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

CONSUMER DIRECT CARE NETWORK

Consumer Name: _____

EMPLOYEE DATA FORM

Clear Form

Assistance with Hiring Process:
Any applicant who needs reasonable accommodation in any step of the hiring process should inform the Consumer (managing employer) and/or Consumer Direct Care Network (CDCN).

Employee Information:

Name: _____ _____ _____
First Middle Last

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

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

Phone – Home: _____ Cell: _____

Do you consent to receiving text messages from CDCN for work activities? ☐ Yes ☐ No

Email: _____ Social Security Number: _____-_____-_____

Date of Birth: ____/____/_____ (must be over 18 years old) Place of Birth (State): _____

Emergency Contact: _____ _____ _____
Name Phone Relationship

Physical Capacity:
Caregivers may be called upon to perform physically demanding work in the performance of their job duties. Physical capacity demands may include the ability to lift 75 lbs, push 75 lbs, pull 50 lbs, sit, stand, walk, kneel, bend, squat, reach, overhead reach, twist, and grasp, hold, or manipulate items with your hands.

Please indicate whether you are able to perform the above physical tasks: ☐ Yes ☐ No

Comments/Explanation: _____

_____

Professional Standards & Licensing:
Have you ever had a Professional License, Certificate, or Driver's License in any state revoked, suspended, or had disciplinary action applied? ☐ Yes ☐ No

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

Please explain any "Yes" answer: _____

_____

Previous Experience with Company:
Have you formerly worked for Consumer Direct Care Network Nevada? ☐ Yes ☐ No

Aliases or Previously Held Names:
Please list any aliases or previously held names: _____

_____

Candidate List/Additional Assignments:
Being listed on the CDCN prospective PCA list (Candidate List) presents opportunities to connect you with additional CDCN consumers after your initial placement. Caregivers who are on the list may want more hours or may need a more permanent assignment. We use this list as a tool for long term, short term, and

emergency employment needs. The Candidate List includes your name, phone number, availability and area of town that you wish to work. CDCN may call caregivers from the list to set up interviews and/or schedule work times.

To remain in good standing with our agency you are expected to adhere to conditions contained in your Employee Handbook – current TB test, CPR, First Aid, Continuing Education, background check and CDCN Coordinator reviews. Should your requirements lapse, you will be removed from the Candidate List. If you are not available for scheduled work after accepting an assignment, you must notify the CDCN office. A no call/no show can result in removal from the Candidate List.

Your choice below will only affect your status on the Candidate List. Once employed with a consumer, you may continue working with that consumer even if you are removed from the list.

I agree with and understand the above information regarding the Candidate List. I wish to:

☐ Be included on the Candidate List.

☐ Not be included on the Candidate List. I am not interested in additional work after initial placement with a consumer. I understand that, by making this choice, I will not be eligible to file Unemployment Claims.

Please Read Carefully

Neither the acceptance of this application nor the subsequent entry into any type of employment relationship with consumers for consideration of employment, either in position applied for or any other position, and regardless of the contents of employee handbooks, personnel manuals, benefit plans, policy statements, and the like as they may exist from time to time, or other CDCN practices, shall serve to create an actual or implied contract of employment or to confer any right to remain an employee of this Company. The relationship cannot be altered except by a written instrument signed by the President or Vice President of this Company. If employed, I understand that the Company may unilaterally change or revise their benefits, policies and procedures and such changes may include reductions in benefits.

I authorize investigation of all statements contained in this application. I understand that misrepresentation or omission of facts called for is cause for dismissal at any time without prior notice. I authorize the investigation of all matters contained in this application and hereby give the Company permission to contact schools, previous employers (unless otherwise indicated), references, and others, and hereby release the Company from any liability as a result of such contact.

The Fair Credit Reporting Act requires us to advise you that, in connection with our routine processing of your employment application, we may request from a consumer reporting agency an investigative consumer report including information as to your character, general reputation, personal characteristics, and mode of living. Upon written request from you, we will provide you with additional information concerning the nature and scope of any report requested by us.

I further understand that my employment with this Company shall be probationary for a period of up to 180 days, during which my relation with the Company is terminable at will for any reason by either party.

Applicant Name: _____

Applicant Signature: _____ ***Date:*** _____

This company is an equal opportunity employer

00361

Employee Application Instructions

CAREGIVER APPLICANTS: After being selected as a candidate for hire by a Consumer, you must complete, sign, and provide the following information to Consumer Direct Care Network (CDCN). After review and approval of all submitted materials, CDCN will notify you in writing when it is okay to begin working with an "Authorization to Begin Work" form.

Payroll Requirements

- Employee Data Form
- Equal Employment Opportunity Disclosure
- I-9 - *Employee completes Section 1, Employer completes Section 2. Additional I-9 instructions are available on the CDCN Nevada website under the Forms tab*
- W-4
- Pay Selection Form
- Wage Memo
- Payroll Deduction
- Health Questionnaire
- Statement of Good Health
- Employee Acknowledgment Form
- New Hire Expected Weekly Hours

Program Requirements

- Two Step TB Skin Test - CDCN will provide you information on clinic locations
- Hepatitis B Vaccination opportunity - sign the form to accept or decline the vaccination
- Fingerprint Cards or Authorization Letter for Fingerprinting - Criminal Background Check
- Civil Applicant Waiver - Criminal Background Check
- Completed Trainings - Caregiver In-Service Training, Enrollment Training Quiz, Initial Training Quizzes (*also submit the Initial Training Log which documents time spent on each required initial training*), Exposure Control Plan Training, and HIPAA Training.
- Copy of CPR Certification & First Aid – CDCN will provide location information for classes. Online certification is not valid or insufficient.

Upon completion of all application documents, deliver or send them to our state office via mail, fax or email attachment using the contact information below.

Reminder: You may not begin working as an employee until all the items listed above are completed, submitted, approved, and an "Authorization to Begin Work" form is provided to you by CDCN. You will need to remain in compliance with Medicaid regulations and program requirements as a condition of employment through CDCN.

Reminder: AuthentiCare EVV instructions and payroll related forms can be downloaded from the CDCN Nevada website at: http://consumerdirectnv.com/

CONSUMER DIRECT CARE NETWORK

EQUAL EMPLOYMENT OPPORTUNITY DISCLOSURE

Name: _____ Social Security # (last 4 digits): _____ Company: CDNV

The purpose of this questionnaire is to aid in complying with required governmental record keeping and/or reporting requirements. **This information will not be considered in the employment/selection process.** The information requested is voluntary, and you will not be subjected to any adverse treatment for choosing not to complete the questionnaire. When reported, the data will be used for statistical and reporting purposes not to identify a specific individual.

Gender (Please select the gender you most closely identify with):

☐ Male ☐ Female

Race/Ethnic Identification:

Please mark the **one box** that describes the race/ethnicity category (as defined by the Equal Employment Opportunity Commission) with which you primarily identify:

☐ Hispanic or Latino	A person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.

