite services.
7. ☐ 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.
8. ☐ 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.
9. ☐ 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.

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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
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: The Hartford's Texas Workers' Compensation Health Care Network

☐ 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

Notificación de Requisitos de Red
Responsabilidades; Información para el empleado

Estimado empleado de Texas:

Consumer Direct Care Network Texas (CDCN) utiliza The Hartford's Texas Workers' Compensation Health Care Network. Se trata de una red certificada de compensación para trabajadores orientada a brindar servicios de cuidados médicos que usted puede utilizar. La llamamos "red de cuidados médicos" porque incluye diferentes tipos de servicios médicos. Esta red se ofrece a través de su empleador. La red ha recibido la certificación de la División de Control de Calidad y Redes de Salud y Compensación para Trabajadores. Si vive en el área que atiende la red (denominada Área Geográfica de Servicio o simplemente "Área de Servicio") y se lesiona en el trabajo, debe recibir tratamiento médico a través de la red. Su empleador debe informarle sobre lo que debe hacer para poder usar la red en caso de lesionarse. No todos los médicos de su área forman parte de esta red. Su empleador también deberá proporcionarle una lista de nombres de médicos a los que puede acudir en su área. La lista de médicos tratantes que forman parte de la red incluye:

- Los nombres y direcciones de los médicos y si son médicos tratantes (el tipo de médico que usted mismo contacta) o especialistas (médicos recomendados por el médico tratante); los médicos que forman parte de la red se enlistan de acuerdo al tipo de servicio que brindan; los médicos tratantes se enlistan separados de los especialistas;
- Los nombres de los médicos que pueden determinar si su padecimiento asociado con el trabajo ha alcanzado la máxima mejora médica y proporcionar calificaciones de discapacidad para su lesión relacionada con el trabajo; e
- Información sobre médicos que están aceptando nuevos pacientes.

La lista de proveedores que forman parte de la red se actualizará al menos cuatro veces por año. Si desea una copia impresa, comuníquese con nosotros al 1-800-327-3636, opción 4 y con gusto le enviaremos una por correo. Si tiene acceso a internet, el directorio electrónico se actualiza más a menudo.

Visite: www.talispoint.com/htfd/external

CDCN utiliza un Gestor de Riesgos para ayudar con las dudas y reclamaciones de compensación para trabajadores.

Si se lesionó, por favor comuníquese con Gestor de Riesgo a la Línea Directa de Lesiones al 1-888-541-1701.

CONSUMER DIRECT CARE NETWORK

RED DE COMPENSACIÓN PARA TRABAJADORES
FORMULARIO DE ACUSE DE RECIBO

He recibido información que me indica cómo obtener atención médica bajo el seguro de compensación para trabajadores.

Si me lastimo en el desempeño de mi trabajo y vivo en el área de servicio que se describe en esta información, comprendo que:

1. Debo elegir un médico tratante de la lista de médicos de la red. O puedo solicitar a mi médico de atención primaria que acepte fungir como mi médico tratante.
2. Debo acudir a mi médico tratante para recibir todo el cuidado necesario para mi lesión Si necesito un especialista, mi médico tratante me dará una referencia. Si necesito atención de emergencia, puedo buscarla en cualquier lugar.
3. La aseguradora pagará al médico tratante y otros proveedores que formen parte de la red.
4. Es posible que yo deba pagar la cuenta si recibo cuidados médicos de alguien que no sea un médico de la red sin aprobación previa de esta.

_____ _____
(Firma) (Fecha)

_____
(Nombre en letra de molde)

Vivo en: _____
(Dirección física)

_____ _____ _____
(Ciudad) (Estado) (Código postal)

Nombre del empleador en letra de molde: _____

Firma del empleador: _____ Fecha: _____

Nombre de la red: The Hartford's Texas Workers' Compensation Health Care Network

THE HARTFORD

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							
El horario de trabajo puede cambiar sin previo aviso a CDCN					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							
El horario de trabajo puede cambiar sin previo aviso a CDCN					Weekly Total Hours		

Schedule II - Tasks

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

_____ _____

Signature — Employer Date

_____ _____

Signature — Employee Date

Servicios Administrados por el Cliente

Acuerdo de servicios entre el empleador y el empleado

El nombre de la persona que recibe servicios, en adelante llamada la "**Persona**", es:

_____ .

El programa de la Persona, _____ , en adelante llamado "**programa**", es financiado y administrado por Comisión de Salud y Servicios Humanos (HHSC) de Texas.

