RETAIN THESE ORIGINALS

MAKE COPIES FOR EACH NEW EMPLOYEE

MAKE EXTRA COPIES OF TIMESHEETS

IMPORTANT

YOUR EMPLOYEE *CANNOT* BE HIRED UNTIL CLEARED BY THE CDS OFFICE

YOUR EMPLOYEE *CANNOT* BE PAID FOR HOURS WORKED PRIOR TO APPROVAL BY THE CDS OFFICE

TO CLEAR AN EMPLOYEE TO WORK, WE NEED THE DOCUMENTS LISTED ON "STEP 1" ON THE NEXT PAGE

SUBMIT YOUR EMPLOYEE PAPERWORK TO

EMAIL: NewHires@cdsintexas.com

FAX: 1-877-726-4919 or 1-210-785-3479

For questions or information about your employee application call:

1-866-675-7331 or 1-210-798-3779 Extension 1691

Employee Hiring Checklist

CDS in Texas

LifeSpan HOME CARE

Date:

General Information **PAGE 1**

Employer Name:	All of the employee forms are available on our website at www.cdsintexas.com or call our office to have them mailed, faxed, or emailed to you. The main number is 866-675-7331 or 210-798-3779.
Client(s):	
Applicant:	

Step One (Review the list of forms that are required BEFORE your employee can start work)**

Completed	Form	Description
☐	**1725**	Criminal History and Registry Check
☐	**1728**	Liability Acknowledgement
☐	**1729**	Applicant Verification - Includes CPR for CLASS and CPR/First Aid for DBMD and MDCP
☐	**1734**	Certificate of Relationship
☐	**I-9**	United States Employment Verification
☐	**W-4**	Employee's Pay Check Tax Election Form
☐	***1747**	Any licensed professional: we will need to be able to verify a current license. Nursing, employees cannot **begin working** until the appropriate **Form 1747** is on file.
☐	***CPR**	**CLASS**: Hands on CPR; **DBMD**: Hands on CPR/First Aid; **MDCP**: CPR/First Aid (can be online)
☐	**2 Proofs of Residence**	For **HCS** and **TxHmL** only (Utility bill, lease agreement, voter registration)
☐	**1735**	**CLASS, HCS, DBMD, MDCP, TxHmL, CFC**: Make sure you review the section on the **Form 1735 Addendum** which explains the requirement for a high school diploma or GED, or if one is lacking, what additional documentation you need to obtain from your employee. Note: You do not need to provide us with the diploma/GED; however, you must have it in your personnel files for review with your CM, SC or utilization review nurse.

If this employee will be providing professional services, please contact your HR Coordinator.

☐	**1747**	If providing Nursing, a LVN will need to have a Supervisor. **Form 1747** must be completed for all nurses. **The LVN is not eligible to work and cannot be paid for hours worked prior to the Supervisor's signature date on the Form 1747.** Check with your HR Coordinator to see if you need to have additional nursing documents sent to you. **With the exception of the MDCP program, all nursing or professional services (OT, PT, ST) provided must have a plan of care signed by a physician**.

Services that can now be self-directed in many programs include nursing, PT, OT, SP, CRT (Cognitive Rehabilitation Therapy), Employment Assistance, and Supported Employment. There are special qualifications that must be met for these employment categories. See the appropriate **Form 1735 Addendum** for a complete list of those services that can be self-directed in your program and for details on employee qualifications.

*****Important**

You will first be notified that your employee has or has not passed the background checks. This does not mean they can start work. They must meet all other qualifications before working. If CPR or first aid is a requirement, your employee will not be paid for hours worked prior to receiving those certifications. If you are a new client, your employee cannot be paid for hours worked prior to the authorized start date for your employee. ***We will process the initial documents in Step One within 2 business days. If you have not heard from us within that time frame please contact our office.

Fax to: **877-726-4919** or **210-785-3479** or Email: **NewHires@cdsintexas.com**

Employee Hiring Checklist

CDS in Texas

LifeSpan HOME CARE

Date:

General Information **PAGE 2**

Employer Name:	Client(s):	Applicant:

Step Two

Send in the documents listed in Step One. Your HR Coordinator in the New Hire Department will notify you when your employee is cleared to work. If you do not hear within **2 business days**, please contact the office. Your paperwork may not have been received. Your employee cannot work until a start date is provided by the New Hire Department.

Step Three (When your applicant has been approved to work, send in the remaining forms listed below)

Completed	Form	Description
☐	**1731**	Employee Work Schedule and Assigned Tasks
☐	**1732**	Management and Training of Service Provider (Must provide training detail)
☐	**1732 EMR**	EMR Notice to Employee (A copy must be provided to your Employee)
☐	**1733**	Exemption from Nursing License. Review form. Sign top section of page two. If your attendant will be providing any of the services listed under "Examples," or if your employee will be working delegated nursing tasks you will need to complete bottom section of this form.
☐	**1737**	Employer and Employee Service Agreement
☐	**1739**	Service Provider Agreement
☐	**SPI Form**	Service Provider Information on Employment and CDS in Texas
☐	**NHR**	Texas Employer New Hire Reporting Form
☐	**DD Form**	Direct Deposit or Payday Card - Please choose one method of payment for your employee
☐	**1727**	Occupational Exposure to Blood borne Pathogens
☐	**1724**	New Employee Packet Cover Sheet
☐	**Employee Physical Profile (Optional)**	
☐	**Skills Competency Checklist (Optional to use with Form 1732)**	If used write "**See attached detail**" in Section II of the **Form 1732**.

Notes

***Important

You've done 1-3 above. Can your employee start work? If you are new to CDS, be sure to verify that your "start date" with CDS has been approved. You can check with our Intake Coordinator at ext. 1690 or your Service Advisor (general mailbox is ext. 1693). Being qualified to work does not mean that your new employee can start work if your CDS service plan date has not been approved or if the Start of Care date has not been reached. Please remember, your Employee cannot start working until a start date is provided for the employee. ***Once all documents are reviewed and corrections are received, the Budget team will determine an approved pay rate for your employee. The New Hire Coordinator will then send you a 1730 to review with your employee and sign, along with your employee. Once signed, please return the signed 1730 to the New Hire Department to complete the employee packet.**

Fax to: **877-726-4919** or **210-785-3479** or Email: **NewHires@cdsintexas.com**

TEXAS Health and Human Services

Form 1724
August 2015-E

Consumer Directed Services

New Employee Packet Cover Sheet

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

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

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

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

TEXAS Health and Human Services

Form 1725
March 2023

Consumer Directed Services

Criminal Conviction History and Registry Checks

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

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

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

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

I understand I may not begin delivering services until the FMSA and Employer confirm that I meet all qualifications to be hired.

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

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

→ _____ Signature - Applicant → _____ Date

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

Individual's Name →	Employer Name →

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

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

→ _____ Signature - Employer → _____ Date

Registry Check

- [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

SEE NEXT PAGE

CHOOSE ONE

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

- ☐ Verbally
- ☐ Encrypted email
- ☐ Certified mail (There will be a cost associated with the Certified mail option. This will be billed to your budget.)

_____
Date of Employer Request

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

DPS Criminal Conviction Criminal History Check

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

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

DPS approved dissemination method used to inform employer of results:

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

Date FMSA staff notified employer: _____

FMSA staff:

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

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

Date report was destroyed: _____

Date employer notified FMSA of hiring decision: _____

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

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

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

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

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

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

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

_____
Signature - FMSA Representative

_____
Date FMSA notified the employer or Designated Representative

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

INDIVIDUAL'S NAME: _____
(person receiving services)

EMPLOYEE NAME: _____

TEXAS
Health and Human Services

Form 1728
October 2013-E

Consumer Directed Services

Liability Acknowledgement

Liability Acknowledgement Between the Employer and the Applicant for Employment

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

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

Employees or service providers are **not** employed or retained by the Texas Health and Human Services Commission (HHSC); any other state or federal governmental agency; or by the Financial Management Services Agency (FMSA).

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

→ _____ Signature – Employer (Must be signed by the employer)

→ _____ Date

→ _____ Signature – Applicant for Employment

→ _____ Date

Liability Notice to Applicants for Employment

Section I:

The employer: CHOOSE ONE: If you are a subscriber of Texas Workers' Compensation, do not complete Section II.

☐ **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: You will complete this section if you are not a subscriber to Texas Workers' Compensation.

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

TEXAS Health and Human Services

Form 1729
March 2023

Consumer Directed Services

Applicant Verification for Employees

Individual's Name

Employer Name

Applicant Name

Applicant Social Security No.

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

Employment Qualifications

Boxes 1 - 5 must be checked for all applicants. In addition boxes 6 - 9 are to be checked if they apply to your specific program.

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

FMSA Certification

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

Only applicants who meet all qualifications may be employed.

