EMPLOYEE ENROLLMENT PACKET

Bexar Veteran Directed Home and Community Based Services (VD-HCBS) Program

6243 IH Ten West, Suite 430, San Antonio, Texas 78201
CDS lines: 210-798-DSSW Fax: 210-798-5200
Toll Free Phone: 866-675-7331 Fax: 866-301-1182
www.cdsintexas.com http://www.facebook.com/CDSinTexas

INFORMATION FOR EMPLOYEES

CDS in Texas serves participants in the consumer directed services delivery model also known as self-direction. We have prepared some frequently asked questions and answers to help you understand your role, the veteran's role as your employer, and how we fit in.

FREQUENTLY ASKED QUESTIONS	
What is consumer direction?	Consumer direction, also known as self-direction, allows the veteran to become the employer of record. It is also called the Veteran Directed Home and Community Based Services Program (VD-HCBS)
Who is CDS in Texas?	We are known as a financial management services agency. We will conduct background checks for your employer and process your timesheets, withhold taxes, and prepare your W-2 at year end.
Who do I work for?	You work for the veteran. You do **not** work for CDS in Texas. Questions regarding hours, pay, timesheets, duties, etc. should be directed to your employer.
How do I apply?	Your employer has all the application forms, or you can download them from our website www.cdsintexas.com. Follow the directions carefully and then fax or email the completed forms to 877- 726-5896. You can also scan and email the application to VD@cdsintexas.com
What comes next?	Once we have the application packet, we do background checks and notify your potential employer of the results. Your employer will decide whether to hire you. If hired, your employer will give you a start date and train you on what services are needed
How do I record my time worked?	Your employer will provide you with a timesheet. Record your time daily. Be sure to sign and date the timesheet.
How do I get paid?	The application packet has forms for direct deposit to a bank account or pre-paid card, or you can select our paycard. When your payroll is processed, you will receive an email notification.
When do I get paid?	Your employer has the payroll schedule. You will be paid every other week on a Friday. If Friday is a holiday, you will be paid on Thursday.
What if my pay is not in my account on payday?	Check with your employer to see if there is a fax or email confirmation. If there is not, re-send and call our office to let us know about the late timesheet. If there is confirmation of receipt, you or your employer should call our office. We should be able to locate the missing timesheet, and we will process as quickly as possible.
How do I get my payroll records	When we enroll you as an employee, you will receive an email registration notice that will tell you how to login to our self-serve web-based payroll system.
What taxes are withheld from my pay?	CDS in Texas will withhold all federal taxes. You will receive email notification when your payroll is processed and will be able to see what taxes have been withheld.
Will I get a W-2?	Your W-2 will be released by January 31.
What else do I need to know?	If the consumer is in the hospital or other facility or loses eligibility, you cannot work.
What if I'm working for two individuals?	You must complete two applications, and if you provide services during the same hours, you cannot be paid twice for hours worked simultaneously
Does CDS in Texas have a website?	Yes. Visit us at www.cdsintexas.com. Follow us on Facebook.

Other important things to know	• You certify your timesheets as true and correct. Record your hours each day and do not sign timesheets until your last shift for that payroll period has been worked. Never sign blank timesheets. Incorrect timesheets may be viewed as fraud.
	• Any over or under payment of payroll will be corrected as soon as possible but no later than the next payroll.
	• Everyone has a responsibility to report abuse, neglect or exploitation (1-800-252-5400).
	• Work with your employer until you fully understand what is expected of you and you understand how your employer wants all tasks completed.
	• Make sure you understand how your employer wants to be notified if you cannot work a scheduled shift. This is an individual, not an agency, so you should give them time to arrange for back up.
Is there anything else I need to do?	***YES !!*** If any of your information changes -- your name, your address, your banking information, your telephone number, your email address -- use the payroll status change form which is part of this packet and fax or email it to us.

EMPLOYEE CHECKLIST AND INSTRUCTIONS

- You must complete all required forms in the packet in order to be paid by CDS in Texas.
- You must fill out any information required and sign where highlighted.
- Your employer must fill out information required and sign where highlighted..

