



## EMPLOYEE ENROLLMENT PACKET



## Central Texas Veteran Directed Care (VDC)

6243 IH Ten West, Suite 430, San Antonio, Texas 78201

CDS lines: 210-798-DSSW Fax: 210-798-5200

Toll Free Phone: 866-675-7331 Fax: 866-301-1182

[www.cdsintexas.com](http://www.cdsintexas.com) <http://www.facebook.com/CDSinTexas>



## INFORMATION FOR EMPLOYEES

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

### FREQUENTLY ASKED QUESTIONS

What is consumer direction?	Consumer direction, also known as self-direction, allows the veteran to become the employer of record. It is also called the Veteran Directed Care or VDC
Who is CDS in Texas?	We are known as a financial management services agency. We will conduct background checks for your employer and process your timesheets, withhold taxes, and prepare your W-2 at year end.
Who do I work for?	You work for the veteran. You do <b>not</b> work for CDS in Texas. Questions regarding hours, pay, timesheets, duties, etc. should be directed to your employer.
How do I apply?	Your employer has all the application forms, or you can download them from our website <a href="http://www.cdsintexas.com">www.cdsintexas.com</a> . Follow the directions carefully and then fax or email the completed forms to 210-640-3913. You can also scan and email the application to <a href="mailto:VD@cdsintexas.com">VD@cdsintexas.com</a>
What comes next?	Once we have the application packet, we do background checks and notify your potential employer of the results. Your employer will decide whether to hire you. If hired, your employer will give you a start date and train you on what services are needed
How do I record my time worked?	Your employer will provide you with a timesheet. Record your time daily. Be sure to sign and date the timesheet.
How do I get paid?	The application packet has forms for direct deposit to a bank account or pre-paid card, or you can select our paycard. When your payroll is processed, you will receive an email notification.
When do I get paid?	Your employer has the payroll schedule. You will be paid semi monthly on every 1 <sup>st</sup> and 15 <sup>th</sup> of the month unless the date falls on a weekend or holiday.
What if my pay is not in my account on payday?	Check with your employer to see if there is a fax or email confirmation. If there is not, re-send and call our office to let us know about the late timesheet. If there is confirmation of receipt, you or your employer should call our office. We should be able to locate the missing timesheet, and we will process as quickly as possible.
How do I get my payroll records	When we enroll you as an employee, you will receive an email registration notice that will tell you how to login to our self-serve web-based payroll system.
What taxes are withheld from my pay?	CDS in Texas will withhold all federal taxes. You will receive email notification when your payroll is processed and will be able to see what taxes have been withheld.
Will I get a W-2?	Your W-2 will be released by January 31.
What else do I need to know?	If the consumer is in the hospital or other facility or loses eligibility, you cannot work.
What if I'm working for two individuals?	You must complete two applications, and if you provide services during the same hours, you cannot be paid twice for hours worked simultaneously
Does CDS in Texas have a website?	Yes. Visit us at <a href="http://www.cdsintexas.com">www.cdsintexas.com</a> . Follow us on Facebook.

Other important things to know	<ul style="list-style-type: none"> <li>You certify your timesheets as true and correct. Record your hours each day and do not sign timesheets until your last shift for that payroll period has been worked. Never sign blank timesheets. Incorrect timesheets may be viewed as fraud.</li> </ul>
	<ul style="list-style-type: none"> <li>Any over or under payment of payroll will be corrected as soon as possible but no later than the next payroll.</li> </ul>
	<ul style="list-style-type: none"> <li>Everyone has a responsibility to report abuse, neglect or exploitation (1-800-252-5400).</li> </ul>
	<ul style="list-style-type: none"> <li>Work with your employer until you fully understand what is expected of you and you understand how your employer wants all tasks completed.</li> <li>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.</li> </ul>
Is there anything else I need to do?	<p><b>YES !!</b> If any of your information changes -- your name, your address, your banking information, your telephone number, your email address – contact CDS in Texas at 210-798-3779 ext 8319 or email at <a href="mailto:VD@cdsintexas.com">VD@cdsintexas.com</a>.</p>



## EMPLOYEE CHECKLIST AND INSTRUCTIONS

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

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

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

Instructions for each form start on the next page.