Acknowledgement

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

Signature — Employer | Date | Signature — FMSA | Date

TEXAS Health and Human Services

Form 1734
March 2023

Consumer Directed Services (CDS)

Service Provider and Employer Certification of Relationship Status for CDS

Section 1: Basic Information

Service Provider Applicant Name →	Maiden Name — if applicable →
Applicant Street Address →	City, State and ZIP Code →
Person Receiving Services →	CDS Employer Name (if different than person receiving services) →
Person Receiving Services Street Address →	City, State and ZIP Code →
Applicant's Relationship to Person Receiving Services (If no relationship, write "none".) →	Designated Representative (DR) — if applicable →
Applicant's Relationship to CDS Employer (If no relationship, write "none".) →	Applicant's Relationship to DR (If no relationship, write "none".) →

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

Section 2: All Programs

The applicant must answer the following questions.

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

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

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

Section 3: Medically Dependent Children Program (MDCP)

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

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

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

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

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

Section 5: Community Living Assistance and Support Services (CLASS) — Respite Service Providers Only

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

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

Section 6: Primary Home Care (PHC), Community Attendant Services (CAS) and Family Care (FC)

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

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

Employer and Service Provider Applicant Verification

If any item above is marked Yes, the applicant is not eligible to be a paid service provider (employee, contractor or vendor) in the CDS option for this individual.

If every item above is marked No or NA, the applicant meets relationship eligibility for employment in the CDS option for this individual, unless contraindicated by requirements of the individual's program. (NA only applies where indicated.) The employer and the applicant certify that the responses are accurate.

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

→ _____ → _____ → _____

Printed Employer Name | Signature — Employer | Date

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

→ _____ → _____ → _____

Printed Service Provider Applicant Name | Signature — Service Provider Applicant | Date

Employment Eligibility Verification

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Additional Information

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Acceptable Receipts

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Supplement B, Reverification and Rehire (formerly Section 3)

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

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

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

Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the [Handbook for Employers: Guidance for Completing Form I-9 (M-274)](#)

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

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

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

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

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

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

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2024

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

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

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

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

Step 3: Claim Dependent and Other Credits

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

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

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2024 if you meet both of the following conditions: you had no federal income tax liability in 2023 **and** you expect to have no federal income tax liability in 2024. You had no federal income tax liability in 2023 if (1) your total tax on line 24 on your 2023 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2024 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2025.

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

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

1. Expect to work only part of the year;

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

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

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

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

Specific Instructions

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

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

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

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

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

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2024 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

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

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

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

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

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

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

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

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

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

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

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

. . . . . **2** $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . **3** $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . **4** $

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . **5** $

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$780	$850	$940	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,370
$10,000 - 19,999	0	780	1,780	1,940	2,140	2,220	2,220	2,220	2,220	2,220	2,570	3,570
$20,000 - 29,999	780	1,780	2,870	3,140	3,340	3,420	3,420	3,420	3,420	3,770	4,770	5,770
$30,000 - 39,999	850	1,940	3,140	3,410	3,610	3,690	3,690	3,690	4,040	5,040	6,040	7,040
$40,000 - 49,999	940	2,140	3,340	3,610	3,810	3,890	3,890	4,240	5,240	6,240	7,240	8,240
$50,000 - 59,999	1,020	2,220	3,420	3,690	3,890	3,970	4,320	5,320	6,320	7,320	8,320	9,320
$60,000 - 69,999	1,020	2,220	3,420	3,690	3,890	4,320	5,320	6,320	7,320	8,320	9,320	10,320
$70,000 - 79,999	1,020	2,220	3,420	3,690	4,240	5,320	6,320	7,320	8,320	9,320	10,320	11,320
$80,000 - 99,999	1,020	2,220	3,620	4,890	6,090	7,170	8,170	9,170	10,170	11,170	12,170	13,170
$100,000 - 149,999	1,870	4,070	6,270	7,540	8,740	9,820	10,820	11,820	12,830	14,030	15,230	16,430
$150,000 - 239,999	1,960	4,360	6,760	8,230	9,630	10,910	12,110	13,310	14,510	15,710	16,910	18,110
$240,000 - 259,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$260,000 - 279,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$280,000 - 299,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,380
$300,000 - 319,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,980	17,980	19,980
$320,000 - 364,999	2,040	4,440	6,840	8,310	9,710	11,280	13,280	15,280	17,280	19,280	21,280	23,280
$365,000 - 524,999	2,720	6,010	9,510	12,080	14,580	16,950	19,250	21,550	23,850	26,150	28,450	30,750
$525,000 and over	3,140	6,840	10,540	13,310	16,010	18,590	21,090	23,590	26,090	28,590	31,090	33,590

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$240	$870	$1,020	$1,020	$1,020	$1,540	$1,870	$1,870	$1,870	$1,870	$1,910	$2,040
$10,000 - 19,999	870	1,680	1,830	1,830	2,350	3,350	3,680	3,680	3,680	3,720	3,920	4,050
$20,000 - 29,999	1,020	1,830	1,980	2,510	3,510	4,510	4,830	4,830	4,870	5,070	5,270	5,400
$30,000 - 39,999	1,020	1,830	2,510	3,510	4,510	5,510	5,830	5,870	6,070	6,270	6,470	6,600
$40,000 - 59,999	1,390	3,200	4,360	5,360	6,360	7,370	7,890	8,090	8,290	8,490	8,690	8,820
$60,000 - 79,999	1,870	3,680	4,830	5,840	7,040	8,240	8,770	8,970	9,170	9,370	9,570	9,700
$80,000 - 99,999	1,870	3,690	5,040	6,240	7,440	8,640	9,170	9,370	9,570	9,770	9,970	10,810
$100,000 - 124,999	2,040	4,050	5,400	6,600	7,800	9,000	9,530	9,730	10,180	11,180	12,180	13,120
$125,000 - 149,999	2,040	4,050	5,400	6,600	7,800	9,000	10,180	11,180	12,180	13,180	14,180	15,310
$150,000 - 174,999	2,040	4,050	5,400	6,860	8,860	10,860	12,180	13,180	14,230	15,530	16,830	18,060
$175,000 - 199,999	2,040	4,710	6,860	8,860	10,860	12,860	14,380	15,680	16,980	18,280	19,580	20,810
$200,000 - 249,999	2,720	5,610	8,060	10,360	12,660	14,960	16,590	17,890	19,190	20,490	21,790	23,020
$250,000 - 399,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$400,000 - 449,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$450,000 and over	3,140	6,450	9,110	11,610	14,110	16,610	18,430	19,930	21,430	22,930	24,430	25,870

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$510	$850	$1,020	$1,020	$1,020	$1,020	$1,220	$1,870	$1,870	$1,870	$1,960
$10,000 - 19,999	510	1,510	2,020	2,220	2,220	2,220	2,420	3,420	4,070	4,070	4,160	4,360
$20,000 - 29,999	850	2,020	2,560	2,760	2,760	2,960	3,960	4,960	5,610	5,700	5,900	6,100
$30,000 - 39,999	1,020	2,220	2,760	2,960	3,160	4,160	5,160	6,160	6,900	7,100	7,300	7,500
$40,000 - 59,999	1,020	2,220	2,810	4,010	5,010	6,010	7,070	8,270	9,120	9,320	9,520	9,720
$60,000 - 79,999	1,070	3,270	4,810	6,010	7,070	8,270	9,470	10,670	11,520	11,720	11,920	12,120
$80,000 - 99,999	1,870	4,070	5,670	7,070	8,270	9,470	10,670	11,870	12,720	12,920	13,120	13,450
$100,000 - 124,999	2,020	4,420	6,160	7,560	8,760	9,960	11,160	12,360	13,210	13,880	14,880	15,880
$125,000 - 149,999	2,040	4,440	6,180	7,580	8,780	9,980	11,250	13,250	14,900	15,900	16,900	17,900
$150,000 - 174,999	2,040	4,440	6,180	7,580	9,250	11,250	13,250	15,250	16,900	18,030	19,330	20,630
$175,000 - 199,999	2,040	4,510	7,050	9,250	11,250	13,250	15,250	17,530	19,480	20,780	22,080	23,380
$200,000 - 249,999	2,720	5,920	8,620	11,120	13,420	15,720	18,020	20,320	22,270	23,570	24,870	26,170
$250,000 - 449,999	2,970	6,470	9,310	11,810	14,110	16,410	18,710	21,010	22,960	24,260	25,560	26,860
$450,000 and over	3,140	6,840	9,880	12,580	15,080	17,580	20,080	22,580	24,730	26,230	27,730	29,230

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

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables.

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 2023 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:
- $27,700 if you're married filing jointly or a qualifying surviving spouse
- $20,800 if you're head of household
- $13,850 if you're single or married filing separately

. . . . . **2** $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . **3** $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . **4** $

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . **5** $

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

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

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

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

Household Employee Tax Exemption Form

PLEASE COMPLETE THIS FORM IF YOU ARE THE PARENT OF THE EMPLOYER OR THE CHILD OF THE EMPLOYER.