When this packet is complete, it must be faxed, scanned and emailed, or mailed to CDS in Texas. Pictures of forms will not be accepted. See our website www.cdsintexas.com for free or inexpensive scanning apps for iPhone and Android.

Important: Do not start working until we have notified your employer that you are cleared to work. You **will not get paid** if you work prior to our authorized start date. You **will not get paid** until we have all of the required forms.

Instructions for each form start on the next page.

Use the **checklist** below to confirm that you have sent all the required items.

	REQUIRED FORMS - RETURN TO CDS IN TEXAS
❒	Employment application filled out and signed
❒	USCIS Form I-9 filled out and signed by you and your employer
❒	Copy of driver's license is **attached** and legible.
❒	Copy of social security card is **attached** and legible.
❒	Direct Deposit Authorization is filled out and signed.
❒	Voided check, prepaid card form, or letter from bank is **attached.**
❒	Exemptions worksheet is filled out and signed.
❒	IRS Form W-4 is filled out and signed.
❒	Employment Agreement is filled out and signed by you and your employer.
❒	Form 1733 is filled out and signed by you and your employer.
❒	Form 1728 is filled out and signed by you and your employer.
❒	Form 1727 is filled out and signed by you and your employer.
❒	Form 1732 is filled out and signed by you and your employer.
❒	Form 1731 is filled out and signed by you and your employer.
❒	Form 1725 Criminal History and Registry check is filled out and signed by you and your employer.
	PACKET SUBMISSION METHODS
	FAX to 877-726-5896
	Scan and email to: VD@cdsintexas.com
	Mail to: CDS in Texas, Attention: Veterans Directed Program, 6243 IH 10 West, San Antonio, Texas 78201
	Questions? Call 866-675-7331, ext. 8391

Employment Application

Veteran Name:_____

Part I: To be Completed by the Applicant

PERSONAL INFORMATION				
First Name:	M.I.:	Last Name:		Gender (optional):
SSN:	DOB: / /	Phone(s)--*include area code:*	Phone(s)--*include area code:*	
Mailing Address:				
City:	State:	Zip:	County:	
Email Address:		Driver's License No:	State of Issuance:	
Relationship to Employer:				

QUALIFICATIONS

The applicant must be of 18 years of age or older AND may not be the authorized representative. Failure to meeting either of these requirements at any time will result in the disqualification of the applicant or employee's eligibility.

	School or Licensing Board	Dates Attended or Licensure Dates	Degree Obtained or License No.
High School or GED			
Technical School			
College			
Specialized Training			
Other			

WORK EXPERIENCE

Please list your last 3 (three) jobs beginning with the most recent.

Company Name	Your Title	Supervisor	Dates	Reason for Leaving

May the employer contact your previous supervisors for reference? YES NO

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REFERENCES ***Please list at least three non-relative references.***		
Name	**Company/Occupation**	**Phone Number(s)**

EMERGENCY CONTACT INFORMATION		
Name	Relationship	Phone Number(s)

BACKGROUND AND OTHER CHECKS

Previous Names Used (if applicable)	**Dates**

Previous Addresses (within the last 5 years)	**Dates**

Voluntary (Optional) Disclosure	
Have you ever pled guilty or nolo contendere to a crime or been convicted of a crime other than a minor traffic offense? YES ❑ NO ❑	Voluntary explanation:

I certify that all of the information included in this application is true and correct to the best of my knowledge. I understand that before employment can be offered to me, I must first undergo background checks which will include a criminal history check. I further state that I understand that this application and any other forms which I complete, along with background check results will be shared with my prospective employer, the financial management services agency, CDS in Texas, and veteran directed program and/or state administrators. I understand CDS in Texas is not my employer and in no way uses this information to determine whether I am able to be employed under the self-directed program. I understand my prospective employer may base the hiring decision on the the results of any check or screening. I understand I may not provide services for payment until all required checks and screening are conducted and the employer reviews the results and hires me. I hereby release CDS in Texas , my employer and his/her agents from any and all liability, claims and/or demands, of whatever kind, related to the compilation or preparation of the investigative reports, checks, and screenings that I authorized herein. I agree to hold CDS in Texas harmless for any consequences resulting from the information provided on the form or any checks or screenings conducted thereunder. I have read and understand this form. If hired, I agree to abide by all program rules and responsibilities as an employee.