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

REQUIRED FORMS - RETURN TO CDS IN TEXAS	
<input type="checkbox"/>	Employment application filled out and signed
<input type="checkbox"/>	USCIS Form I-9 filled out and signed by you and your employer
<input type="checkbox"/>	Copy of driver's license is <b>attached</b> and legible.
<input type="checkbox"/>	Copy of social security card is <b>attached</b> and legible.
<input type="checkbox"/>	Direct Deposit Authorization is filled out and signed.
<input type="checkbox"/>	Voided check, prepaid card form, or letter from bank is <b>attached</b> .
<input type="checkbox"/>	Paycard Authorization Form filled out and signed
<input type="checkbox"/>	Exemptions worksheet is filled out and signed.
<input type="checkbox"/>	IRS Form W-4 is filled out and signed.
<input type="checkbox"/>	Employment Agreement is filled out and signed by you and your employer.
<input type="checkbox"/>	Form 1733 is filled out and signed by you and your employer.
<input type="checkbox"/>	Form 1728 is filled out and signed by you and your employer.
<input type="checkbox"/>	Form 1727 is filled out and signed by you and your employer.
<input type="checkbox"/>	Form 1731 is filled out and signed by you and your employer.
<input type="checkbox"/>	Form 1725 Criminal History and Registry check is filled out and signed by you and your employer.
PACKET SUBMISSION METHODS	
FAX to 210-640-3913	
Scan and email to: VD@cdsintexas.com	
Mail to: CDS in Texas, Attention: Veterans Directed Program, 6243 IH 10 West, San Antonio, Texas 78201	
Questions? Call 210-798-3779 ext. 8319	



## Employment Application

Veteran Name: \_\_\_\_\_

**Part I: To be Completed by the Applicant**

PERSONAL INFORMATION				
First Name:	M.I.:	Last Name:		Gender (optional):
SSN:	DOB: / /	Phone(s)--include area code:	Phone(s)--include area code:	
Mailing Address:				
City:	State:	Zip:	County:	
Email Address:		Driver's License No:	State of Issuance:	
Relationship to Employer:				
QUALIFICATIONS				
The applicant must be of 18 years of age or older AND may not be the authorized representative. Failure to meeting either of these requirements at any time will result in the disqualification of the applicant or employee's eligibility.				
WORK EXPERIENCE				
<i>Please list your last 3 (three) jobs beginning with the most recent.</i>				
Company Name	Your Title	Supervisor	Dates	Reason for Leaving
<div style="border: 1px solid black; padding: 5px; display: flex; justify-content: space-between;"> <span>May the employer contact your previous supervisors for reference?</span> <span>YES</span> <span>NO</span> </div>				

<b>REFERENCES</b>		
<i>Please list at least three non-relative references.</i>		
Name	Company/Occupation	Phone Number(s)
<b>EMERGENCY CONTACT INFORMATION</b>		
Name	Relationship	Phone Number(s)
<b>BACKGROUND AND OTHER CHECKS</b>		
Previous Names Used (if applicable)		Dates
Previous Addresses (within the last 5 years)		Dates
<i>Voluntary (Optional) Disclosure</i>		
Have you ever pled guilty or nolo contendere to a crime or been convicted of a crime other than a minor traffic offense?  YES <input type="checkbox"/> NO <input type="checkbox"/>	Voluntary explanation:	

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

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date



# Employment Eligibility Verification

## Department of Homeland Security

### U.S. Citizenship and Immigration Services

**USCIS**  
**Form I-9**  
OMB No.1615-0047  
Expires 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
<p><b>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.</b></p>		Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):				
		<input type="checkbox"/> 1. A citizen of the United States				
		<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)				
		<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)				
<input type="checkbox"/> 4. A noncitizen (other than <b>Item Numbers 2.</b> and <b>3.</b> above) authorized to work until (exp. date, if any)						
If you check <b>Item Number 4.</b> , 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)	<p><b>Additional Information</b></p>				
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)	<p><input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.</p>				
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