-OR-

☐ White (not Hispanic or Latino)	A person having origins in any of the original people of Europe, North Africa, or the Middle East.
☐ American Indian or Alaska Native (not Hispanic or Latino)	A person having origins in any of the original peoples of North or South America, and who maintain cultural identification through tribal affiliation or community attachment.
☐ Black or African American (not Hispanic or Latino)	A person having origins in any of the original peoples of Africa.
☐ Asian (not Hispanic or Latino)	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.
☐ Native Hawaiian or Other Pacific Islander (not Hispanic or Latino)	A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
☐ Two or More Races (not Hispanic or Latino)	A person who identifies with more than one of the above races.

Decline Self Identification:

☐ I do not wish to self-identify.

Although I do not wish to self-identify my gender, ethnicity and/or race, I understand that my employer is required by the federal government to determine this information (complete this form) by visual survey and/or other available information.

Employee Signature: _____ **Date**: _____

Staff Option:

Only sign here if employee declined to self-identify their gender, ethnicity and/or race, and you were the employee who determined this information by "visual survey" and/or other available information.

Staff Signature (completed this form): _____ **Date**: _____

Instructions for Completing Form I-9 Section 1

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

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

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

Employee (steps 1-9)

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

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

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

④ Print your Social Security Number.

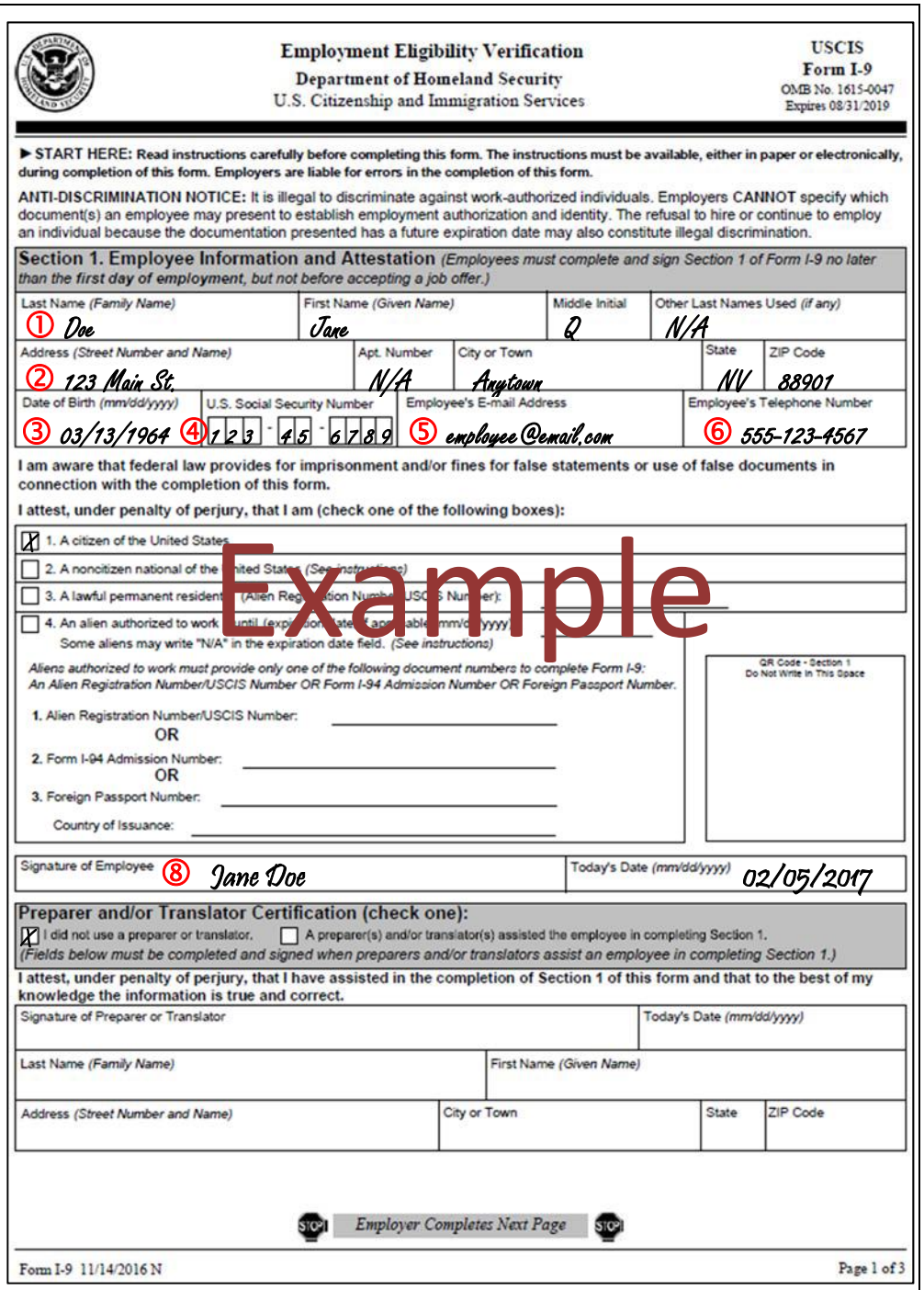
⑤ Print your email address or print "N/A" if you choose to not provide it.

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

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

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

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



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

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

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

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

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

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

Address (Street Number and Name)	Apt. Number	City or Town	State	ZIP Code
② 123 Main St.	N/A	Anytown	NV	88901

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

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

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

⑦
- [X] 1. A citizen of the United States
- [ ] 2. A noncitizen national of the United States (See instructions)
- [ ] 3. A lawful permanent resident (Alien Registration Number/USCIS Number):
- [ ] 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy)
  Some aliens may write "N/A" in the expiration date field. (See instructions)

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

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

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date (mm/dd/yyyy)
⑧ Jane Doe	02/05/2017

⑨ **Preparer and/or Translator Certification (check one):**

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

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

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

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

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

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

STOP Employer Completes Next Page STOP

Form I-9 11/14/2016 N — Page 1 of 3

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

Instructions for Completing Form I-9 Section 2

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

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

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

Employer (steps 1-10)

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

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

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

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

OR

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

Only accept unexpired, original documents (no photocopies).

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

⑤ Sign the form.