Employee Signature _____ Date _____

Employment Eligibility Verification

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

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

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

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

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

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

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

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

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

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

☐ 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

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

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

Veteran Name: _____

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

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

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

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

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

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

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

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

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

DIRECT DEPOSIT AUTHORIZATION AGREEMENT

You must complete this entire form and send all required attachments for your payments to be processed.

REQUESTOR INFORMATION			
Name:		SSN:	
Phone:		DOB:	
Email:			
Address:			

Account Information			
Routing Number	**Account Number**	**Type of Account**	**Submission Reason**
		❒ Checking ❒ Savings ❒ Prepaid Card	❒ Checking ❒ Savings ❒ Prepaid Card
Documentation Attached**			
❒ Financial Institution letter ❒ Voided check ❒ Typed form from card company			

I understand I must attach documentation to this form. All documentation must contain my printed name, account number and routing number. Temporary checks or deposit slips are not acceptable. If using a prepaid card, I must get a statement from the issuing authority demonstrating that this is an active account. I understand I should be able to go to the prepaid card issuer's website to obtain this information.

By signing below I acknowledge that if this form is not submitted timely with acceptable documentation, payments will be delayed. I am authorizing automatic deposits to the account shown above. I authorize CDS in Texas to initiate debit entries for any erroneous deposited amounts. If the account above has been closed or does not contain adequate funds, I authorize the withholding of any erroneous deposit from future payments owed to me.

I understand that any changes to the above account must be immediately submitted to CDS in Texas and agree that CDS in Texas is not responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or my financial institution. **I understand that it is my responsibility to verify the crediting of funds to my account before writing checks or initiating debits against my account** and I will not hold CDS in Texas responsible for any charges I incur from my financial institution as a result of initiating withdrawals before funds are deposited.

_____ DATE: _____

Requestor Signature

Household Employee Determination of Tax Exemption

Under IRS rules, certain individuals are exempt from certain state and federal taxes. Please complete the form below so that we can determine your status.

PLEASE PRINT CLEARLY

Veteran's Name_____

Employee's Name_____ Birthdate: _____

1. **Tax Exemptions for a Child Employed by his/her own Parent.** Are you the child of the employer?
   - ☐ Yes **My employer is my parent**.
   - ☐ No My employer **is NOT my parent**.

2. **Tax Exemptions for a Parent Employed by his/her own Child.** Are you the parent of the employer?
   - ☐ Yes **My employer is my child**.
   - ☐ No My employer **is NOT my child**.

FOR-PAYROLL DEPARTMENT: This employee ❒ is ❒ is not exempt from SUTA/FUTA. This employee ❒ is ❒ is not exempt from FICA/Medicare DATE:

Household–Employee Determination of Overtime Exemption

Department of Labor rules require overtime to be paid to any employee who works more than 40 hours in a work week. However, ***if*** the employee lives in the home with the participant at least 5 days of the workweek s/he may be exempt from the overtime provision. Please check the box below if this fits your status.
❒ **Yes, I live with the veteran at least 5 days of the workweek.** I understand that by selecting this statement, I am not eligible for overtime wages. Hours worked over 40 I a single workweek will be paid at the regular hourly rate in accordance with the budget. My employer is responsible for notifying CDS in Texas immediately of any change to my residence status that affects this exemption.
❒ **No, I do not live with the veteran,** and I understand that unless funds have been specifically designated for overtime in my employer's budget**, it will be my employer's responsibility to pay any overtime wages not covered by the budget.**

Employee Signature: _____ Date: _____

EMPLOYER NAME: _____

Form W-4 (2019)

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

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

Exemption from withholding. You may claim exemption from withholding for 2019 if **both** of the following apply.

- For 2018 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2019 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2019 expires February 17, 2020. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2019 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at ***www.irs.gov/W4App*** to determine your tax withholding more accurately. Consider using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income not subject to withholding outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2019. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Filers with multiple jobs or working spouses. If you have more than one job at a time, or if you're married filing jointly and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

Nonwage income. If you have a large amount of nonwage income not subject to withholding, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Additional Income Worksheet on page 3 or the calculator at *www.irs.gov/W4App* to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at *www.irs.gov/W4App* to find out if you should adjust your withholding on Form W-4 or W-4P.