**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.

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

**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
<ol style="list-style-type: none"> <li>1. U.S. Passport or U.S. Passport Card</li> <li>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</li> <li>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</li> <li>4. Employment Authorization Document that contains a photograph (Form I-766)</li> <li>5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole:                             <ol style="list-style-type: none"> <li>a. Foreign passport; and</li> <li>b. Form I-94 or Form I-94A that has the following:                                     <ol style="list-style-type: none"> <li>(1) The same name as the passport; and</li> <li>(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.</li> </ol> </li> </ol> </li> <li>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</li> </ol>	OR	<ol style="list-style-type: none"> <li>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</li> <li>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</li> <li>3. School ID card with a photograph</li> <li>4. Voter's registration card</li> <li>5. U.S. Military card or draft record</li> <li>6. Military dependent's ID card</li> <li>7. U.S. Coast Guard Merchant Mariner Card</li> <li>8. Native American tribal document</li> <li>9. Driver's license issued by a Canadian government authority</li> <li style="text-align: center;"><b>For persons under age 18 who are unable to present a document listed above:</b></li> <li>10. School record or report card</li> <li>11. Clinic, doctor, or hospital record</li> <li>12. Day-care or nursery school record</li> </ol>	AND	<ol style="list-style-type: none"> <li>1. A Social Security Account Number card, unless the card includes one of the following restrictions:                             <ol style="list-style-type: none"> <li>(1) NOT VALID FOR EMPLOYMENT</li> <li>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</li> <li>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</li> </ol> </li> <li>2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)</li> <li>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</li> <li>4. Native American tribal document</li> <li>5. U.S. Citizen ID Card (Form I-197)</li> <li>6. Identification Card for Use of Resident Citizen in the United States (Form I-179)</li> <li>7. Employment authorization document issued by the Department of Homeland Security                             <p style="margin-left: 20px;">For examples, see <a href="#">Section 7</a> and <a href="#">Section 13</a> of the M-274 on <a href="https://uscis.gov/i-9-central">uscis.gov/i-9-central</a>.</p> <p style="margin-left: 20px;">The Form I-766, Employment Authorization Document, is a List A, <b>Item Number 4</b>, document, not a List C document.</p> </li> </ol>
<p><b>Acceptable Receipts</b></p> <p>May be presented in lieu of a document listed above for a temporary period.</p> <p>For receipt validity dates, see the M-274.</p>				
<ul style="list-style-type: none"> <li>• Receipt for a replacement of a lost, stolen, or damaged List A document.</li> <li>• Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual.</li> <li>• Form I-94 with "RE" notation or refugee stamp issued to a refugee.</li> </ul>	OR	<p>Receipt for a replacement of a lost, stolen, or damaged List B document.</p>	AND	<p>Receipt for a replacement of a lost, stolen, or damaged List C document.</p>

\*Refer to the Employment Authorization Extensions page on [I-9 Central](#) for more information.





## DIRECT DEPOSIT AUTHORIZATION AGREEMENT

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

REQUESTOR INFORMATION			
Name:		SSN:	
Phone:		DOB:	
Email:			
Address:			
Account Information			
Routing Number	Account Number	Type of Account	Submission Reason
		<input type="checkbox"/> Checking <input type="checkbox"/> Savings <input type="checkbox"/> Prepaid Card	<input type="checkbox"/> Checking <input type="checkbox"/> Savings <input type="checkbox"/> Prepaid Card
Documentation Attached**			
<input type="checkbox"/> Financial Institution letter <input type="checkbox"/> Voided check <input type="checkbox"/> Typed form from card company			

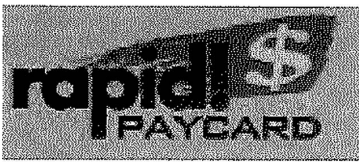
I understand I must attach documentation to this form. All documentation must contain my printed name, account number and routing number. Temporary checks or deposit slips are not acceptable. If using a prepaid card, I must get a statement from the issuing authority demonstrating that this is an active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

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

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

DATE:

Requestor Signature



# PAYCARD ENROLLMENT FORM

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**SEND COMPLETED FORM TO DS OFFICE \*\***