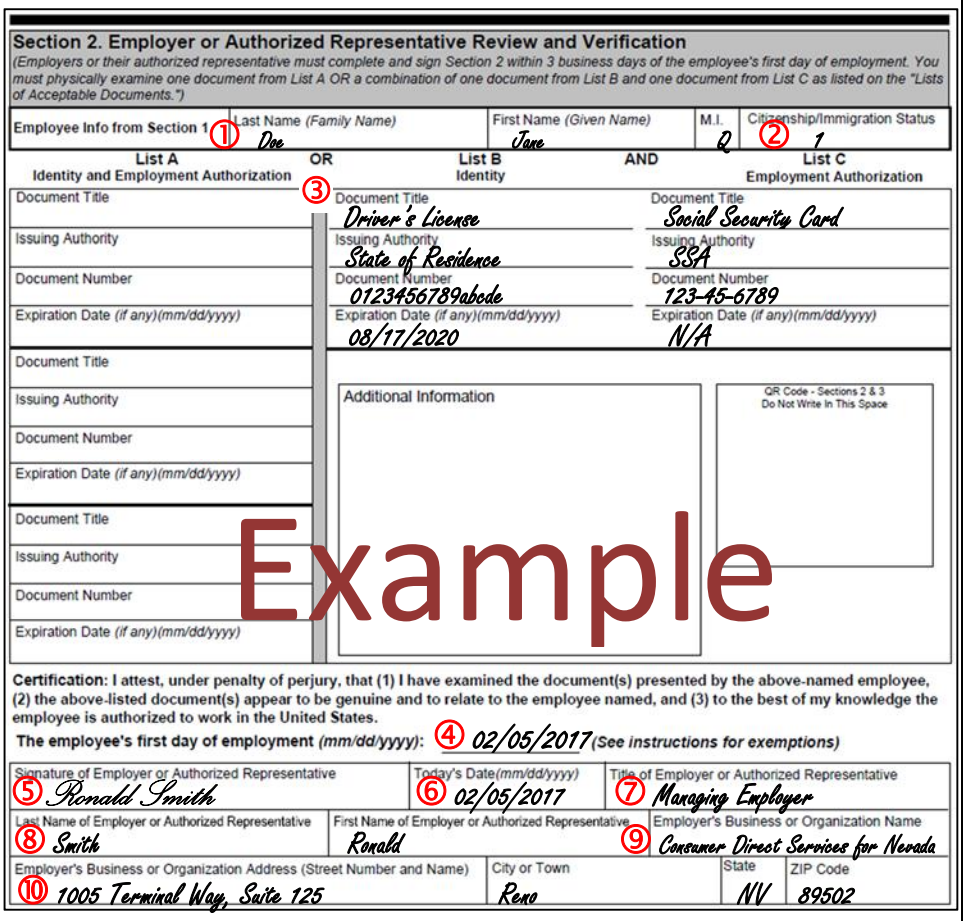
⑥ Print the date you signed the form. **Must be completed and signed within 3 days of employee's first day of work.**

⑦ Print "Managing Employer."

⑧ Print your last then first name.

⑨ If not pre-populated, print Consumer Direct's name.

⑩ If not pre-populated, print Consumer Direct's address.



Section 2. Employer or Authorized Representative Review and Verification

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

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

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title	③	Document Title: Driver's License		Document Title: Social Security Card
Issuing Authority		Issuing Authority: State of Residence		Issuing Authority: SSA
Document Number		Document Number: 0123456789abcde		Document Number: 123-45-6789
Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy): 08/17/2020		Expiration Date (if any)(mm/dd/yyyy): N/A
Document Title		Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				

Example

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

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

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

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
⑧ Smith	Ronald	⑨ Consumer Direct Services for Nevada

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code
⑩ 1005 Terminal Way, Suite 125	Reno	NV	89502

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

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

Employment Eligibility Verification

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

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

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

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

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

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

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

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

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

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

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

STOP *Employer Completes Next Page* STOP

03149

Employment Eligibility Verification

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

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

Section 2. Employer or Authorized Representative Review and Verification

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

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

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

Additional Information

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

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

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

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

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
		Consumer Direct Services for Nevada

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code
1005 Terminal Way, Suite 125	Reno	NV	89502

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

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

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

Refer to the instructions for more information about acceptable receipts.

00540

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

2022

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 widow(er)**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the estimator at *www.irs.gov/W4App*, and privacy.

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . ► ☐

TIP: To be accurate, submit a 2022 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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

Step 3: Claim Dependents

If your 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 and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

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 2022 if you meet both of the following conditions: you had no federal income tax liability in 2021 **and** you expect to have no federal income tax liability in 2022. You had no federal income tax liability in 2021 if (1) your total tax on line 24 on your 2021 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), 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 2022 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, 2023.

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

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

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

1. Expect to work only part of the year;

2. Have dividend or capital gain income, or are subject to additional taxes, such as Additional Medicare Tax;

3. Have self-employment income (see below); or

4. Prefer the most accurate withholding for multiple job situations.

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

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

Specific Instructions

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

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

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

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

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

Step 3. 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 2022 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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

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

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

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . **1** $

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . **2a** $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . **2b** $

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . **2c** $

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3**

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . **4** $

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

1 Enter an estimate of your 2022 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:
- $25,900 if you're married filing jointly or qualifying widow(er)
- $19,400 if you're head of household
- $12,950 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 possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

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

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

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

Married Filing Jointly or Qualifying Widow(er)

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$110	$850	$860	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,770	$1,870
$10,000 - 19,999	110	1,110	1,860	2,060	2,220	2,220	2,220	2,220	2,220	2,970	3,970	4,070
$20,000 - 29,999	850	1,860	2,800	3,000	3,160	3,160	3,160	3,160	3,910	4,910	5,910	6,010
$30,000 - 39,999	860	2,060	3,000	3,200	3,360	3,360	3,360	4,110	5,110	6,110	7,110	7,210
$40,000 - 49,999	1,020	2,220	3,160	3,360	3,520	3,520	4,270	5,270	6,270	7,270	8,270	8,370
$50,000 - 59,999	1,020	2,220	3,160	3,360	3,520	4,270	5,270	6,270	7,270	8,270	9,270	9,370
$60,000 - 69,999	1,020	2,220	3,160	3,360	4,270	5,270	6,270	7,270	8,270	9,270	10,270	10,370
$70,000 - 79,999	1,020	2,220	3,160	4,110	5,270	6,270	7,270	8,270	9,270	10,270	11,270	11,370
$80,000 - 99,999	1,020	2,820	4,760	5,960	7,120	8,120	9,120	10,120	11,120	12,120	13,150	13,450
$100,000 - 149,999	1,870	4,070	6,010	7,210	8,370	9,370	10,510	11,710	12,910	14,110	15,310	15,600
$150,000 - 239,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	15,340	16,540	16,830
$240,000 - 259,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	15,340	16,540	17,590
$260,000 - 279,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	16,100	18,100	19,190
$280,000 - 299,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	13,700	15,700	17,700	19,700	20,790
$300,000 - 319,999	2,040	4,440	6,580	7,980	9,340	11,300	13,300	15,300	17,300	19,300	21,300	22,390
$320,000 - 364,999	2,100	5,300	8,240	10,440	12,600	14,600	16,600	18,600	20,600	22,600	24,870	26,260
$365,000 - 524,999	2,970	6,470	9,710	12,210	14,670	16,970	19,270	21,570	23,870	26,170	28,470	29,870
$525,000 and over	3,140	6,840	10,280	12,980	15,640	18,140	20,640	23,140	25,640	28,140	30,640	32,240