El nombre del empleador, en adelante llamado "**Empleador**", es: _____ .

El Empleador es ☐ la Persona ☐ uno de los padres de un menor o ☐ el tutor o curador de la Persona nombrado por la corte.

Este acuerdo se celebra entre el Empleador y _____

en adelante llamado el "**Empleado**".

El Empleador acuerda:

1. **Avisar al Empleado lo antes posible de cualquier cambio en el horario de trabajo, las tareas que debe hacer o el número de horas que el Empleado trabajará.**
2. Cumplir con todas las leyes y normas federales, estatales y locales relacionadas con el empleo.
3. Aceptar responsabilidad por:
   a. cualquier negligencia u omisión del Empleador, sus Empleados y proveedores de servicios, el representante designado (si aplica), la Persona u otras personas en el lugar de trabajo; y
   b. controlar los riesgos y la responsabilidad legal de cualquier lesión o enfermedad relacionada con el trabajo sufrida por el Empleado.
4. Dar orientación y capacitación al Empleado sobre las tareas y actividades que debe desempeñar.
5. Dar al Empleado un aviso escrito sobre el pago por los servicios prestados.

El Empleado acuerda:

1. Yo, _____ , el Empleado, estoy dispuesto y puedo desempeñar las tareas descritas y dirigidas por el Empleador, la Persona o el representante designado, si aplica..
2. Dar al Empleador la información y los documentos necesarios para mantener al día los expedientes laborales. La información y los documentos son, entre otros, cambios de dirección o teléfonos, condenas penales y prueba de su situación laboral, educación y experiencia.
3. No usar la propiedad personal del Empleador o la Persona sin su aprobación previa. El Empleado reembolsará al Empleador cualquier gasto relacionado con su uso personal de la propiedad personal.
4. Respetar los derechos y la dignidad de la Persona y seguir las medidas de seguridad que beneficien a la Persona y al Empleado.
5. Avisar al Empleador tan pronto como sea posible cuando el Empleado vaya a llegar tarde al trabajo o no pueda trabajar, y no ir a trabajar cuando su enfermedad o estado pueda poner en peligro la salud y seguridad de la Persona.

Tanto el Empleador como el Empleado acuerdan que:

1. Este documento es un acuerdo, no un contrato de empleo.
2. El Empleador está empleando al Empleado. El Empleado no es un contratista independiente. El Empleador controla la capacitación y la administración, la evaluación y el despido o la terminación del Empleado.
3. El Empleado no tiene una relación con la Persona, el Empleador o representante designado (si aplica) que le impida ser su Empleado.
4. La agencia de Servicios de administración financiera (FMSA) es responsable de la administración de los fondos del programa en nombre del Empleador, incluso de la nómina.
5. La financiación de los servicios para pagar al Empleado proviene de fuentes públicas, y se aplican las normas de responsabilidad financiera y legal al uso de los fondos. Tanto el Empleador como el Empleado tienen la responsabilidad individual y conjunta de dar cuentas de los fondos públicos usados por medio de la opción de CDS y deben comprender que presentar hojas de tiempo falsas o fraudulentas, presentar hojas de tiempo de un proveedor de servicios no cualificado, o presentar hojas de tiempo por tareas diferentes a las aprobadas en el plan de servicio o plan de implementación es un fraude de Medicaid, y se denunciará como tal a las autoridades competentes para su investigación y posible enjuiciamiento.