Mande la forma llena a la oficina de CDS

**WE WILL SEND YOU A TEMPORARY CARD TO USE UNTIL YOUR PERMANENT CARD CAN BE MAILED TO YOU (2 TO 3 WEEKS)** Le enviaremos una tarjeta temporal para usar mientras le llega la permanente por correo. (De 2 a 3 semanas)

Client /Cliente Name/Nombre		Employer/ Empleador Name/Nombre	
<b>Cash Card – Account Owner Information (Employee)(Please Print Legibly)</b>			
First Name/Nombre:	Middle Initial/Inicial	Last Name/Apellido:	
Street Address/Domicilio		Apartment #/ Numero de apartamento	
City/Ciudad:	State/Estado:	Zip Code/Codigo:	
Home Telephone/Teléfono de Casa:	Date of Birth/ Fecha de Nacimiento: (MM/DD/YYYY):    /    /		
Social Security Number/Seguro Social:  --      --			
Employee Signature/Firma del Empleado		Date/Fecha	

BOTTOM SECTION WILL BE COMPLETED BY CDS IN TEXAS

La Parte de abajo será llenada por CDS IN TEXAS/LIFESPAN-CDS/ DSSW-CDS

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

Card Number    --    --    --

**ATTACH COPY OF CARD**



## Exemptions Worksheet

Employee Name: \_\_\_\_\_

Employee Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

Employer Name: \_\_\_\_\_

Participant Name: \_\_\_\_\_

### OVERTIME EXEMPTION

The Department of Labor requires all employees be paid overtime wages for any hours worked over 40 in a single work week UNLESS the employee lives in the home with the participant at least 5 days of the workweek. To determine whether you, the employee, are exempt from this rule, **you and your employer must check on of the statements below:**

**Yes, I live with the participant at least 5 days of the workweek.** I understand that by selecting this statement, I am not eligible for overtime wages. Hours worked over 40 in a single work week will be paid at the regular hourly rate in accordance with the budget. My employer is responsible for notifying CDS in Texas immediately of any change to my residence status that affects this exemption.

**No, I do not live with the participant, and my employer will pay overtime wages from his/her personal funds.** My employer does not wish CDS in Texas to apply available funds in my budget to pay overtime wages. My employer understands that by selecting this option, it is my employer's responsibility to pay all overtime wages owed to me from his/her personal funds.

### FAMILY MEMBER TAX EXEMPTION

Employees who provide domestic or household services in the home of a self-directing participant or their representative may be exempt from paying certain taxes that are normally paid through employment. To determine any tax exemption status, please **check any of the statements below that apply to you and your relationship to your employer:**

**I am the spouse of my employer**  
*--You and your employer are both exempt from paying FICA, and your employer is exempt from paying FUTA on wages paid to you.*

**I am the parent of my employer**  
*--You and your employer are both exempt from paying FICA, and your employer is exempt from paying FUTA on wages paid to you.*

**I am the child of my employer, and I am under the age of 21 during the entire tax year.**  
*--You and your employer are both exempt from paying FICA, and your employer is exempt from paying FUTA on wages paid to you until you turn 21.*

**I am the child of my employer, and I am over the age of 21.**  
*--You and our employer are subject to both FICA and FUTA taxes.*

**None of the options above apply to me—I am not the spouse, child, or parent of my employer.**

The family member rules only pertain to situations in which domestic work is performed in the employer's private home. (See IRS Publication 15 and IRS Revenue Procedure 2013-39 for more details.)