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	$400	$930	$1,020	$1,020	$1,250	$1,870	$1,870	$1,870	$1,870	$1,970	$2,040	$2,040
$10,000 - 19,999	930	1,570	1,660	1,890	2,890	3,510	3,510	3,510	3,610	3,810	3,880	3,880
$20,000 - 29,999	1,020	1,660	1,990	2,990	3,990	4,610	4,610	4,710	4,910	5,110	5,180	5,180
$30,000 - 39,999	1,020	1,890	2,990	3,990	4,990	5,610	5,710	5,910	6,110	6,310	6,380	6,380
$40,000 - 59,999	1,870	3,510	4,610	5,610	6,680	7,500	7,700	7,900	8,100	8,300	8,370	8,370
$60,000 - 79,999	1,870	3,510	4,680	5,880	7,080	7,900	8,100	8,300	8,500	8,700	8,970	9,770
$80,000 - 99,999	1,940	3,780	5,080	6,280	7,480	8,300	8,500	8,700	9,100	10,100	10,970	11,770
$100,000 - 124,999	2,040	3,880	5,180	6,380	7,580	8,400	9,140	10,140	11,140	12,140	13,040	14,140
$125,000 - 149,999	2,040	3,880	5,180	6,520	8,520	10,140	11,140	12,140	13,320	14,620	15,790	16,890
$150,000 - 174,999	2,040	4,420	6,520	8,520	10,520	12,170	13,470	14,770	16,070	17,370	18,540	19,640
$175,000 - 199,999	2,720	5,360	7,460	9,630	11,930	13,860	15,160	16,460	17,760	19,060	20,230	21,330
$200,000 - 249,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,310
$250,000 - 399,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,310
$400,000 - 449,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,470
$450,000 and over	3,140	6,290	8,880	11,380	13,880	16,010	17,510	19,010	20,510	22,010	23,380	24,680

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	$760	$910	$1,020	$1,020	$1,020	$1,190	$1,870	$1,870	$1,870	$2,040	$2,040
$10,000 - 19,999	760	1,820	2,110	2,220	2,220	2,390	3,390	4,070	4,070	4,240	4,440	4,440
$20,000 - 29,999	910	2,110	2,400	2,510	2,680	3,680	4,680	5,360	5,530	5,730	5,930	5,930
$30,000 - 39,999	1,020	2,220	2,510	2,790	3,790	4,790	5,790	6,640	6,840	7,040	7,240	7,240
$40,000 - 59,999	1,020	2,240	3,530	4,640	5,640	6,780	7,980	8,860	9,060	9,260	9,460	9,460
$60,000 - 79,999	1,870	4,070	5,360	6,610	7,810	9,010	10,210	11,090	11,290	11,490	11,690	12,170
$80,000 - 99,999	1,870	4,210	5,700	7,010	8,210	9,410	10,610	11,490	11,690	12,380	13,370	14,170
$100,000 - 124,999	2,040	4,440	5,930	7,240	8,440	9,640	10,860	12,540	13,540	14,540	15,540	16,480
$125,000 - 149,999	2,040	4,440	5,930	7,240	8,860	10,860	12,860	14,540	15,540	16,830	18,130	19,230
$150,000 - 174,999	2,040	4,460	6,750	8,860	10,860	12,860	15,000	16,980	18,280	19,580	20,880	21,980
$175,000 - 199,999	2,720	5,920	8,210	10,320	12,600	14,900	17,200	19,180	20,480	21,780	23,080	24,180
$200,000 - 449,999	2,970	6,470	9,060	11,480	13,780	16,080	18,380	20,360	21,660	22,960	24,250	25,360
$450,000 and over	3,140	6,840	9,630	12,250	14,750	17,250	19,750	21,930	23,430	24,930	26,420	27,730

CONSUMER DIRECT CARE NETWORK

PAY SELECTION FORM

Employee Name: _____ Date of Birth: ___/___/_____

Consumer Direct Care Network (CDCN) issues pay by direct deposit to a bank account or pay card. Pay stubs and W-2s are sent to you by mail to your address on file or electronically.

Please check one pay option below.

Note: You will be enrolled in the Wisely Pay card option if (1) you make no selection below, or (2) you select direct deposit to a bank account but provide invalid account information or your account is closed.

☐ **Direct Deposit to a Wisely Pay Card Account.** I authorize CDCN to issue me a Wisely Pay card. The card will be tied to my identification on file. CDCN will make payroll deposits to my card account. I will receive the card in 7 to 10 business days after initial processing.

☐ **Direct Deposit to an Existing Checking, Savings or Pay Card Account.** I authorize CDCN to initiate payroll deposits to my bank or financial institution.

The Name of my bank is: _____

The Account Type is (check one): ☐ Checking ☐ Savings ☐ Pay Card

AN ATTACHMENT IS REQUIRED.

For a Checking Account. Please attach a voided check. This is preferred. A bank-issued direct deposit form or bank letter* is ok too.

For a Savings Account or Pay Card. Please attach a bank-issued direct deposit form or bank letter.*

**Do not submit a deposit slip*. *The routing numbers differ from direct deposit routing numbers.*

Acknowledgement. I authorize CDCN to process my selected method of pay. I understand that:

- CDCN reserves the right to refuse any direct deposit request.
- I am responsible to confirm that each deposit has occurred. I must pay any fees caused by overdrafts on my account.
- All direct deposits are made through an Automated Clearing House (ACH). Processing is subject to ACH terms. The terms of my bank also apply.
- If funds are deposited to my account in error, or an improper payment is made, I authorize CDCN to debit my account to correct the error. If my account cannot be debited due to closure or insufficient balance, then CDCN may withhold future payments until the erroneous deposited amounts are repaid.
- I may receive a paper check while my selected method of pay is being set up.
- I must submit a new Pay Selection Form to CDCN if I wish to change my Direct Deposit option.

_____ _____

Employee Signature *Date*

Sign up for the Wisely® Pay card today!

It's a reloadable prepaid pay card that's **yours to keep no matter where you work**.[1] There's no fee to sign up, and there's **no credit check** to get the Wisely Pay card because it's not a credit card.[2]

Enjoy these great benefits when you activate your Wisely Pay card account.

Shop and Pay Bills — In stores, by phone, or online, everywhere Visa debit cards are accepted and where Debit Mastercard is accepted.[3] Pay with a single touch anywhere Apple Pay®, Samsung Pay®, or Google Pay™ is accepted.