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

Specific Instructions

Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

Line C. *Head of household please note:* Generally, you may claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

Line E. Child tax credit. When you file your tax return, you may be eligible to claim a child tax credit for each of your eligible children. To qualify, the child must be under age 17 as of December 31, must be your dependent who lives with you for more than half the year, and must have a valid social security number. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

Line F. Credit for other dependents. When you file your tax return, you may be eligible to claim a credit for other dependents for whom a child tax credit can't be claimed, such as a qualifying child who doesn't meet the age or social security number requirement for the child tax credit, or a qualifying relative. To learn more about this credit, see Pub. 972. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total

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Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records.

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

Employee's Withholding Allowance Certificate

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

OMB No. 1545-0074

2019

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

5	Total number of allowances you're claiming (from the applicable worksheet on the following pages)	**5**	
6	Additional amount, if any, you want withheld from each paycheck	**6**	$
7	I claim exemption from withholding for 2019, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here . . . . . ►	**7**	

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

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

8 Employer's name and address (**Employer:** Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)	**9** First date of employment	**10** Employer identification number (EIN)

EMPLOYER AND EMPLOYEE SERVICE AGREEMENT

This Service Agreement between the Employer and Employee contains the responsibilities to which both parties agree to adhere, and signify their agreement by initialing and/or signing where indicated.

The Employer agrees:

To adhere to all federal, state, and local employment-related laws and regulations.

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

The Employee agrees:

1) To provide information and documents to the Employer, as required, to maintain current, up-to-date personnel records. The information and documents include at least changes in address and/or telephone numbers, criminal convictions and evidence of employment status and qualifications.
2) That the Employee meets eligibility requirements for employment.
3) To not use the personal property of the Employer or the Individual without prior approval. The Employee will reimburse the Employer for any expense incurred related to his/her personal use of the personal property.
4) To respect the rights and dignity of the Veteran and to follow safety procedures for the benefit of the Veteran and the Employee.
5) That personal medical and personal information and data about the Veteran and the Employee is confidential. This information is not to be discussed, directly or indirectly, with others outside of the work environment at any time, currently or in the future.
6) To notify the Employer as soon as possible when the Employee will be late for work or is not able to work, as well as not report to work when illness or another condition may jeopardize the health and safety of the Veteran.
7) That by signing this agreement, Employee is willing and able to perform the tasks as outlined by, and at the direction of, the Employer, the Individual or the Designated Representative, if applicable.
8) That if an overpayment is deposited to the Employee's account, it will be recouped as soon as detected, and if funds are not immediately available, the amount due will be deducted from future payments.

Both the Employer and Employee Agree:

1) That this document serves as an agreement, not an employment contract.
2) That the Employer employs the Employee. The Employee is not an independent contractor. The Employer controls the training and management, evaluation and firing/termination of the Employee. The Employee does not work for CDS in Texas or the Bexar Area Agency on Aging.
3) That the Employee is not barred by relationship to the Individual, Employer or Designated Representative, if applicable, from being an Employee.
4) That funds for services to pay the Employee are from public sources, and financial accountability and liability applies to the use of the funds. Both the Employer and the Employee have an individual and joint responsibility to be accountable for the public funds spent through the Veteran

Employer's initials _____ Employee Initials _____

Directed Program and understand that submitting false or fraudulent time sheets, submitting a time sheet of an unqualified service provider, submitting a time sheet for tasks other than those approved on the service plan or implementation plan will be reported to the appropriate authorities for investigation and possible prosecution as fraud.

5) To provide an accurate accounting of services delivered by the Employee, and to submit accurate time sheets and documentation for reimbursement to CDS in Texas.
6) That a Financial Management Services Agency (FMSA) is responsible for the administration of program funds on behalf of the Employer, including payroll functions.
7) To submit timesheets only for actual time worked and allowable, budgeted benefits, and invoices for approved, budgeted expenses.
8) The Employer must not charge any fee to the Employee. The Employee must not make any payment to the Employer related to the Employee's employment. Any corrections to payroll are made by CDS in Texas.
9) That neither CDS in Texas nor the Area Agency on Aging of Central Texas is responsible or liable for any negligent acts, work-related injuries or omissions by the Employer, Individual, Employee, other Employees and service providers and/or the Designated Representative, if applicable.