You have been identified as someone who may be exempt from certain state and federal taxes because of your age and/or relationship to your employer. Please fill out the questionnaire below so we can determine your status.

PLEASE PRINT CLEARLY

Client's Name: _____

Employer's Name: _____

Employee's Name: _____

Employee's Date of Birth: _____

1. Tax Exemptions for a Child Employed by his/her own Parent. Are you the child of the employer?

☐ Yes I am an employee in the CDS program and **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 I am an employee in the CDS program and **my employer is my child.**

☐ No My employer **is NOT my child.**

If you answered **"NO"** to **Question Number 2** you have completed the questionnaire.

If you answered **"YES"** to **Question Number 2** answer the questions below by circling "YES" or "No":

Additional Questions for a Parent Employed by his/her Child

- Do you care for your grandchild **"who is living"** in your son or daughter's home? **YES** or **NO**
- Your grandchild is under age 18 all of the current year and has a physical or mental condition that requires personal care of an adult for at least four continuous weeks? **YES** or **NO**
- Is your son or daughter **(who employs you)** a single parent, who is widowed, divorced and not remarried? **YES** or **NO**
- Is your son or daughter **(who employs you)** living with a spouse who has a mental or physical condition which prohibits them from caring for your grandchild for at least four continuous weeks? **YES** or **NO**

New Employee Budget Questions

Date	Client Name
Employer Name	Designated Representative Name
Employee Name	Employee Date of Hire

1. Will the employee you are hiring today be replacing another employee? (circle one)
    a. Yes
    b. No

- If Yes to question #1:
    - Who is the employee replacing? _____
    - Reason this individual is no longer working? _____
    - What is the last day or approximate day this individual worked? _____
    - Would you consider this individual rehireable or not? _____
    - Fill out 1732 Termination Form and give it to the New Hire Admin to complete the termination process.

2. Are there any other Employees that need to be terminated in the system? (circle one)
    a. Yes (if yes, please answer the below questions for each employee)
    b. No
        - Name of individual(s)? _____
        - Reason the individual is no longer working? _____
        - What is the last day or approximate last day worked? _____
        - Would you consider the individual rehireable or not? _____
        - Fill out 1732 Termination Form and give it to the New Hire Admin to complete the termination process.

3. Is this new employee going to be a backup employee? (circle one)
    a. Yes
    b. No

4. Are there additional clients that are under this Employer? (circle one)
    a. Yes
    b. No
        - If yes, will this new employee be working for these additional clients as well? (circle one)
            - Yes
            - No
        - List out the additional client names and Kantime ID's: _____

5. What services will this employee be working and how many hours per each service will the employee be working per week?

Attendant:	_____ hrs per week/_____ Pay Rate	Respite:	_____ hrs per week/_____ Pay Rate
Protective Supervision:	_____ hrs per week/_____ Pay Rate	Transportation:	_____ hrs per week/_____ Pay Rate
LVN:	_____ hrs per week/_____ Pay Rate	RN:	_____ hrs per week/_____ Pay Rate
Intervener:	_____ hrs per week/_____ Pay Rate	Intervener I:	_____ hrs per week/_____ Pay Rate
Intervener II:	_____ hrs per week/_____ Pay Rate	Intervener III:	_____ hrs per week/_____ Pay Rate
Value Added Respite:	_____ hrs per week/_____ Pay Rate	Supported Emp:	_____ hrs per week/_____ Pay Rate

TEXAS Health and Human Services

Form 1730
October 2013-E

Consumer Directed Services

Wage and Benefits Plan Employee Compensation

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

Service	Regular Hourly Wage
☐	$
☐	$
☐	$
☐	$

Calculation of Overtime Hourly Wage

*** Employees who work over 40 hours per work week will be paid overtime. Overtime is calculated based upon Department of Labor's weighted average method in a variable pay rate environment.

Benefits: ***Optional***

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

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

Withholdings:

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

☐ **Required Garnishments**

Type:	Amount:
Frequency:	Payment To:

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

Type:	Amount:
Frequency:	Payment To:

☐ **Other** (*specify*): _____

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

Accurate, signed time sheets are due: Every other Monday by 5:00 pm

Paychecks are distributed by (*method*): Check or Direct Deposit at least twice a month on _____

or every other week starting Friday .

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

Signature - Employer or Designated Representative	Date	Signature - Employee	Date

TEXAS
Health and Human Services

Form 1731
January 2007-E

Consumer Directed Services

Employee Work Schedule and Assigned Tasks

Employee Name: _____ Client Name: _____

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

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

Effective Date: _____

Schedule I LIST WORK SCHEDULE BELOW. IF THE SCHEDULE CHANGES, PLEASE SUBMIT AN UPDATED 1731 TO CDS IN TEXAS.

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

Schedule I - Tasks

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 _____
- 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) LIST WORK SCHEDULE BELOW. IF THE SCHEDULE CHANGES, PLEASE SUBMIT AN UPDATED 1731 TO CDS IN TEXAS.

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

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 _____
- 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: _____

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

_____ Signature — Employer

_____ Date

_____ Signature — Employee

_____ Date

TEXAS Health and Human Services

Form 1732
October 2015-E

Consumer Directed Services

Management and Training of Service Provider

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

I. Purpose

☒ Initial Orientation ☐ Ongoing Training

☐ Evaluation

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

☐ Supervision

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

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

☐ Conflict Resolution ☐ Other _____

II. Documentation of Topics Covered at Initial Orientation or Ongoing Training:

(Initial orientation must include training related to the individual's condition and the tasks the service provider will perform as well as any required training described in an applicable addendum to Form 1735, Employer and Financial Management Services Agency Service Agreement.) **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.**

_____ **Employee was trained on EVV use and procedures for the client.**

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:

_____ 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 Health and Human Services

Form 1732-EMR
October 2014-E

Consumer Directed Services (CDS)

Management and Training of Service Provider Addendum

Employee Misconduct Registry Notification

Employee Name: ⟶ _____ Date of Hire: _____

Position: **Home Care Provider** Employer Name: ⟶ _____

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

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

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

Rules regarding the EMR can be found on the Secretary of State's website at:
http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=40&pt=19&ch=711&sch=O&rl=Y.

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

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

I, ⟶ _____, have read and understand the above notification.
Printed Employee Name

⟶ _____ ⟶ _____
Signature Employee Signature Date

TEXAS
Health and Human Services

Form 1733
January 2018-E

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

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

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

Government Code, Title 4, Subtitle I, Chapter 531, Subchapter B, Section 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, Section 225.13,Tasks Prohibited From Delegation),*** including***:***

1. physical, psychological, and social assessment, which requires professional nursing judgment, intervention, referral, or follow-up;
2. formulation of the nursing care plan and evaluation of the client's response to the care rendered;
3. specific tasks involved in the implementation of the care plan that require professional nursing judgment or intervention;
4. the responsibility and accountability for client or client's responsible adult health teaching and health counseling which promotes client or client's responsible adult education and involves the client's responsible adult in accomplishing health goals; and
5. the following tasks related to medication administration:
    A. calculation of any medication doses except for measuring a prescribed amount of liquid medication and breaking a tablet for administration, provided the RN has calculated the dose;
    B. administration of medications by an injectable route except for subcutaneous injectable insulin as permitted by Section 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 Section 225.10(10) of this title (relating to Task That May Be Delegated);
    D. responsibility for receiving or requesting verbal or telephone orders from a physician, dentist, or podiatrist; and
    E. administration of the initial dose of a medication that has not been previously administered to the client.

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

1. bathing, including feminine hygiene;
2. grooming, including nail care, except for individuals with medical conditions like diabetes;
3. feeding, including feeding through a permanently placed feeding tube;
4. routine skin care, including decubitus Stage 1;
5. transferring, ambulation or positioning;
6. exercising and range of motion; and digital stimulation;
7. the administering of a bowel and bladder program, including suppositories, catheterization, enemas, manual evacuation and digital stimulation;
8. administering oral medications that are normally self-administered, including administration through a gastrostomy tube; and
9. non-invasive and non-sterile treatments with low risk of infection.

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

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, Section 225.13, **Tasks Prohibited From Delegation**, must not be provided by the employee. Checked tasks indicate the employee may perform those tasks when the LAR is not present to supervise.

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

NOTE: FILL IN THE SECTION ABOVE IF THE EMPLOYEE WILL BE PROVIDING ANY OF THE 9 TYPES OF SERVICES LISTED ON THIS FORM OR WITH THE SPECIFIC DELEGATED TASKS THE INDIVIDUAL IS AUTHORIZED.

Consumer Name: _____

TEXAS Health and Human Services

Form 1737
September 2013-E

Consumer Directed Services

Employer and Employee Service Agreement

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

_____ .

The Individual's program, _____ , hereafter referred to as the "**program**," is funded and administered by the Texas Health and Human Services Commission (HHSC).

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

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

This agreement is between the Employer and _____

hereafter referred to as "**Employee**."