6. Darán cuentas precisas de los servicios prestados por el Empleado y presentarán a la FMSA hojas correctas de las horas trabajadas y la documentación para reembolsos.
7. Cobrarán las horas trabajadas, los beneficios permitidos y los gastos relacionados con la opción de CDS (la FMSA no pagará si se cobra por servicios y artículos no permitidos o no presupuestados).
8. El Empleador no puede cobrar ninguna tarifa al Empleado. El Empleado no puede hacer ningún pago al Empleador relacionado con su empleo. La FMSA hará cualquier corrección a la nómina.
9. Ni la FMSA ni el HHSC es legalmente responsable de ninguna negligencia, lesión relacionada con el empleo u omisión por parte del Empleador, la Persona, el Empleado, otros Empleados y proveedores de servicios ni del representante designado (si aplica).
10. La información médica y personal de la Persona y del Empleado es confidencial. No se debe hablar de esta información, directa o indirectamente, con otras personas fuera del entorno laboral en ningún momento ahora ni en el futuro.

Duración y modificación del acuerdo de servicios

1. Este acuerdo de servicios entrará en vigor a partir de la fecha en que lo firmen el Empleador y el Empleado. Este acuerdo de servicios no puede ser anterior a la fecha en que la Persona llena los requisitos de participación en el programa o en Servicios Administrados por el Cliente.
2. El acuerdo de servicios se puede modificar por acuerdo mutuo de las partes, a menos que las reglas o normas del HHSC, o alguna regla estatal, federal o local lo prohíban.
3. Este acuerdo de servicios vencerá cuando:
   a. la participación de la Persona en la opción de CDS termine voluntaria o involuntariamente;
   b. la Persona ya no llene los requisitos del programa del HHSC o de participación en la opción de CDS;
   c. el Empleado sea declarado culpable de un delito o esté inscrito en algún registro que prohíba su empleo por ley;
   d. la relación cambie y se le prohíba seguir trabajando; o
   e. el Empleado no mantenga o no presente la documentación para llenar los requisitos o la educación y experiencia necesarios para seguir trabajando.
4. Cualquiera de las partes puede terminar este acuerdo de servicios sin motivo avisando por escrito con 14 días calendarios de anticipación. Se puede usar un plazo diferente si las dos partes lo aceptan por escrito.

Los siguientes documentos necesarios se incorporan por referencia:

Documento	Fecha en que se firmó
Forma 1725 del HHSC	
Forma 1729 del HHSC	
Forma 1733 del HHSC, si aplica	
Forma 1734 del HHSC	

Reconocimiento del acuerdo de servicios, incluso los documentos incorporados por referencia:

Empleador:

Nombre en letra de molde

Firma

Fecha

Empleado:

Nombre en letra de molde

Firma

Fecha

Servicios Administrados por el Cliente

Acuerdo con el proveedor de servicios

Este acuerdo es entre la **Comisión de Salud y Servicios Humanos (HHSC) de Texas**, el departamento estatal de Medicaid; una **agencia de Servicios de Administración Financiera** (FMS), y un **proveedor de servicios** que presta servicios a una o más personas mediante la opción de Servicios Administrados por el Cliente (CDS).

El proveedor de servicios, _____ ☑ una persona o

☐ una entidad localizada en (Dirección) _____ ,

_____ ; Teléfono: _____ Fax: _____

El proveedor de servicios acepta:

- prestar servicios o brindar artículos o bienes que hayan sido autorizados antes de su compra para personas que participan en programas de apoyo en el hogar y en la comunidad de acuerdo con las normas y reglas de dichos programas;
- mantener documentación de los servicios, artículos y bienes adquiridos de acuerdo con las normas y reglas del programa;
- aceptar cheques de la agencia de FMS como pago completo de servicios, artículos o bienes autorizados que las personas hayan adquirido, y que se hayan brindado mediante programas de servicios en el hogar y en la comunidad;
- no aplicar ningún cargo adicional por los servicios, artículos o bienes que el cheque pague ni aceptar dicho cargo de nadie; y
- dar documentación y otra información si lo solicita la persona, la agencia de FMS, la HHSC, o su representante.

La agencia de FMS y la HHSC aceptan:

- que la agencia de FMS pague al proveedor de servicios por los servicios, artículos o bienes brindados a la persona según este acuerdo y las normas y reglas del programa, y
- permitir que el proveedor de servicios cobre a la persona por las mejoras o compras aprobadas que no hayan sido autorizadas según este acuerdo y las normas y reglas del programa.