Salary and Benefits:

1) Employee and Employer agree that the starting salary will be $ _____ per hour and that overtime will be paid for hours worked over 40 unless Employee is determined to be exempt from overtime.
2) Employee will be paid at least twice a month.
3) Employee will provide Employer with any legal garnishments which must be withheld from Employee's pay, such as child support or student loans.
4) Other benefits may include: _____

_____

Duration and Modification of Service Agreement:

This Service Agreement will be in effect as of the date this agreement is signed by the Employer and Employee or the date services for the Veteran are approved, whichever occurs first.

This Service Agreement cannot be modified.

This Service Agreement will terminate when:

a. The Veteran is no longer participating in the Veteran Directed Program.
b. The Employee becomes ineligible to work due to a conviction barring employment or a listing on any national or state registry prohibiting employment.
c. The Employee fails to maintain and provide documentation of eligibility for employment.
d. The Employee is found to have jeopardized the health and safety of Veteran or to have been reported for abuse, neglect or exploitation of Veteran.

This Service Agreement may be terminated, without cause, by either party with 14-calendar days written notice. A different time frame may be used if both parties agree in writing.

Employer:

Date: _____

_____
(Signature)

_____
(Printed Name)

Employee:

Date: _____

_____
(Signature)

_____
(Printed Name)

Name of Veteran if different than Employer: _____

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

Form 1733
October 2013-E

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

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

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

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

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

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

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

(5) the following tasks related to medication administration:

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

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

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

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

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

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

(1) bathing, including feminine hygiene;

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

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

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

(5) transferring, ambulation or positioning;

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

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

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

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

(Signing this section indicates you understand what tasks are exempt from the requirement to have a nursing license.)

Employee:

→ _____
Printed Name

→ _____
Signature

→ _____
Date

Employer:

→ _____
Printed Name

→ _____
Signature

→ _____
Date

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

If the employee will be doing any of the tasks listed in 1 – 9, fill in those tasks here; otherwise, leave blank.

☐ _____ ☐ _____ ☐ _____

☐ _____ ☐ _____ ☐ _____

☐ _____ ☐ _____ ☐ _____

☐ _____ ☐ _____ ☐ _____

Employee:

→ _____
Signature

→ _____
Date

Employer:

→ _____
Signature

→ _____
Date

NOTE: ONLY FILL IN THE SECOND SECTION ABOVE IF THE EMPLOYEE WILL BE PROVIDING ANY OF THE 9 TYPES OF SERVICE LISTED ON THIS FORM.

Veteran Name: _____

Veteran Directed Services

Liability Acknowledgement

Liability Acknowledgement Between the Employer and the Applicant for Employment

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

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

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

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

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

Liability Notice to Applicants for Employment

Section I:

The employer: CHOOSE ONE

- ☐ **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: CHOOSE ONE

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

- ☐ I have made the following arrangement(s) for employee work-related injuries/illnesses:
  - ☐ self-insurance;
  - ☐ homeowner's personal liability insurance;
  - ☐ renter's personal liability insurance;
  - ☐ medical coverage insurance;
  - ☐ risk pool insurance;
  - ☐ other: _____
- ☐ I have **no** insurance or other protection against employee work-related injuries/illnesses for my employee(s).

Acknowledgement by Employer and Applicant for Employment

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

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

Veteran Name:_____ Employee Name:_____

Veteran Directed Services

Occupational Exposure to Bloodborne Pathogens

Universal Precautions

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

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

Employee Initials: _____ Date: _____

Hepatitis B

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

Employee Initials: _____ Date: _____

Hepatitis B Vaccination

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

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

Dose 2 is administered 30 days after Dose 1.

Dose 3 is administered five months following Dose 2.