No Charge for Direct Deposit — Get paid up to 2 days early[4] for your pay and other sources of income.[5] A no-fee[6] upgrade is required.[7]

Safe and Secure — Balance is protected from fraud if the card is lost or stolen, and is FDIC insured.[8]

Manage your Money — Save for a rainy day, plan your budget, and track your spending to boost your financial wellness with myWisely® app.[9]

[1] Adding funds from other sources requires additional cardholder identification verification.
[2] Wisely Pay is not a credit card and does not build credit.
[3] Additional terms and third-party fees may apply.
[4] You must opt into early direct deposit on myWisely.com/pay or myWisely mobile app. Early direct deposit of funds is not guaranteed and is subject to payer's support and the timing of payer's payment instruction. Faster-funding claim is based on a comparison of our policy of making funds available upon our receipt of payment instruction with the typical banking practice of posting funds at settlement. Please see full disclosures on myWisely.com or myWisely app. Please allow up to 3 weeks for funds to be loaded to the card after initial setup of direct deposit to your card.
[5] Please allow up to 3 weeks for your pay to be loaded to the card after initial setup of direct deposit to your card.
[6] While this feature is available at no additional charge, certain other transaction fees and costs, terms, and conditions are associated with the use of this Card. See the cardholder agreement for more details.
[7] Additional verification required and may not be available to all cardholders.
[8] You must notify us immediately and assist us in our investigation if your card is lost or stolen or you believe someone is using your card without your permission.
[9] Standard text message fees and data rates may apply.

WiselyCard_Poster_V4 Rev. Aug 2020

CONSUMER DIRECT CARE NETWORK

WAGE MEMORANDUM

Employee Name	Consumer Name	Consumer CDCN ID #

POSITION	WAGE
Personal Care Program Services: Personal Care, Skilled by Unlicensed	$11.10/ hour
PAS Program - Personal Care, **Cope Program** - Personal Care, **Waiver** - Social Supervision	$11.10/ hour
Waiver Attendant Care Services: Homemaker & Chore	$10.50/ hour
Training Wage* *only 8 hours training that is completed as part of annual continuing education requirement	$10.50/ hour
Respite Care (Waiver) Service: Respite	$10.50/ hour

Overtime: **Overtime is generally not allowed**. Any exception must be approved in advance of time worked and in writing by the Consumer Direct Care Network (CDCN) office. Overtime is defined as either **more than 8 hours in a day or 40 hours in a week**. Prior to working an overtime schedule, you will need to have CDCN approval and sign a Modified Wage Agreement.

Paid Time Off: Caregivers will accrue 0.01923 hour of Paid Time Off (PTO) for every hour worked, up to a maximum of 40 hours annually. PTO may be used starting 90 days after initial hire date. Time may be claimed through submittal of a paper timesheet, with Consumer/PCR signature, using the code "SICK". Employee must consult with the Consumer/PCR prior to taking time off. Refer to your Employee Handbook for additional information.

Date Effective: _____

_____ _____

Employee Signature *Date*

_____ _____ _____ _____

Consumer/PCR Signature *Date* *CDCN Representative Signature* *Date*

CONSUMER DIRECT CARE NETWORK

PAYROLL DEDUCTION

For required fingerprinting and background checks

_____

Employee Name (please print)

Consumer Direct Care Network (CDCN) is offering to assist caregivers with the cost of paying for state-required fingerprinting and background checks. CDCN will share the total cost of fingerprinting and background checks 50/50 with the caregiver. CDCN will pay the upfront cost and deduct payments for 50% of the total cost of the fingerprinting and background checks from initial paychecks until the cost is repaid.

Please complete the section below to either accept or waive the payroll deduction.

☐ **Accept Payroll Deduction**

50% of the total cost of the fingerprint and background checks will be divided into equal payments to be deducted from your initial paychecks (deductions will continue until payment of 50% the total cost of the fingerprinting and background checks has been repaid).

My signature below authorizes CDCN to make the above-noted payroll deductions.

_____ _____

Employee Signature *Date*

OR

☐ **Waive Payroll Deduction**

I authorize CDMS to waive the payroll deduction since CDCN Nevada will not incur any cost to obtain the State and FBI background reports for this caregiver.

_____ _____

CDNV Staff Signature *Date*

For office use only:

Total Deduction Amount	Deduction per Paycheck	# of Paychecks	End Date

02236

CONSUMER DIRECT CARE NETWORK

EMPLOYEE HEALTH QUESTIONNAIRE

Employee Name: _____
(please print)

Background: You have been conditionally hired to provide services for the service recipient in accordance with their authorized plan of care. You may be required to perform physical tasks. The purpose of this Health Questionnaire is to assess your ability to safely perform the authorized tasks. The information provided on this Questionnaire will be used to help manage your employment in a safe manner. Your responses are considered *Confidential*.

Instructions: Respond to each item as to whether you have a medical or physical activity restriction or limitation. **Please explain each "Yes" answer on the backside of this form and attach additional information as necessary.**

Return this completed form and other employment forms to the Consumer Direct Care Network (CDCN) office.

	Do you currently have a Physical Activity Restriction for:	NO	YES
1	Sitting		
2	Stationary Standing		
3	Walking		
4	Ability to be Mobile		
5	Crouching (bending at knee)		
6	Kneeling/Crawling		
7	Stooping (bending at waist)		
8	Twisting (knees/waist/neck)		
9	Turning/Pivoting		
10	Climbing		
11	Balancing		
12	Reaching overhead		
13	Reaching extension		
14	Grasping		
15	Pushing/Pulling		
16	Lifting/Carrying		
17	Whole/Partial Loss of Hearing		
18	Blindness (partial or complete) or Eye Problems		
19	Have you ever been advised by a health care professional to restrict your physical activities in any way?		
	Personal Medical History – In the past 5 years, have you had or been treated for:	**NO**	**YES**
20	Epilepsy		
21	Fainting/Dizzy Spells		
22	Hernia		
23	Muscular Strain		
24	Neck or Back Injury		
25	Ruptured Intervertebral Disc		
26	Joint Injury or Pain		
27	Fractures		
28	Tuberculosis or Non-Negative TB Test		
29	Lung Problems/Disease		
30	Head Injury		
31	Other Current Problems, Diseases, Conditions		
32	Have you been hospitalized or undergone surgery, other than for childbirth?		
33	Have you refused a recommended surgical procedure?		
34	Are you currently taking any medication or drugs, whether by prescription or not, that could impair your judgment?		

CONSUMER DIRECT CARE NETWORK

EMPLOYEE HEALTH QUESTIONNAIRE

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

CDCN does not discriminate in hiring, promotion, or other terms and conditions of employment. In addition, CDCN does not discriminate against persons who have, in good faith, filed a claim for or received benefits according to State Workers' Compensation Laws. Requests for Accommodations which allow employees to perform the essential functions need to be requested in writing and will be provided if they do not cause an undue hardship.

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

I affirm that I have answered the above questions to the best of my knowledge. My answers are true and complete. I understand that knowingly providing false information is cause for dismissal and may result in denial of workers' compensation benefits.

Employee Signature: _____ Date: _____/_____/_____

Office Use Only

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

State Office/Location: _____ Risk Mgr Review: [_____] Date _____/_____/_____

05095

Statement of Good Health

This person is in a state of good health, is free from active tuberculosis and any other communicable disease in a contagious stage.