The Employer Agrees:

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

The Employee Agrees:

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

Both the Employer and the Employee Agree:

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

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

Duration and Modification of Service Agreement

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

The following required documents are incorporated by reference:

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

Acknowledgement of service agreement, including documents incorporated by reference:

Employer:

Printed Name

Signature

Date

Employee:

Printed Name

Signature

Date

TEXAS Health and Human Services

Form 1739
October 2013-E

Consumer Directed Services
Service Provider Agreement

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

The **service provider,** → _____ [x] an individual or

[ ] an entity, located at (Address) → _____,

_____; Telephone → _____ Fax → _____

Email Address: → _____

The service provider agrees to:

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

The FMSA and HHSC agree:

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

The service provider, FMSA and HHSC mutually agree that:

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

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

→ _____	→ _____	→ _____
Service Provider or Representative* (Print)	Service Provider or Representative* (Signature)	Date
_____	_____	_____
FMSA Representative* (Print)	FMSA Representative* (Signature)	Date

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

CDS in Texas

LifeSpan HOME CARE

Service Provider Information on Employment and CDS in Texas

Consumer's Name – Client	Employer Name
Service Provider – Employee	CDS in Texas, 6243 IH-10 West Suite 430, San Antonio, TX 78201 Phone: 877.675.7331 Fax: 877.726.4919

CDS in Texas serves as the vendor fiscal/employer agent for individuals (consumers) who hire their own employees for their Medicaid services. We provide payroll services and deposit and report taxes on behalf of these individuals.

What does a FMSA do that involves a Service Provider?

- FMSAs have the following roles and responsibilities that apply to Services Providers:
  - verify qualifications of applicants before services are delivered;
  - monitor continued eligibility of service providers;
  - ensure all forms are complete for each employer's service provider before issuing the initial payment for services;
  - manage payroll, including calculations of employee withholdings and employer contributions and depositing these funds with appropriate agencies;
  - comply with applicable government regulations concerning employee withholdings, garnishments, mandated withholdings, and benefits.

What do we want the Employer and Service Provider to know about CDS services?

- We (the FMSA) are NOT your employer. You work for the individual or that person's legally authorized representative. Questions regarding hours, pay, timesheets, duties, etc. should be directed to your employer.
- We do need your current address, telephone number, and/or email. Notify us in writing of changes by fax to 877.726.4919 or email: NewHires@cdsintexas.com.
- You cannot work until our office has cleared you for employment and the service start date has occurred. If you work prior to either of these days, you will not be paid by our office.
- If the consumer is in the hospital or loses Medicaid, your employer must notify us. We cannot pay for services provided while the consumer is hospitalized or has no Medicaid. If you turn in a timesheet for payment during hospitalization or loss of Medicaid eligibility, that may be considered Medicaid fraud.
- You are not expected to perform tasks that are not directly related to support for the consumer. If you are concerned about the tasks you are asked to perform, please contact us. Examples would be: preparing food for the whole family or cleaning the garage.
- Payroll is issued bi-weekly. By signing this document, you are agreeing to receive your payroll by direct deposit or pay card and you understand and agree that the initial payrolls may be issued in the form of a check and sent to you by 1st class mail through the U.S. Post Office.
- If you work hours which are not authorized on the client's service plan, we will not pay for those hours. Your employer will be liable.
- Any over or under payment of payroll will be corrected as soon as possible but no later than the next payroll. You are agreeing to recoupment of overpayments when you sign this document.
- If you are working in a household where there is more than one consumer, you cannot charge twice for hours worked simultaneously.
- 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 Medicaid fraud.
- Use the EVV system to clock in when EVV services begin and clock out when EVV services end with one of the EVV methods (EVV Mobile Method, EVV Home Phone Landline, Alternative Device).
- Information on rules referenced in the Form 1729 can be found at www.hhs.texas.gov.
- Everyone has a responsibility to report abuse, neglect, and 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.

Acknowledged:

Signature of Employer _____ Date _____

Signature of Employee _____ Date _____

Texas Employer New Hire Reporting Form

Submit within 20 calendar days of new employee's first day of work to:

ENHR Operations Center, P.O. Box 149224
Austin, TX 78714-9224
Phone: 1-800-850-6442 FAX: 1-800-732-5015
Online: www.employer.texasattorneygeneral.gov

To ensure the highest level of accuracy, please print neatly in capital letters and avoid contact with the edges of the boxes. The following will serve as an example:

A B C 1 2 3

Employer Information

1. Federal Employer ID Number (FEIN):
Please use the same FEIN that appears on quarterly wage reports.

2. State Employer ID Number (Optional):

3. Employer Name:

4. Employer Address (Please indicate the address where the Income Withholding Orders should be sent):
6243 IH-10 WEST
#4300

5. Employer City (if US): SAN ANTONIO

6. State (if US): TX

7. ZIP Code (if US): 78201 –

8. Province/Region (if foreign):

9. Country (if foreign):

10. Postal Code (if foreign):

11. Employer Telephone (Optional):

12. Employer FAX (Optional):

13. New Hire Contact Person (Optional):

Employee Information

14. Social Security Number (SSN):

15. Date of Hire (MM/DD/YYYY):

16. Employee First Name:

17. Employee Middle Name:

18. Employee Last Name:

19. Employee Home Address:

20. Employee City (if US):

21. State (if US):

22. ZIP Code (if US): –

23. Province/Region (if foreign):

24. Country (if foreign):

25. Postal Code (if foreign):

26. State Where Employee Was Hired (Optional):

27. Employee DOB (MM/DD/YYYY) (Optional):

28. Employee's Salary (Dollars and Cents) (Optional):

29. Salary Frequency (Check One ONLY) (Optional):
☐ Hourly ☐ Weekly ☐ Biweekly ☐ Semi-Monthly ☐ Monthly ☐ Annually

DIRECT DEPOSIT AUTHORIZATION AGREEMENT

You must complete this entire form and send all required attachments to receive payment by direct deposit.

EMPLOYEE INFORMATION			
Name:		**SSN:**	
Phone:		**DOB:**	
Email:			
Address:			

Account Information			
Routing Number	**Account Number**	**Type of Account**	**Submission Reason**
		❒ Checking ❒ Savings ❒ Prepaid Card	❒ Bank Change ❒ Account Change ❒ New Request
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. Accounts in the name of the Client or Employer (or jointly held) 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.

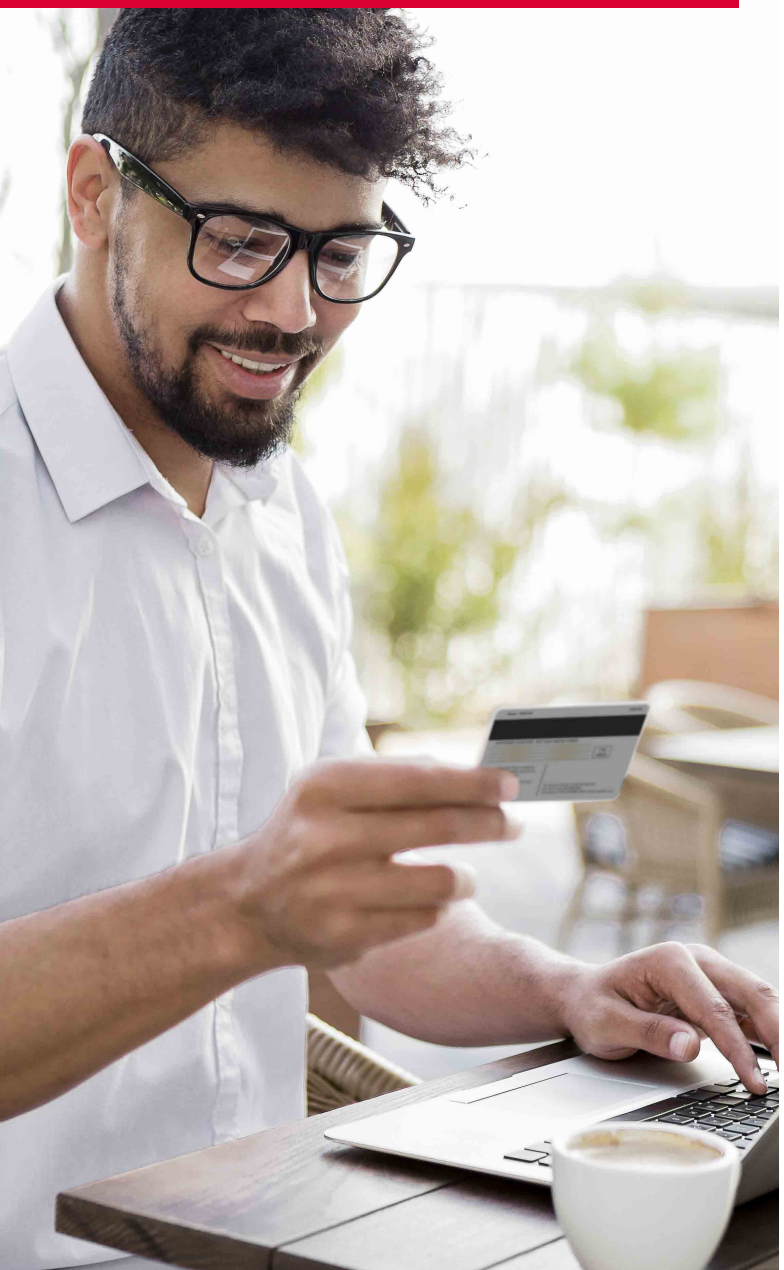
By signing below, I acknowledge that if this form is not submitted timely with acceptable documentation, payments will be delayed. I am authorizing automatic deposits to the account shown above. I authorize CDS in Texas to initiate debit entries for any erroneous deposited amounts. If the account above 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: _____

Employee Signature

WELCOME TO RAPID! PAYCARD



What is the rapid! PayCard®?

rapid! PayCard Visa® Payroll Card is a prepaid card that does not require a credit check[1]; therefore, only an identity check is needed and most people qualify. It allows you to collect and spend your pay without hassle or inconvenience. A rapid! PayCard can be used at millions of ATMs[2] and merchant locations worldwide, anywhere Visa Debit Cards are accepted. This card provides you with added safety and security over carrying cash.