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

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

Employee Initials: _____ Date: _____

Veteran Name:_____ Employee Name:_____

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

Veteran Name: _____

TEXAS Department of Aging and Disability Services

Veteran 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 (Choose one)

☐ 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 should initial below.**

_____ Employee oriented to individual's condition and trained to perform approved tasks.

_____ Employee demonstrated knowledge of individual's condition, any special needs, and showed competence to perform the approved Tasks.

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

_____ Employee was trained on acts which constitute abuse, neglect, and/or exploitation and understands the responsibility to report instances of ANE and understands actions that will be taken if they are reported to have committed ANE.

IV. Evaluation/Performance Review:

V. Corrective Action Plan (if applicable):

Date for follow-up on corrective action plan: _____

VI. Service Provider Comments: (if any)

_____ Signature of Service Provider _____ Date

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

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

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

Texas Department of Aging and Disability Services

Veteran Directed Services

Form 1731
January 2007

Employee Work Schedule and Assigned Tasks

Employee Name: _____ Veteran Name: _____

Purpose of Form:
- [x] Initial
- [ ] Change

Activity Involved:
- [x] Tasks
- [x] Schedule

Effective Date: _____

Schedule I LIST WORK SCHEDULE; IT MAY CHANGE WITHOUT NOTICE TO CDS

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

If no set schedule, you can write "flexible" in the grid above

Schedule I – Tasks

Check those that apply - refer to your care plan or your Habilitation plan

- Assist with medications _____
- Bathing _____
- Grooming _____
- Toileting _____
- Personal Hygiene _____
- Dressing _____
- Cleaning _____
- Meal Preparation _____
- Feeding, Eating _____
- Laundry _____
- Assistance with Shopping _____
- Escort _____
- Transfer and Ambulation _____
  (includes positioning, standby assistance, assistance with wheelchair and/or prostheses or braces.)
- Locomotion/Mobility _____
  (inside or outside)
- Habilitation Training _____
  (refer to person centered planning or habilitation plan)
- Approved Health Related Tasks _____
- Other: _____
- Other: _____

Schedule II (OPTIONAL)

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

Schedule II – Tasks

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

_____ Signature – Employer

_____ Date

_____ Signature – Employee

_____ Date

TEXAS Department of Aging and Disability Services

Consumer Directed Services

Criminal Conviction History and Registry Checks

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

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

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

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

_____ _____

Signature - Applicant | Date

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

Is this a New Employee? ❒ **Is this a Re-hire of an old employee? ❒**

Individual's Name (Last, First, Middle)	Alias	Maiden Name
Date of Birth (mm/dd/yyyy)	Social Security No.	Employee Phone Number

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

Veteran's Name (Person using Services)	Employer Name

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

- [X] 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.
- [X] 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.
- [X] I understand that all criminal records and reports obtained by my FMSA, and the information they contain, are confidential information.
- [X] 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.
- [X] I understand that sharing of criminal history information with any person or agency may be prosecuted as a Class A Misdemeanor.

_____ _____

Signature - Employer | Date

Registry Check

- [X] I request that my FMSA obtain the applicant's status with the Employee Misconduct Registry and the Nurse Aide Registry initially and annually.
- [X] 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).
- [X] 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

☐

_____
Date

Section III - Criminal Conviction History and Registry Check Results

DPS Criminal Conviction Criminal History Check

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

Date disseminated by FMSA: _____

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

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

Date report was destroyed: _____

Date employer notified FMSA of hiring decision: _____

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

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

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

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

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

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

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

_____
Signature - FMSA Representative

_____
Date FMSA notified the employer or Designated Representative

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

VETERAN'S NAME: _____
(Person receiving services)

EMPLOYEE NAME: _____

CDS in Texas - 2019 Payroll Schedule

If Friday is a holiday, payday will be on a Thursday

NOTE: Payroll is processed bi-weekly (every other week). Timesheet due dates and paydays have changed. Timesheets are due every other Monday. Payday will now be every other Friday