El proveedor de servicios, la agencia de FMS y la HHSC aceptan de mutuo acuerdo que:

- la agencia de FMS, Alamo Consumer Direct, LLC , operando en Richardson, TX , preste servicios de administración financiera (FMS) a la persona que recibe servicios para realizar compras del proveedor de servicios;
- la agencia de FMS es responsable de adquirir el acuerdo completo y conservar el original en nombre de la HHSC;
- la agencia de FMS no realizará el pago hasta que no reciba este acuerdo;
- el pago de la agencia de FMS está financiado por la HHSC con fondos del gobierno; y
- la agencia de FMS no es una agencia estatal de Texas ni federal.

Este acuerdo entrará en vigor el _____ , y terminará cuando el proveedor de servicios ya no preste servicios a personas mediante la agencia de FMS.

Proveedor de servicios o representante* (Escribir en letra de molde)	Proveedor de servicios o representante* (Firma)	Fecha
Representante de la agencia de FMS (Escribir en letra de molde)	Representante de la agencia de FMS (Firma)	Fecha

**Si el proveedor de servicios es una entidad, tiene que firmar un representante de la entidad con autorización para negociar este acuerdo en nombre de la entidad.*

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: _____

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

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.

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

TEXAS Health and Human Services

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.)*

Employer and caregiver agree to maintain a current copy of the caregiver's CPR and First Aid certifications and will send certification renewals to CDCN. If the caregiver's CPR and First Aid certifications expire, the caregiver's services will be placed on hold and the caregiver will not be paid for services until a renewal is obtained. CPR* and First Aid* certifications are required for CLASS and DBMD (*hands-on only) and MDCP Star Kids and StarPlus Respite (*online or hands-on).

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

Training provided on identifying and reporting Abuse, Neglect and/or Exploitation tot he Dept. of Family & Protective Services. Reviewed reporting procedures and contact information.

IV. Evaluation/Performance Review:

V. Corrective Action Plan (if applicable):

Date for follow-up on corrective action plan: _____

VI. Service Provider Comments:

_____ _____
Signature of Service Provider Date

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

_____ _____ _____ _____
Signature of Employer Date Signature of Witness Date

01770

Date sent to FMSA: _____ **Date received by FMSA:** _____

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.

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

TEXAS Health and Human Services

Form 1747
December 2018-E

Consumer Directed Services (CDS) Option

Acknowledgement of Nursing Requirements

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 MCDP, 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.

04067

TEXAS Health and Human Services

Form 1747-LVN
October 2014-E

Consumer Directed Services (CDS) Option

Licensed Vocational Nurse (LVN) Supervision

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

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

The LVN must complete this form before providing nursing services.

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

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

Créditos fiscales por oportunidades laborales - Consumer Direct Care Network

Consumer Direct Care Network (CDCN) participa en el programa Work Opportunity Tax Credit (WOTC). WOTC es un crédito fiscal federal disponible para los empleadores. ADP administra WOTC en nombre de CDCN. Siga los pasos que se enumeran a continuación para seleccionar el programa WOTC. Apreciamos tu cooperación.

Instrucciones del solicitante

- Abra *https://tcs.adp.com/consumerdirectcare* o escanee el código QR a continuación.
  ** Nota: Si usa un dispositivo de detección compartido, asegúrese de que el dispositivo no tenga habilitada una función de autocompletar / autocompletar

- Responda cada pregunta para completar la evaluación voluntaria.

- A los solicitantes elegibles se **les pedirá que firmen electrónicamente** y hagan clic en Enviar para completar la selección.

- A los solicitantes no elegibles se les pedirá que hagan clic en Enviar para finalizar la selection. No se le pedirá que firme electronicamente.