With your PIN, you may use your card to obtain cash from any Point-of-Sale ("POS") device, as permissible by merchant that bears the Visa brand. With your PIN, you may use your card to obtain cash from any Automated Teller Machine ("ATM") that bears the Visa, Allpoint®[2] or MoneyPass®[2] brand. All ATM transactions are treated as cash withdrawal transactions.

What is the difference between the personalized rapid! PayCard and the instant issue rapid! PayCard?

The first card you receive is the instant issue rapid! PayCard. It has a Visa brand mark but it does not have your name embossed on it. When you call Customer Support at 1.888.727.4314 to activate this card you may also request an upgrade to a personalized card with your name embossed on it at no additional cost. When the personalized rapid! PayCard arrives in the mail (7-10 business days) the instant issue card remains fully usable until you activate your new personalized card.

When will my payroll funds be available on my rapid! PayCard?

Your pay will typically be available by 10:00 am EST on your payday. You can check your balance anytime with our mobile app[3] rapid!PAY or by calling 1.888.727.4314 or by visiting www.rapidfs.com.

What happens if I lose my rapid! PayCard? What should I do?

Most importantly, your money is protected with Visa Zero Liability[4] Policy. Just call 1.888.727.4314 to report it lost/stolen and request a new card, or ask your employer for a new card. Call 1.888.727.4314 (press 0) and tell the representative this is a replacement card.

Is this payroll direct deposit different from other types of direct deposit?

Not at all, the funds are deposited directly to your account.

How do I apply for a rapid! PayCard and get started with Direct Deposit?

It's easy to apply for your own rapid! PayCard. Just ask your employer or the Payroll department of your company for a rapid! PayCard direct deposit form.

Can I add additional funds to my rapid! PayCard?

The rapid! PayCard is fully portable. This means that you can take the card to any of your employers, regardless of who enrolled you in rapid! PayCard direct deposit. In addition, you can direct deposit your income tax refund, social security benefit, military pension, or any other payment that can be direct-deposited. Please login to www.rapidfs.com to access your direct deposit account number or ask one of our Customer Service Representatives.

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1 Because this is not a credit card, your credit will not be checked.

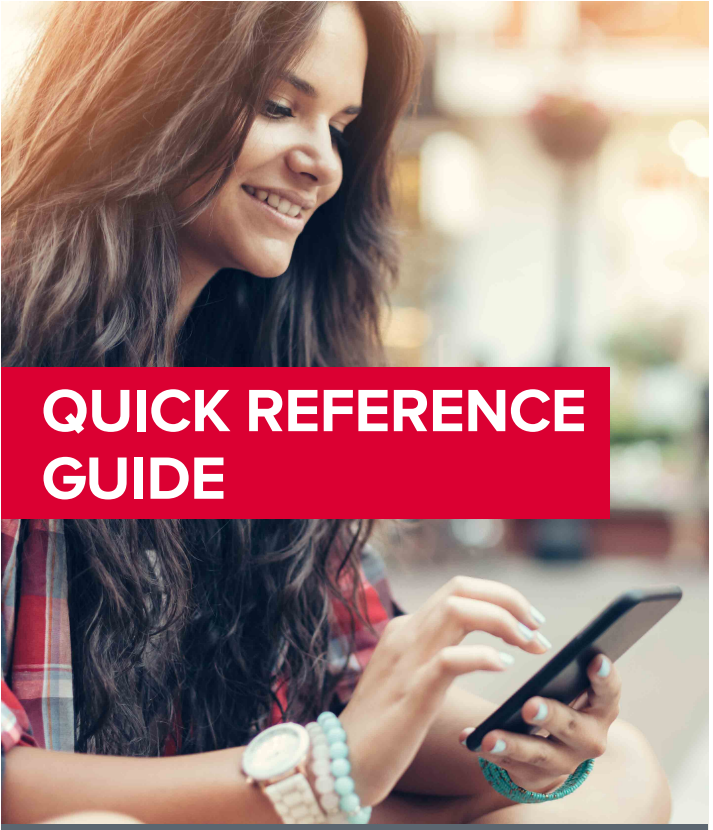
2 Cardholder has surcharge free access to Allpoint® and MoneyPass® networks. Fees apply for out-of-network withdrawals, plus what the ATM owner may charge. Limits apply.

3 While rapid! PayCard does not charge for this feature and service, standard text messaging, data and cellular rates may apply. Please check with your cell phone carrier and inquire about fees your carrier may associate with these services.

4 Visa's Zero Liability Policy covers U.S.- issued cards and does not apply to certain commercial card transactions, or any transactions not processed by Visa. You must notify your financial institution immediately of any unauthorized use. For specific restrictions, limitations and other details, please consult your issuer.

Important Information for opening a Card account: To help the federal government fight the funding of terrorism and money laundering activities, the USA PATRIOT Act requires all financial institutions and their third parties to obtain, verify, and record information that identifies each person who opens a Card account. What this means for you: When you open a Card account, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

rapid! Customer Support
1.888.727.4314



QUICK REFERENCE GUIDE

Convenient Ways[6] to Access Your Pay at no cost

- POS Store Purchase (including cash back, where available)
- Allpoint® and MoneyPass® ATM[2] Withdrawal
- Request A Check
- U.S. Post Office Money Order
- Electronic Transfer to a bank account
- ChekToday convenience checks, request them by calling the toll-free number for Customer Service (888.727.4314)
- Over-the-Counter Cash Withdrawal at banks displaying the Visa® Acceptance Mark (logo)

rapid! PAYCARD

How to Use Your Card

Making Purchases — Anywhere Visa Debit Cards are accepted

- At a retailer — either swipe your card or hand it to the cashier. For online or phone purchases, follow the instructions you are given.
- If you choose "debit", enter your PIN when prompted to complete the transaction. If you choose "credit", accept the amount and sign your name.
- Take your card and receipt.

Getting Cash Back with In-Store Purchases (at participating merchants)

- Swipe your card or hand it to the cashier.
- Select "debit" as your method of payment and enter your PIN on the pad when prompted.
- Tell the cashier you want "cash back" and the amount you would like to receive.
- Take your cash, card and receipt.

Getting Cash from an ATM[2]

- Insert your card into the machine and enter your PIN when prompted.
- Select "checking" and the amount you want to withdraw.
- Accept the fee when prompted.
- Take your cash and your card.

Accessing Your Card Account

Online — www.rapidfs.com

- View your card account balance and activity
- View your monthly statement and card account history
- Update or change your PIN, address and other information
- Sign up for a savings account, Text Alerts[7] and other card features
- Read more about the types of transactions you can make and get helpful tips
- Transfer funds to a companion card or bank account
- Get a direct deposit form to have other sources of income deposited to your card

By Phone — 888.727.4314

You can access your card account by calling 1.888.727.4314 toll-free and use the automated system for quick access or to speak with a Customer Service Representative.

Convenient Card Features

TEXT ALERTS[7]

Text alerts to your cell phone are the most convenient way to check your card balance. Available at no additional cost, you can enroll at www.rapidfs.com and choose your alerts. Plus, you can get up-to-the-minute balance information by simply texting "BAL" on your cell phone to 90831.

CASH BACK REWARDS[8]

Make purchases that earn rewards and get cash back each month. It's that simple — no promotion codes or coupons needed. Go to www.rapidfs.com to learn more and view offers.

SAVINGS ACCOUNT

Take advantage of your card's Savings Account at no cost. This interest-bearing account is a great way to save for your future and expenses. This feature also allows you to schedule auto-transfers. Go to www.rapidfs.com to enroll.

BILL PAY[8]

Pay bills online or by phone using the money on your card at no cost.

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[6] When one of these transactions is your first transaction after you've been paid, the transaction is free, otherwise you will be charged a fee. Please refer to the Cardholder Agreement for a complete list of fees.