_____ _____

Physician's Signature *Date*

_____ _____

Physician's Name (please print) Caregiver's Name (please print)

_____ _____

Office Address Address of Caregiver

_____ _____

Office Phone Number Phone Number of Caregiver

Please return the completed form to Consumer Direct Care Network:

1005 Terminal Way, Suite #125
Reno, NV 89502-2179

Toll Free Fax: 1-877-786-4998
Email: InfoCDNV@consumerdirectcare.com

EMPLOYEE ACKNOWLEDGEMENT FORM

Employee Name	Consumer Name

Instructions: Review each topic, ask questions as necessary, and sign below to signify your acknowledgement.

1. I have received the Consumer Direct Services for Nevada, LLC, doing business as Consumer Direct Care Network Nevada (CDCN) Employee Handbook. The Handbook provides guidelines on the policies, procedures, and programs affecting my employment with this organization. I understand that CDCN can, at its sole discretion, supersede, modify, revoke, suspend, terminate or deviate from the guidelines, policies, procedures, benefits and information in the Handbook as circumstances or situations warrant, in whole or in part, at any time with or without notice.

   Furthermore, I acknowledge that the Handbook is neither a contract of employment nor a legal document and nothing in the Handbook creates an express or implied contract of employment. I understand that I should consult my Consumer (supervisor) or CDCN (Employer of Record) if I have questions that are not answered in the Handbook.

   I accept responsibility for familiarizing myself with the information, seeking clarification of its terms or guidance, where necessary, and complying with the content. I acknowledge & accept my responsibility to abide by the policies & procedures contained in the Handbook.

2. I have received a copy of the Consumer's Service Plan, and understand that CDCN is not financially responsible for payment of services in situations where:
   - The Consumer becomes ineligible for Medicaid
   - The Consumer/Personal Care Representative allows their caregiver to work unauthorized overtime (hours in excess of 40 per week or eight (8) per day)
   - The Consumer/Personal Care Representative allows their caregiver to work in excess of time approved or for tasks not approved on the Consumer's Service Plan

3. I acknowledge I have received the following training modules, am responsible for learning/training upon the information provided in each one, and completing & submitting the associated training quiz: Tuberculosis Brochure, Bloodborne Pathogen Booklet, Lifting & Moving Patients Booklet, and HIPAA & Confidentiality.

4. I acknowledge that I have received a Status Change Form. I am responsible for notifying CDCN immediately of a resignation and within 10 days of any change in the following: name, address, telephone number, licenses, certifications, type of service or area of specialty, and any criminal convictions or pending criminal charges not previously disclosed since hire date.

5. I acknowledge I have received an AuthentiCare 2.0 Electronic Visit Verification (EVV) user guide. I must sign in and sign out for each shift worked using the AuthentiCare EVV system. In the event the system is unavailable or I forget to clock in or clock out, I must submit a paper correction form with Consumer signature. EVV exceptions may delay pay. Repeated noncompliance with EVV may result in corrective action by CDCN, up to and including termination.

6. Current CPR certification, TB screening, caregiver training hours, and fingerprint background check are required by the State of Nevada. **I understand that remaining in compliance with Nevada Medicaid regulations is a condition of my employment through CDCN and that I will be suspended immediately if I fall out of compliance. I understand I cannot be compensated for any services provided when (1) the Consumer is in the hospital or under the care of another health professional, (2) authorized tasks on the Care Plan cannot be performed with the Consumer, or (3) I am out of compliance with Nevada Medicaid regulations.**

7. Verification of current automobile liability insurance is required to accept transport assignments (applies, if transporting Consumers.)

8. I am a managed employee of the Consumer, and an employee of record of CDCN.

9. **Personal Care Assistant Responsibilities**
   CDCN caregivers are responsible for the following:
   - It is a condition of employment to remain in compliance with all regulatory and program requirements as detailed in the employee handbook.
   - I have read and understand the provision of NAC.449 concerning Agency to Provide Personal Care services in the home. In addition, I have read and understand the provisions and was provided a copy or electronic access to NRS 449 concerning Medical and Other related Facilities:
     - Web site for NRS 449: http://www.leg.state.nv.us/nrs/NRS-449.html
     - Web site for NAC 449: http://www.leg.state.nv.us/NAC/NAC-449.html
   - Documentation including time worked
   - Follow the service/care plan for each consumer
   - Maintain Confidentiality
   - I understand I must report Serious Occurrences within 24 hours as explained to me at enrollment. Serious Occurrences include but are not limited to: Injuries on the job, Falls (with or without injury), Unplanned Hospitalizations, Emergency Room/Urgent Care Visits, and Assault/Abuse/Neglect/Exploitation.

10. **Non-Emergent Care/Responding to Emergencies**
    - I acknowledge that the Self-Directed Personal Care Services Program is not designed to be an emergency or acute medical service plan. The caregiver understands that the Consumer or Personal Care Representative should report any potential risky health situation to their physician or by calling the local emergency service, such as 911, as appropriate and not rely upon themselves to make acute medical situation determinations.
    - I received training about recognizing and responding to emergencies, including, without limitation, fires and medical emergencies. The Consumer(s) I work for will review their Back Up and Emergency Plan with me as well.

11. **Overtime Acknowledgment**
    - **Overtime is not allowed** without prior written approval by CDCN (any overtime exception must be approved <u>in advance of time worked</u> and <u>in writing</u>).

- Overtime is defined as either more than 8 hours in a day or 40 hours in a week.

12. **Direct Deposit**

CDCN wants all employees to be paid in a timely and consistent manner. CDCN offers two direct deposit pay options, either to a bank account specified by you or to a pay card. CDCN considers these to be the most regular and efficient method of pay delivery. I understand that if I choose to receive checks that delivery is dependent upon federal holidays, other U.S. mail disruptions and payroll corrections. Pay stubs (a summary of your pay) and W-2s are sent by first class mail to your address on file or electronically.

13. **Effective Date**

Employment effective date will be upon completion of the CDCN employment package and approval by a CDCN Representative, which will be communicated via the "Authorization to Begin Work" form.

Employee Signature	*Date*	*Consumer/PCR Signature*	*Date*

CONSUMER DIRECT CARE NETWORK

AUTHORIZATION/DECLINATION
HEPATITIS B VACCINATION

_____
Employee Name

The above-named employee is authorized to receive or complete the **Hepatitis B vaccination series** through a Public Health Nurse, Local Clinic, or Concentra and have the charges billed to the Consumer Direct Care Network (CDCN) at:

Consumer Direct Care Network
1005 Terminal Way, Suite #125
Reno, NV 89502-2179

Phone: 1-877-786-4999
Fax: 1-877-786-4998

***** CLINIC OR HEALTH PERSONNEL *****

THIS AUTHORIZATION IS NOT VALID UNLESS SIGNED

_____ _____
Authorization Approval: CDCN Representative DATE

HEPATITIS B VACCINATION ACCEPT/DECLINE

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 receive Hepatitis B vaccination at no charge. I can choose to decline the Hepatitis B vaccination at this time. I understand that if I decline this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. I understand that I may elect to receive the vaccine now or at a future date, while employed with Consumer Direct Personal Care.