PAY PERIOD	PAYROLL START	END	DUE		PAY DATE
1	12/16/2018	12/29/2018	12/31/2018		01/11/2019
2	12/30/2018	01/12/2019	01/14/2019		01/25/2019
3	01/13/2019	01/26/2019	01/28/2019		02/08/2019
4	01/27/2019	02/09/2019	02/11/2019		02/22/2019
5	02/10/2019	02/23/2019	02/25/2019		03/08/2019
6	02/24/2019	03/09/2018	03/11/2019		03/22/2019
7	03/10/2019	03/23/2019	03/25/2019		04/05/2019
8	03/24/2019	04/06/2019	04/08/2019		04/19/2019
9	04/07/2019	04/20/2019	04/22/2019		05/03/2019
10	04/21/2019	05/04/2019	05/06/2019		05/17/2019
11	05/05/2019	05/18/2019	05/20/2019		05/31/2019
12	05/19/2019	06/01/2019	06/03/2019		06/14/2019
13	06/02/2019	06/15/2019	06/17/2019		06/28/2019
14	06/16/2019	06/29/2019	07/01/2019		07/12/2019
15	06/30/2019	07/13/2019	07/15/2019		07/26/2019
16	07/14/2019	07/27/2019	07/29/2019		08/09/2019
17	07/28/2019	08/10/2019	08/12/2019		08/23/2019
18	08/11/2019	08/24/2019	08/26/2019		09/06/2019
19	08/25/2019	09/07/2019	09/09/2019		09/20/2019
20	09/08/2019	09/21/2019	09/23/2019		10/04/2019
21	09/22/2019	10/05/2019	10/07/2019		10/18/2019
22	10/06/2019	10/19/2019	10/21/2019		11/01/2019
23	10/20/2019	11/02/2019	11/04/2019		11/15/2019
24	11/03/2019	11/16/2019	11/18/2019		11/29/2019
25	11/17/2019	11/30/2019	12/02/2019		12/13/2019
26	12/01/2019	12/14/2019	12/16/2019		12/27/2019
1	12/15/2019	12/28/2019	12/30/2019		01/10/2020

All timesheets are due by 5 PM on Monday, EVEN IF IT IS A HOLIDAY

EMPLOYEES SHOULD NOT TRY TO CASH THEIR CHECKS EARLY. Our bank receives a list of approved checks on payday. Any checks cashed prior to that date will be returned.

PLEASE USE THE FAX NUMBERS OR EMAIL BELOW TO SEND ALL VETERAN TIMESHEETS

Veteran Fax Numbers
877-726-5896 210-733-3119
Email Address
VD@cdsintexas.com

Alternate numbers: If above numbers are not working: 866 301 1182 or 866 462 6671 or 877 812 3789

For all Veteran related questions or inquiries, please contact Luis Ochoa

210-798-3779 Ext. 1624
lochoa@cdsintexas.com

Bi-Weekly

*You may email timesheets to VD@cdsintexas.com or fax number to 1-877-726-5896

Employer Name:

Employee Name:

Veteran - Directed Home - Employee Time Sheet

Service Types

PC - Personal Care Services
HM - Homemaker Services
RS - Respite Care Services
ES - Escort Services
VA - Vacation Time
SK - Sick Time
HD - Holiday Pay

**USE 24 HOUR TIME: 8:00 A.M OR 20:00 FOR 8:00 P.M.

Service Type	Service Date	Day	Time In	Time Out	Time In	Time Out	Total Hours	Daily Mileage
		Sunday						
		Monday						
		Tuesday						
		Wednesday						
		Thursday						
		Friday						
		Saturday						
		Sunday						
		Monday						
		Tuesday						
		Wednesday						
		Thursday						
		Friday						
		Saturday						
							Total Hours	Total Mileage

Comments

Employer and Employee here by certify that the work hours listed above are accurate, that the services provided are in accordance with the current tasks authorized I understand that falsification of this time sheet is considered fraud, and may result in dismissal from the program and criminal prosecution.

Employee Signature **Date**

Employer Signature **Date**

Timesheet Tasks

Acceptable Unacceptable Notified Employer

FMSA Comments

Bi-Weekly

*You may email timesheets to VD@cdsintexas.com or fax number to 1-877-726-5896

Employer Name:

Employee Name:

Veteran - Directed Home - Service Notes (Required)

Service Date	Written/Narrative Summary of Services Provided