[7] While rapid! PayCard does not charge for this feature and service, standard text messaging, data and cellular rates may apply. Please check with your cell phone carrier and inquire about fees your carrier may associate with these services.

[8] This optional offer is not a MetaBank® product or service nor does MetaBank endorse this offer.

The rapid! PayCard® Visa® Payroll Card is issued by MetaBank®, Member FDIC, pursuant to a license from Visa U.S.A. Inc. This card can be used everywhere Visa debit cards are accepted.

Important Information for opening a Card account: To help the federal government fight the funding of terrorism and money laundering activities, the USA PATRIOT Act requires all financial institutions and their third parties to obtain, verify, and record information that identifies each person who opens a Card account. What this means for you: When you open a Card account, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

rapid! Customer Support
1.888.727.4314

rapid! PAYCARD

PICK EITHER DIRECT DEPOSIT OR THE PAYCARD. IF YOU SUBMIT BOTH, WE WILL DEFAULT TO DIRECT DEPOSIT.

PAYCARD ENROLLMENT FORM

**** SEND COMPLETED FORMS TO YOUR PAYROLL CENTER ****

Card Number _____--_____--_____--_____

RAPID PAY CARD – Account Owner Information (Please Print Legibly)			
First Name: →	**Middle Initial:** →	**Last Name:** →	
Street Address: →		**Apartment #:** →	
City: →		**State:** →	**Zip Code:** →
Home Telephone: ( ) →		**Date of Birth (MM/DD/YYYY):** / / →	
Social Security Number: -- -- →		**Employee ID #:**	
→ **Employee Signature**		→ **Date**	

LOCATION INFORMATION (All fields must be completed by a company representative)	
Location Name:	**Location Number:**
Form Completed By:	**Telephone Number:**

ATTACH COPY OF CARD

Consumer Directed Services

Occupational Exposure to Bloodborne Pathogens

Universal Precautions

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

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

Employee Initials: → _____ Date: → _____

Hepatitis B

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

Employee Initials: → _____ Date: → _____

Hepatitis B Vaccination

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

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

Dose 2 is administered 30 days after Dose 1.

Dose 3 is administered five months following Dose 2.

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

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

Employee Initials: → _____ Date: → _____

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 _____

CDS in Texas Bi-Weekly 2024 Payroll Schedule

EVV Option 1 approvals/visit maintenance and EVV Option 2 & 3 timesheets are due every other Monday. Even if it is a Holiday.

Payday is every other Friday.

If Friday is a Holiday, payday will be on a Thursday.

PAY PERIOD	PAYROLL	End	DUE		PAY DATE
1	12/10/2023	12/23/2023	12/25/2023		01/05/2024
2	12/24/2023	01/06/2024	01/08/2024		01/19/2024
3	01/07/2024	01/20/2024	01/22/2024		02/02/2024
4	01/21/2024	02/03/2024	02/05/2024		02/16/2024
5	02/04/2024	02/17/2024	02/19/2024		03/01/2024
6	02/18/2024	03/02/2024	03/04/2024		03/15/2024
7	03/03/2024	03/16/2024	03/18/2024		03/29/2024
8	03/17/2024	03/30/2024	04/01/2024		04/12/2024
9	03/31/2024	04/13/2024	04/15/2024		04/26/2024
10	04/14/2024	04/27/2024	04/29/2024		05/10/2024
11	04/28/2024	05/11/2024	05/13/2024		05/24/2024
12	05/12/2024	05/25/2024	05/27/2024		06/07/2024
13	05/26/2024	06/08/2024	06/10/2024		06/21/2024
14	06/09/2024	06/22/2024	06/24/2024		07/05/2024
15	06/23/2024	07/06/2024	07/08/2024		07/19/2024
16	07/07/2024	07/20/2024	07/22/2024		08/02/2024
17	07/21/2024	08/03/2024	08/05/2024		08/16/2024
18	08/04/2024	08/17/2024	08/19/2024		08/30/2024
19	08/18/2024	08/31/2024	09/02/2024		09/13/2024
20	09/01/2024	09/14/2024	09/16/2024		09/27/2024
21	09/15/2024	09/28/2024	09/30/2024		10/11/2024
22	09/29/2024	10/12/2024	10/14/2024		10/25/2024
23	10/13/2024	10/26/2024	10/28/2024		11/08/2024
24	10/27/2024	11/09/2024	11/11/2024		11/22/2024
25	11/10/2024	11/23/2024	11/25/2024		12/06/2024
26	11/24/2024	12/07/2024	12/09/2024		12/20/2024
1	12/08/2024	12/21/2024	12/23/2024		01/03/2025

Guidance on ways to submit your timesheets

EVV Time Submission Deadlines

EVV Option 1 approvals and all EVV Option 2 & 3 timesheets are **due by 5 PM on Monday**

Vesta EVV CDV link for visit maintenance and approval: https://cdv.vestaevv.com/#/login (Option 1 Only)

Ways you can submit your Timesheet or Documenation of Tasks worked

Option 1 - HCS & Texas Home Living and EVV Option 2 & 3 can use the following methods to submit:

Timesheet Upload: https://dsswtx.jotform.com/220174908128051

Scan and email to cds@cdsintexas.com

Fax Numbers

Toll Free: **(877) 726-4910** Local: **(210)785-3470** Alternate Numbers: (866) 301-1182 or (866) 462-6671 or (877) 812-3789

Additional Information

CONTACT CDS: If you have questions about payroll please contact us at CUSTOMERSUPPORT@cdsintexas.com or (210) 798-3779 x 0

New Hire Paperwork NEWHIRES@cdsintexas.com

Requests for Reimbursement ACCOUNTSPAYABLE@cdsintexas.com FAX (877) 726-4919 or (210) 785-3479

Know your rights! Visit our website for a complete copy of your rights or request it from your Service Advisor.

Complaints

It is your right to register a complaint if you are dissatisfied with the service you receive.

To do so, visit https://www.hhs.texas.gov/services/your-rights/complaint-incident-intake or call 1-800-458-9858.

Abuse / Neglect / Exploitation

We all have a responsibility to report abuse, neglect, or exploitation. If an emergency, call 911.

To report online, go to: https://www.txabusehotline.org/Login/Default.aspx. To report by phone, call the Texas Abuse Hotline at 1-800-252-5400.

Fraud / Waste / Abuse

You can report suspected fraud, waste, or abuse in Texas Health and Human Services Programs by filling out a report at: https://oig.hhsc.state.tx.us/wafrep/.

To report by phone, call the Texas Office of Inspector General at 1-800-436-6184.

Visit our website for more information and access forms: www.CDSINTEXAS.com

DOCUMENTATION OF SERVICES DELIVERED - CDS

Bi-Weekly

*You may email timesheets to cds@cdsintexas.com or reference the pay schedule for the appropriate fax number to send in your timesheet

CDS in Texas

Consumer Name:	Program Selection (Please Circle) TxHml CLASS PHC DBMD STAR Plus HCS STAR Kids(MDCP) STAR Kids(PCS)
Employer Name:	Type of Service (Please Circle) HAB PAS PAS/HAB RESPITE Protective Supervision
Service Provider Name:	

EVV 1722 Option 2 and 3 - Timesheet - Hours Worked Documentation

Pay Period Number:

**USE 24 HOUR TIME: 8:00 A.M OR 20:00 FOR 8:00 P.M. Enter 12:00 AM as 00:00

DATE	DAY	TIME IN	TIME OUT	TIME IN	TIME OUT	TIME IN	TIME OUT	TOTAL TIME	COMMENTS / NARRATIVE
	Sunday								
	Monday								
	Tuesday								
	Wednesday								
	Thursday								
	Friday								
	Saturday								
	Sunday								
	Monday								
	Tuesday								
	Wednesday								
	Thursday								
	Friday								
	Saturday								

Total Payroll / Pay Period Hours Delivered:

Service:_____

_____ Hours Vacation

_____ Hours Sick

_____ Hours Holiday

_____ Bonus

_____ Other _____

FMSA Agency Only

Date Processed:

By Whom:

FMSA Comments

Was the consumer hospitalized or in an medical care facility during this pay period? Please list dates:_____

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 and the services were NOT provided while the consumer was in the hospital, nursing home, or the Medicaid-reimbursed healthcare facility. I understand that falsification of this time sheet is considered Medicaid Fraud, and may result in dismissal from the program and criminal prosecution.