I choose to: ☐ be vaccinated ☐ decline vaccination

_____ _____
Employee Signature *Date*

STATE OF NEVADA

STEVE SISOLAK
Governor

RICHARD WHITLEY, MS
Director, DHHS

JULIE KOTCHEVAR, Ph.D.
Administrator

LEON RAVIN, M.D.
Chief Medical Officer

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
BUREAU OF HEALTH CARE QUALITY AND COMPLIANCE
727 Fairview Dr., Suite E, Carson City, NV 89701
Telephone: 775-684-1030, Fax: 775-684-1073
dpbh.nv.gov

NOTICE OF NONCRIMINAL JUSTICE APPLICANT'S RIGHTS, CONSENTS AND SELF DISCLOSURE OF CRIMINAL HISTORY

FINGERPRINT BACKGROUND WAIVER – NOTICE OF NONCRIMINAL JUSTICE APPLICANT'S RIGHTS

As an applicant who is the subject of a Federal Bureau of Investigation (FBI) fingerprint-based criminal history record check for a noncriminal justice purpose you have certain rights which are discussed below.

1. You must be notified by (enter name of requesting agency) Consumer Direct Services for Nevada that your fingerprints will be used to check the criminal history records of the FBI and the State of Nevada.

2. If you have a criminal history record, the officials making a determination of your suitability for the job, license or other benefit for which you are applying must provide you the opportunity to complete or challenge the accuracy of the information in the record. You may review and challenge the accuracy of any and all criminal history records which are returned to the submitting agency. The proper forms and procedures will be furnished to you by the Nevada Department of Public Safety, Records Bureau upon request. If you decide to challenge the accuracy or completeness of your FBI criminal history record, Title 28 of the Code of Federal Regulations, Section 16.34, provides for the proper procedure to do so:

> **16.34 - Procedure to obtain change, correction or updating of identification records.**
> If, after reviewing his/her identification record, the subject thereof believes that it is incorrect or incomplete in any respect and wishes changes, corrections or updating of the alleged deficiency, he/she should make application directly to the agency which contributed the questioned information. The subject of a record may also direct his/her challenge as to the accuracy or completeness of any entry on his/her record to the FBI, Criminal Justice Information Services (CJIS) Division, ATTN: SCU, Mod. D-2, 1000 Custer Hollow Road, Clarksburg, WV 26306. The FBI will then forward the challenge to the agency which submitted the data requesting that agency to verify or correct the challenged entry. Upon the receipt of an official communication directly from the agency which contributed the original information, the FBI CJIS Division will make any changes necessary in accordance with the information supplied by that agency.

3. Based on 28 CFR § 50.12 (b), officials making such determinations should not deny the license or employment based on information in the record until the applicant has been afforded a reasonable time to correct or complete the record or has declined to do so.

4. You have the right to expect that officials receiving the results of the fingerprint-based criminal history record check will use it only for authorized purposes and will not retain or disseminate it in

violation of federal or state statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council.

5. I hereby authorize (enter name of requesting agency) Consumer Direct Services for Nevada, to submit a set of my fingerprints to the Nevada Department Public Safety, Records Bureau for the purpose of accessing and reviewing State of Nevada and FBI criminal history records that may pertain to me.

In giving this authorization, I expressly understand that the records may include information pertaining to notations of arrest, detainments, indictments, information or other charges for which the final court disposition is pending or is unknown to the above referenced agency. For records containing final court disposition information, I understand that the release may include information pertaining to dismissals, acquittals, convictions, sentences, correctional supervision information and information concerning the status of my parole or probation when applicable.

6. I hereby release from liability and promise to hold harmless under any and all causes of legal action, the State of Nevada, its officer(s), agent(s) and/or employee(s) who conducted my criminal history records search and provided information to the submitting agency for any statement(s), omission(s), or infringement(s) upon my current legal rights. I further release and promise to hold harmless and covenant not to sue any persons, firms, institutions or agencies providing such information to the State of Nevada on the basis of their disclosures. I have signed this release voluntarily and of my own free will.

CONSENT TO CHECK OF REGISTRIES

I consent to have a check of registries conducted, including, but not limited to, any government abuse registries, licensing registries, sexual abuse registries, the Office of Inspector General List of Excluded Individuals and Entities registry and any other registries that may be required by the Division of Public and Behavioral Health.

SELF DISCLOSURE STATEMENT OF CRIMINAL HISTORY

I attest that I have never been convicted of any of the following crimes:

- Murder, voluntary manslaughter or mayhem;
- Assault or battery with intent to kill or to commit sexual assault or mayhem;
- Sexual assault, statutory sexual seduction, incest, lewdness or indecent exposure, or any other sexually related crime that is punished as a felony (including felony prostitution);
- A crime involving domestic violence that is punished as a felony;
- Abuse or neglect of a child or contributory delinquency;
- Abuse, neglect, exploitation or isolation of older persons or vulnerable persons, including, without limitation, a violation of any provision of NRS 200.5091 to NRS 200.50995, inclusive, or a law of any other jurisdiction that prohibits the same or similar conduct;
- A violation of any provision of NRS 422.450 to NRS 422.590, inclusive; or
- Any other felony involving the use or threatened use of force or violence against the victim or the use of a firearm or other deadly weapon.

I attest that I have not been convicted of any of the following crimes within the immediately preceding 7 years:

- Prostitution, solicitation, lewdness or indecent exposure, or any other sexually related crime that is punished as a misdemeanor;
- A crime involving domestic violence that is punished as a misdemeanor;
- A violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of NRS;

- A violation of any provision of law relating to the State Plan for Medicaid or a law of any other jurisdiction that prohibits the same or similar conduct;
- A criminal offense under the laws governing Medicaid or Medicare;
- Any offense involving fraud, theft, embezzlement, burglary, robbery, fraudulent conversion or misappropriation of property; or
- An attempt or conspiracy to commit any of the offenses listed in this Self Disclosure Statement of Criminal History section.

CONSENT TO BE ENROLLED IN A RAP (Record of Arrests and Prosecutions) BACK SYSTEM
(optional – check only if you consent)
☐I understand that if I check this box, the facility, hospital, agency, program or home I am under employment/contract/service with or the Division of Public and Behavioral Health may enroll me in a RAP (Record of Arrests and Prosecutions) back system which would allow the Central Repository for Nevada Records of Criminal History to notify my employer and the Division of Public and Behavioral Health of any criminal offenses that I may be convicted of in the future.

AUTHORIZATION OF SUBMISSION OF FINGERPRINTS
I authorize the submission of my fingerprints to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for its background check report.