***ADP se comunicará con las nuevas contrataciones elegibles para WOTC por correo electrónico o mensaje de texto para solicitar un comprobante de edad o documentación de dirección, cuando sea necesario.**

** Si no puede realizar la pantalla a través del enlace web, comuníquese con ADP al 1-800-237-3279 (1-800 - ADP - EASY) disponible de 6 am a 11 pm ET, los 7 días de la semana e ingrese el código de la compañía que se muestra a continuación para pantalla de Créditos fiscales. **CÓDIGO IVR: 410849**

CONSUMER DIRECT CARE NETWORK

HOW TO ACCESS YOUR

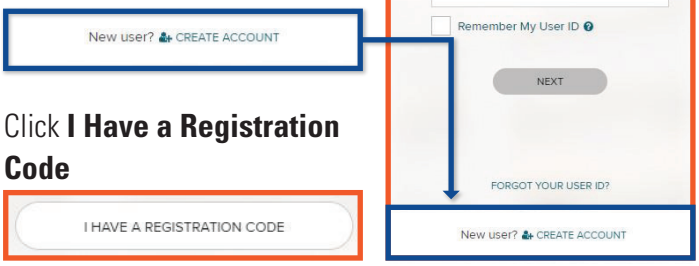
ADP **Registration Instructions**

W-2s are available on ADP. You can access ADP at **myADP.com**. The first time you visit **myADP.com**, you must register for an account. Please follow the steps below to get started.

Note: If you are a new employee, you cannot register until after you receive your first paycheck.

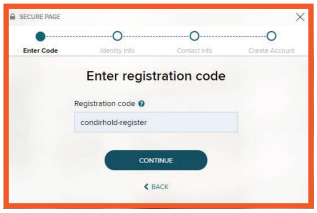
HOW TO ACCESS ADP

1. Click on this link: **myADP.com**
2. On the Log Into ADP screen, click **Create Account**

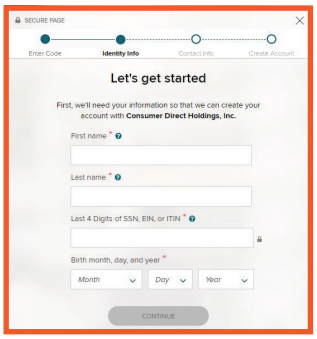


3. Click **I Have a Registration Code**

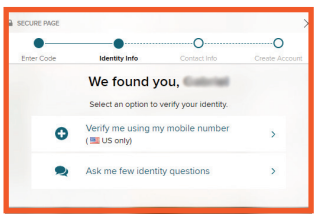
4. Enter your registration code: **condirhold-register**
   Click **Continue**.



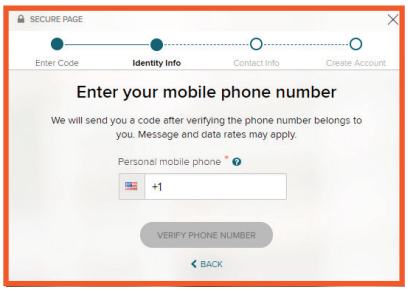
5. Enter your personal information. Click **Continue**.



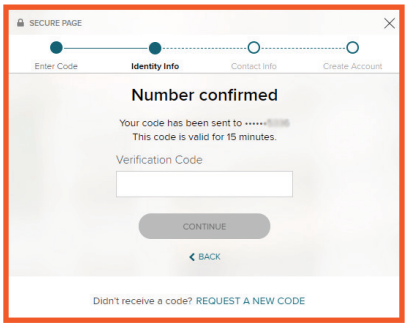
6. Select an option to verify your identity. You may choose to verify by:
   - Using your mobile number or
   - Answering a few identity questions



7. If you select to verify using your mobile phone number, enter your mobile phone number and click **Verify Phone Number.**



8. ADP will send a verification code to your mobile phone. Enter the verification code.
   Click **Continue**.
   If you did not receive a code, click **Request a New Code** to have another code sent to your mobile phone.



9. Enter your email address and select if you'd like to receive texts or calls about your ADP account. Click **Continue**.
10. Create a password for your ADP account. Accept the terms and conditions. Click **Continue**.
11. The **account created** screen will load. On this screen you will see your User ID under the Account Created Please Sign In message. Your User ID will include **condirhold** at the end of it. **Please take note of your User ID.**
12. You may now sign into **myADP.com**.

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