Service Provider Signature Date

Employer or DR Signature Date

DOCUMENTATION OF SERVICES DELIVERED - CDS

Bi-Weekly

*You may email timesheets to cds@cdsintexas.com or reference the pay schedule for the appropriate fax number to send in your timesheet

CDS in Texas

Consumer Name:	Client Name
Employer Name:	Employer Name
Service Provider Name:	Employee Name

Program Selection (Please Circle)

TxHml (CLASS) PHC DBMD STAR Plus HCS STAR Kids(MDCP) STAR Kids(PCS)

Type of Service (Please Circle)

HAB (PAS) PAS/HAB RESPITE Protective Supervision

EVV 1722 Option 2 and 3 - Timesheet - Hours Worked Documentation

Pay Period Number: Pay Period

**USE 24 HOUR TIME: 8:00 A.M OR 20:00 FOR 8:00 P.M. Enter 12:00 AM as 00:00

DATE	DAY	TIME IN	TIME OUT	TIME IN	TIME OUT	TIME IN	TIME OUT	TOTAL TIME	COMMENTS / NARRATIVE
	Sunday								
10/31/2023	Monday	8 am	10:30 pm					2.5	Cooking, Cleaning
11/01/2023	Tuesday	7 am	9 pm					2	Doctor Appointment
	Wednesday								
11/03/2023	Thursday	8 am	2 pm					6	Laundry, Doctor, Groies
	Friday								
	Saturday								
	Sunday								
11/07/2023	Monday	8 am	11am					3	Cooking, Cleaning
11/08/2023	Tuesday	8 am	11am					3	Cooking, Cleaning
11/09/2023	Wednesday	12pm	1 pm					1	Cooking
11/10/2023	Thursday	3 pm	4 pm					1	Cooking
	Friday								
11/12/2023	Saturday	3 pm	5:30pm					2.5	Cooking, Cleaning, Laundry

SAMPLE

Total Payroll / Pay Period Hours Delivered:

Service:_____

_____ Hours Vacation

_____ Hours Sick

_____ Hours Holiday

_____ Bonus

_____ Other _____

FMSA Agency Only

Date Processed:

By Whom:

FMSA Comments

Was the consumer hospitalized or in an medical care facility during this pay period? Please list dates:_____

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 and the services were NOT provided while the consumer was in the hospital, nursing home, or the Medicaid-reimbursed healthcare facility. I understand that falsification of this time sheet is considered Medicaid Fraud, and may result in dismissal from the program and criminal prosecution.

Employee Signature with Date

Service Provider Signature Date

ER/DR Signature with Date

Employer or DR Signature Date

THESE NOTICES MUST BE POSTED WHERE YOUR EMPLOYEES CAN SEE THEM

Equal Employment Opportunity is

THE LAW

Private Employers, State and Local Governments, Educational Institutions, Employment Agencies and Labor Organizations

Applicants to and employees of most private employers, state and local governments, educational institutions, employment agencies and labor organizations are protected under Federal law from discrimination on the following bases:

RACE, COLOR, RELIGION, SEX, NATIONAL ORIGIN

Title VII of the Civil Rights Act of 1964, as amended, protects applicants and employees from discrimination in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment, on the basis of race, color, religion, sex (including pregnancy), or national origin. Religious discrimination includes failing to reasonably accommodate an employee's religious practices where the accommodation does not impose undue hardship.

DISABILITY

Title I and Title V of the Americans with Disabilities Act of 1990, as amended, protect qualified individuals from discrimination on the basis of disability in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. Disability discrimination includes not making reasonable accommodation to the known physical or mental limitations of an otherwise qualified individual with a disability who is an applicant or employee, barring undue hardship.

AGE

The Age Discrimination in Employment Act of 1967, as amended, protects applicants and employees 40 years of age or older from discrimination based on age in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment.

SEX (WAGES)

In addition to sex discrimination prohibited by Title VII of the Civil Rights Act, as amended, the Equal Pay Act of 1963, as amended, prohibits sex discrimination in the payment of wages to women and men performing substantially equal work, in jobs that require equal skill, effort, and responsibility, under similar working conditions, in the same establishment.

GENETICS

Title II of the Genetic Information Nondiscrimination Act of 2008 protects applicants and employees from discrimination based on genetic information in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. GINA also restricts employers' acquisition of genetic information and strictly limits disclosure of genetic information. Genetic information includes information about genetic tests of applicants, employees, or their family members; the manifestation of diseases or disorders in family members (family medical history); and requests for or receipt of genetic services by applicants, employees, or their family members.

RETALIATION

All of these Federal laws prohibit covered entities from retaliating against a person who files a charge of discrimination, participates in a discrimination proceeding, or otherwise opposes an unlawful employment practice.

WHAT TO DO IF YOU BELIEVE DISCRIMINATION HAS OCCURRED

There are strict time limits for filing charges of employment discrimination. To preserve the ability of EEOC to act on your behalf and to protect your right to file a private lawsuit, should you ultimately need to, you should contact EEOC promptly when discrimination is suspected:

The U.S. Equal Employment Opportunity Commission (EEOC), 1-800-669-4000 (toll-free) or 1-800-669-6820 (toll-free TTY number for individuals with hearing impairments). EEOC field office information is available at www.eeoc.gov or in most telephone directories in the U.S. Government or Federal Government section. Additional information about EEOC, including information about charge filing, is available at www.eeoc.gov.

Employers Holding Federal Contracts or Subcontracts

Applicants to and employees of companies with a Federal government contract or subcontract are protected under Federal law from discrimination on the following bases:

RACE, COLOR, RELIGION, SEX, NATIONAL ORIGIN

Executive Order 11246, as amended, prohibits job discrimination on the basis of race, color, religion, sex or national origin, and requires affirmative action to ensure equality of opportunity in all aspects of employment.

INDIVIDUALS WITH DISABILITIES

Section 503 of the Rehabilitation Act of 1973, as amended, protects qualified individuals from discrimination on the basis of disability in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. Disability discrimination includes not making reasonable accommodation to the known physical or mental limitations of an otherwise qualified individual with a disability who is an applicant or employee, barring undue hardship. Section 503 also requires that Federal contractors take affirmative action to employ and advance in employment qualified individuals with disabilities at all levels of employment, including the executive level.

DISABLED, RECENTLY SEPARATED, OTHER PROTECTED, AND ARMED FORCES SERVICE MEDAL VETERANS

The Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended, 38 U.S.C. 4212, prohibits job discrimination and requires affirmative action to employ and advance in employment disabled veterans, recently separated veterans (within three years of discharge or release from active duty), other protected veterans (veterans who served during a war or in a campaign or expedition for which a campaign badge has been authorized), and Armed Forces service medal veterans (veterans who, while on active duty, participated in a U.S. military operation for which an Armed Forces service medal was awarded).

RETALIATION

Retaliation is prohibited against a person who files a complaint of discrimination, participates in an OFCCP proceeding, or otherwise opposes discrimination under these Federal laws.

Any person who believes a contractor has violated its nondiscrimination or affirmative action obligations under the authorities above should contact immediately:

The Office of Federal Contract Compliance Programs (OFCCP), U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210, 1-800-397-6251 (toll-free) or (202) 693-1337 (TTY). OFCCP may also be contacted by e-mail at OFCCP-Public@dol.gov, or by calling an OFCCP regional or district office, listed in most telephone directories under U.S. Government, Department of Labor.

Programs or Activities Receiving Federal Financial Assistance

RACE, COLOR, NATIONAL ORIGIN, SEX

In addition to the protections of Title VII of the Civil Rights Act of 1964, as amended, Title VI of the Civil Rights Act of 1964, as amended, prohibits discrimination on the basis of race, color or national origin in programs or activities receiving Federal financial assistance. Employment discrimination is covered by Title VI if the primary objective of the financial assistance is provision of employment, or where employment discrimination causes or may cause discrimination in providing services under such programs. Title IX of the Education Amendments of 1972 prohibits employment discrimination on the basis of sex in educational programs or activities which receive Federal financial assistance.

INDIVIDUALS WITH DISABILITIES

Section 504 of the Rehabilitation Act of 1973, as amended, prohibits employment discrimination on the basis of disability in any program or activity which receives Federal financial assistance. Discrimination is prohibited in all aspects of employment against persons with disabilities who, with or without reasonable accommodation, can perform the essential functions of the job.

If you believe you have been discriminated against in a program of any institution which receives Federal financial assistance, you should immediately contact the Federal agency providing such assistance.

EMPLOYEE RIGHTS

UNDER THE FAIR LABOR STANDARDS ACT

FEDERAL MINIMUM WAGE

$7.25 PER HOUR

BEGINNING JULY 24, 2009

The law requires employers to display this poster where employees can readily see it.

OVERTIME PAY

At least 1½ times the regular rate of pay for all hours worked over 40 in a workweek.

CHILD LABOR

An employee must be at least 16 years old to work in most non-farm jobs and at least 18 to work in non-farm jobs declared hazardous by the Secretary of Labor. Youths 14 and 15 years old may work outside school hours in various non-manufacturing, non-mining, non-hazardous jobs with certain work hours restrictions. Different rules apply in agricultural employment.

TIP CREDIT

Employers of "tipped employees" who meet certain conditions may claim a partial wage credit based on tips received by their employees. Employers must pay tipped employees a cash wage of at least $2.13 per hour if they claim a tip credit against their minimum wage obligation. If an employee's tips combined with the employer's cash wage of at least $2.13 per hour do not equal the minimum hourly wage, the employer must make up the difference.