A reproduction of this authorization for release of information by photocopy, facsimile or similar process, shall for all purposes be as valid as the original.

In consideration for processing my application I, the undersigned, whose name and signature voluntarily appears below; do hereby and irrevocably agree to the above.

I understand that a person who willfully provides a false statement or information connected with a background investigation that would disqualify the person from employment, including without limitation, a conviction of a crime listed in NRS 449.174, is guilty of a misdemeanor.

I declare under penalty of perjury that the foregoing is true and correct. Executed on:

Applicant's Name : _____
(PLEASE PRINT LAST, FIRST, MIDDLE)

Address: _____

Applicant's Signature: _____Date: _____

Submitting Agency: Consumer Direct Services for Nevada

Address: 1005 Terminal Way, Suite 125, Reno NV 89502

Agency representative: _____
(PLEASE PRINT LAST, FIRST, MIDDLE)

Agency representative's Signature: _____ Date: _____

CONSUMER DIRECT CARE NETWORK

EXPECTED WEEKLY HOURS - NEW HIRE

CAREGIVER/NURSE
(Non-FEA)

Employee Name: _____

Entity: CDNV

Email Address: _____

-- Office Use Only --

Hire Date: _____

Anticipated Weekly Hours:

How many hours per week do you reasonably expect this employee to work for the foreseeable future?

- ☐ Full-time (30+ hours)
- ☐ Part-time (10-29 hours)
- ☐ Less than 10 hours
- ☐ Variable – unable to make a reasonable determination*

Comments:

CDCN Representative Name: _____

Benefits will be offered to employees on the first of the month following/coinciding with 30 days from their first day worked.

Employees marked "variable" will not be offered benefits upon hire.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

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

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the Human Resources Department

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

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

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
Consumer Direct Services for Nevada	30-0122521
5. Employer address 100 Consumer Direct Way	6. Employer phone number 844.360.4747

7. City	8. State	9. ZIP code
Missoula	MT	59808

10. Who can we contact about employee health coverage at this job?	
Human Resources Department	
11. Phone number (if different from above)	12. Email address InfoBenefits@consumerdirectcare.com

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

Regular status employees working at least 30 hours/week

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Spouse or domestic partner, child(ren) up to age 26

☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?** ***Varies by employee - please check with your local office***

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☒ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $32.90
b. How often? ☐ Weekly ☐ Every 2 weeks ☒ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

CONSUMER DIRECT CARE NETWORK

2022 Benefits Summary

NV Caregivers

Benefit	Eligibility Requirements	Enrollment	Important Details
Health Insurance	30+ Hours per week	First of the month following 30 days of employment	Free preventative care. In-network co-pays: $15 doctor visit, $25 specialist, $400 emergency room, $400 outpatient imaging.
TransChoice Advance (Medical Buy Up)	30+ Hours per week and enrolled in company Medical Insurance Plan	First of the month following 30 days of employment	Add to your Medical Plan a hospital/surgical benefit. Pays $250/day in-hospital and/or surgery payments per calendar year maximums. Note: Minimum participation requirement of 10 enrollees.
Telemedicine by 98point6	30+ Hours per week and enrolled in company Medical Insurance Plan	First of the month following 30 days of employment	App allows you to text directly with a doctor about non-emergency medical issues. Doctors are available 24/7 by text messaging and can prescribe some medications. Prescription and lab fees are at your own expense.
Health Care Flexible Spending Account (FSA)	30+ Hours per week	First of the month following 30 days of employment	Employees can defer up to $2,750 per calendar year in pre-tax dollars to use for eligible medical expenses. Unused funds (up to $550) are rolled over to the following year's FSA.
Dependent Care Flexible Spending Account (FSA)	10+ Hours per week	First of the month following 30 days of employment	Employees can defer up to $5,000 per calendar year in pre-tax dollars to use for daycare or disabled adult dependent care expenses. Unused funds are forefeited at the end of the year.
Vision Insurance	10+ Hours per week	First of the month following 30 days of employment	Plan participants receive a free annual eye exam with in-network providers, and can choose between new lenses or frames with $20 copay OR free contacts (within allowance). Additional discounts available.
Basic Life/AD&D Insurance	10+ Hours per week	**Automatic**: First of the month following 30 days of employment	In the event of an employee's death, this **company paid** plan pays their beneficiary a benefit equal to $10,000. Life and AD&D Benefits reduce to 65% at age 65 and to 45% at age 80.
Voluntary Supplemental Life Insurance	10+ Hours per week	First of the month following 30 days of employment	Employees can elect amounts in $10,000 increments, up to the lesser of $300,000 or 5 times your annual earnings. Verification may be required in certain circumstances. Life Benefits reduce to 65% at age 65 and to 45% at age 80.
Unum Supplemental Insurances	10+ Hours per week	First of the month following 30 days of employment	Coverages Available: Critical Illness, Accident and Hospital Insurance
Paid Sick Days	Automatic	Automatic	Employees will receive one hour of sick leave per 52 hours worked, and may accrue up to 40 hours per year. Able to use after 90 days of employment in an eligible job status.
Employee Assistance Program (EAP)	No hours requirement	**Automatic:** All employees and eligible family members	The EAP offers free and confidential counseling and assistance resolving situations that may inpact your personal or professional life. Employees are given 3 counseling sessions per issue.
401(k) Retirement Plan	No hours requirement Must be age 18 or older	First of the month following 90 days of employment	Employees can defer pre-tax dollars into the company's 401(k) plan.
Pet Insurance	No hours requirement	No waiting period	MetLife Pet Insurance offers assistance to pay for your pet's medical care, including check-ups, testing, surgery, and hospitalization. Contact MetLife at www.metlife.com/getpetquote or 800-438-6388.

For additional assistance please contact our Benefit Advocates at bac.consumerdirect@ajg.com or 833-678-7790.

Work Opportunity Tax Credits - Consumer Direct Care Network

Consumer Direct Care Network (CDCN) participates in the Work Opportunity Tax Credit (WOTC) program. WOTC is a Federal tax credit available to employers. ADP administers WOTC on behalf of CDCN. Please follow the steps listed below to screen for the WOTC program. We appreciate your cooperation.

Applicant Instructions

- Open https://tcs.adp.com/consumerdirectcare or scan the QR code below.
  ***Note: If using a shared screening device, ensure the device does not have an autofill/auto complete function enabled*
- Please answer each question to complete the voluntary screening.
- Eligible applicants will be asked to **Electronically Sign and click Submit** to complete the screening.
- Ineligible applicants will be asked to click **Submit** to finish the screening. You will not be asked to electronically sign.

ADP will contact WOTC-eligible new hires via email or text to request proof of age or address documentation, when needed.

***If you are unable to screen via the Web Link please contact ADP at 1-800-237-3279 (1-800-ADP-EASY) available 6am-11 pm ET, 7 days a week and enter company code shown below to screen for Tax Credits.*

IVR CODE: 410849