PUMP AT WORK

The FLSA requires employers to provide reasonable break time for a nursing employee to express breast milk for their nursing child for one year after the child's birth each time the employee needs to express breast milk. Employers must provide a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public, which may be used by the employee to express breast milk.

ENFORCEMENT

The Department has authority to recover back wages and an equal amount in liquidated damages in instances of minimum wage, overtime, and other violations. The Department may litigate and/or recommend criminal prosecution. Employers may be assessed civil money penalties for each willful or repeated violation of the minimum wage or overtime pay provisions of the law. Civil money penalties may also be assessed for violations of the FLSA's child labor provisions. Heightened civil money penalties may be assessed for each child labor violation that results in the death or serious injury of any minor employee, and such assessments may be doubled when the violations are determined to be willful or repeated. The law also prohibits retaliating against or discharging workers who file a complaint or participate in any proceeding under the FLSA.

ADDITIONAL INFORMATION

- Certain occupations and establishments are exempt from the minimum wage, and/or overtime pay provisions. Certain narrow exemptions also apply to the pump at work requirements.
- Special provisions apply to workers in American Samoa, the Commonwealth of the Northern Mariana Islands, and the Commonwealth of Puerto Rico.
- Some state laws provide greater employee protections; employers must comply with both.
- Some employers incorrectly classify workers as "independent contractors" when they are actually employees under the FLSA. It is important to know the difference between the two because employees (unless exempt) are entitled to the FLSA's minimum wage and overtime pay protections and correctly classified independent contractors are not.
- Certain full-time students, student learners, apprentices, and workers with disabilities may be paid less than the minimum wage under special certificates issued by the Department of Labor.

WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR

1-866-487-9243
www.dol.gov/agencies/whd

WH1088 REV 04/23

Texas Workforce Commission

ATTENTION EMPLOYEES

Your employer reports your wages to the Texas Workforce Commission. If you become unemployed or your work hours are reduced, you may be eligible for unemployment benefit payments. File online at www.twc.texas.gov or call 1-800-939-6631. Additional assistance may be available at your local Workforce Solutions Office; please visit the directory at: www.twc.texas.gov/directory-workforce-solutions-offices-services.

Unemployment Insurance (UI) benefits are available to workers who are unemployed and who meet the requirements of state UI eligibility laws.

To file, you will need to provide your full legal name and your social security number or your authorization to work.

The Texas Payday Law, Title II, Chapter 61, Texas Labor Code, requires Texas employers to pay their employees who are exempt from the overtime pay provisions of the Fair Labor Standards Act of 1938 at least once per month. All other employees must be paid at least twice a month and each pay period must consist as nearly as possible of an equal number of days.

Scheduled paydays: (You must indicate date or dates of the month for employees paid monthly or semi-monthly, and day of the week for employees paid weekly or at other times.)

MONTHLY: _____ SEMI-MONTHLY: _____ WEEKLY: _____ OTHER: _____

TO EMPLOYERS: Texas Labor Code section 208.001(b) and 40 T.A.C. 815.1(14)(A) & (B) require that this notice, or its equivalent, be displayed in a location reasonably calculated to be encountered by all employees, and that an employer provide such information, individually, to an employee upon separation from employment.

To report suspected fraud, waste or abuse of the program call 800-252-3642.

Comisión de la Fuerza Laboral de Texas

ATENCIÓN EMPLEADOS

Su compañía le declaró sus salarios a la Comisión de la Fuerza Laboral de Texas. Si se ve desempleado o si le reducen sus horas de trabajo, quizás sea elegible al pago de beneficios de desempleo. Presente una solicitud en línea en www.twc.texas.gov o llame al 1-800-939-6631. Quizás haya ayuda adicional en la oficina local de Soluciones de la Fuerza Laboral; favor de ir al directorio en www.twc.texas.gov/directory-workforce-solutions-offices-services.

Los Beneficios de Seguro de Desempleo (UI) están disponibles para trabajadores que están desempleados y que reúnen los requisitos de leyes elegibles estatales de UI.

Para solicitar, tendrá que dar su nombre legal completo y su número de seguro social o su autorización para trabajar.

La ley de Día de Paga de Texas, Título II, Capítulo 61, Código Laboral de Texas, requiere que compañías de Texas les paguen a sus empleados exentos de la paga de tiempo extra bajo las estipulaciones de la Ley de Normas Laborales Justas de 1938 cuando menos una vez al mes. Se les debe pagar a todos los otros empleados cuando menos dos veces al mes y cada período de paga deberá de constar lo más cerca posible de un número igual de días.

Días de paga programados: (Debe indicar fecha o fechas del mes para los empleados a quienes se les paga mensualmente, o dos veces al mes, y día de la semana para los empleados pagados semanalmente o en otro momento.)

MENSUALMENTE: _____ DOS VECES AL MES: _____ SEMANALMENTE: _____ VARIOS: _____

PARA COMPAÑÍAS: el Código Laboral de Texas fracción 208.001(b) y 40 T.A.C. 815.1(14)(A) & (B) requiere que este aviso, o su equivalente, se muestre en un lugar que razonablemente verían todos los empleados, y que la compañía proporcione información individualmente a un empleado cuando este se separe de su empleo.

Para informar sobre sospechas de fraude, desperdicio o abuso del programa llamar al 800-252-3842.

ATTENTION EMPLOYEES

The Texas Payday Law, Title 2, Chapter 61, Texas Labor Code, requires Texas employers to pay their employees who are exempt from the overtime pay provisions of the Fair Labor Standards Act of 1938 at least once per month. All other employees must be paid at least as often as semi-monthly and each pay period must consist as nearly as possible of an equal number of days.

Scheduled paydays: (You must indicate date or dates of the month for employees paid monthly or semi-monthly, and day of the week for employees paid weekly or at other times.)

MONTHLY _____

SEMI-MONTHLY _____

WEEKLY _____

OTHER _____

For more information write or contact the Texas Workforce Commission in Austin or contact your nearest TWC office. TWC offices are located in major cities throughout the state.

TEXAS WORKFORCE COMMISSION
Labor Law Section
101 East 15th Street, Room 514
Austin, Texas 78778-0001

1-800-832-9243
TDD 1-800-735-2989 (Hearing Impaired)

TO EMPLOYERS: *The law requires that this notice or its equivalent be posted in conspicuous places at your business.*

ATENTO AVISO A LOS EMPLEADOS

La Ley Tejana del Salario Atrasado, Título II, Capítulo 61 del Código del Trabajo de Tejas, exige que los patrones de Tejas paguen no menos de una vez al mes a sus empleados que estén eximidos de las disposiones de la ley de Normas Laborales Justas de 1938, en lo referente al pago de horas adicionales. A todos los demás empleados hay que pagarles no menos de dos veces mensuales, y cada período salarial debe, en la medida de lo posible, tener igual número de días.

Días de pago establecidos: (Hay que indicar en qué día(s) del mes se paga a los empleados con salario quincenal o mensual y en qué día de la semana en que se paga a los empleados pagados semanalmente o en algún otro período.)

MENSUAL _____

QUINCENAL _____

SEMANAL _____

OTRO PERIODO _____

Para mayores informes, sírvase escribir o llamar a la Comisión de la Fuerza Laboral de Tejas, Austin, Tejas 78778 o communicarse con la oficina más próxima de la Comisión. Se encuentran oficinas de la Comisión en las principales ciudades del estado.

TEXAS WORKFORCE COMMISSION
Labor Law Section
101 East 15th Street, Room 514
Austin, Texas 78778-0001

1-800-832-9243 or TDD 1-800-735-2989 (Hearing Impaired)

A LOS PATRONES: La ley requiere fijar este aviso, o un aviso equivante, dentro de su empresa y a la vista de todos.

LL-10S (1117)

YOUR RIGHTS UNDER USERRA

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- ☆ you ensure that your employer receives advance written or verbal notice of your service;
- ☆ you have five years or less of cumulative service in the uniformed services while with that particular employer;
- ☆ you return to work or apply for reemployment in a timely manner after conclusion of service; and
- ☆ you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- ☆ are a past or present member of the uniformed service;
- ☆ have applied for membership in the uniformed service; or
- ☆ are obligated to serve in the uniformed service;

then an employer may not deny you:

- ☆ initial employment;
- ☆ reemployment;
- ☆ retention in employment;
- ☆ promotion; or
- ☆ any benefit of employment

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

HEALTH INSURANCE PROTECTION

- ☆ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.

- ☆ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

ENFORCEMENT

- ☆ The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

- ☆ For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its website at **http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **http://www.dol.gov/elaws/userra.htm**.

- ☆ If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.

- ☆ You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: **http://www.dol.gov/vets/programs/userra/poster.htm**. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

U.S. Department of Labor
1-866-487-2365

U.S. Department of Justice

Office of Special Counsel

1-800-336-4590

Publication Date — April 2017