\_\_\_\_\_  
Employer Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

6243 IH Ten West, Suite 430, San Antonio, Texas 78201

CDS lines: 210-798-3779 Fax: 210-798-5200

Toll Free Phone: 866-675-7331 Fax: 866-301-1182

[www.cdsintexas.com](http://www.cdsintexas.com)

# 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.

**2024**

<b>Step 1:</b> <b>Enter Personal Information</b>	(a) First name and middle initial	Last name	(b) Social security number
	Address		<b>Does your name match the name on your social security card?</b> If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to <a href="http://www.ssa.gov">www.ssa.gov</a> .
	City or town, state, and ZIP code		
	(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

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

<b>Step 3:</b> <b>Claim Dependent and Other Credits</b>	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		<b>3</b> \$ _____
<b>Step 4 (optional): Other Adjustments</b>	(a) <b>Other income (not from jobs).</b> 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		<b>4(a)</b> \$ _____
	(b) <b>Deductions.</b> 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		<b>4(b)</b> \$ _____
	(c) <b>Extra withholding.</b> Enter any additional tax you want withheld each pay period		<b>4(c)</b> \$ _____

**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**

<b>Employers Only</b>	Employer's name and address	First date of employment	Employer identification number (EIN)



## EMPLOYER AND EMPLOYEE SERVICE AGREEMENT

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

### The Employer agrees:

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

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

### The Employee agrees:

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

### Both the Employer and Employee Agree:

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

Employer's initials \_\_\_\_\_ Employee Initials \_\_\_\_\_

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

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

**Salary:**

- 1) Employee and Employer agree that the starting salary will be \$\_\_\_\_\_per hour.
- 2) Employee will be paid at least twice a month.
- 3) Employee will provide Employer with any legal garnishments which must be withheld from Employee's pay, such as child support or student loans.

**Duration and Modification of Service Agreement:**

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

This Service Agreement cannot be modified.

This Service Agreement will terminate when:

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

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

**Employer:**

**Employee:**

Date: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Printed Name)

\_\_\_\_\_  
(Printed Name)

Name of Veteran if different than Employer: \_\_\_\_\_

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

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

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

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

- (1) physical, psychological, and social assessment, which requires professional nursing judgment, intervention, referral, or follow-up;
- (2) formulation of the nursing care plan and evaluation of the client's response to the care rendered;
- (3) specific tasks involved in the implementation of the care plan that require professional nursing judgment or intervention;
- (4) the responsibility and accountability for client or client's responsible adult health teaching and health counseling which promotes client or client's responsible adult education and involves the client's responsible adult in accomplishing health goals; and
- (5) the following tasks related to medication administration:
  - (A) calculation of any medication doses except for measuring a prescribed amount of liquid medication and breaking a tablet for administration, provided the RN has calculated the dose;
  - (B) administration of medications by an injectable route except for subcutaneous injectable insulin as permitted by §225.11(b) of this title (relating to Delegation of Administration of Medications From Pill Reminder Container and Administration of Insulin);
  - (C) administration of medications by way of a tube inserted in a cavity of the body except as permitted by §225.10(10) of this title (relating to Task That May Be Delegated);
  - (D) responsibility for receiving or requesting verbal or telephone orders from a physician, dentist, or podiatrist; and
  - (E) administration of the initial dose of a medication that has not been previously administered to the client.

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

- (1) bathing, including feminine hygiene;
- (2) grooming, including nail care, except for consumers with medical conditions like diabetes;
- (3) feeding, including feeding through a permanently placed feeding tube;
- (4) routine skin care, including decubitus Stage 1;
- (5) transferring, ambulation or positioning;
- (6) exercising and range of motion; and digital stimulation;
- (7) the administering of a bowel and bladder program, including suppositories, catheterization, enemas, manual evacuation and digital stimulation;

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

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

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

Employee:

Employer:



Printed Name



Printed Name



Signature



Signature



Date



Date

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

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

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

Employee:

Employer:



Signature



Signature



Date



Date

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

Participant Name: \_\_\_\_\_



Veteran Directed Services  
**Liability Acknowledgement**

**Liability Acknowledgement Between the Employer and the Applicant for Employment**

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

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

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

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

\_\_\_\_\_  
Signature – Employer  
(Must be signed by the employer)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature – Applicant for Employment

\_\_\_\_\_  
Date

**Liability Notice to Applicants for Employment**

**Section I:**

**CHOOSE ONE**

The employer:

- is** a subscriber of Texas Workers' Compensation through the Texas Department of Insurance, Division of Workers' Compensation.
- is not** a subscriber of Texas Workers' Compensation through the Texas Department of Insurance, Division of Workers' Compensation. (Employer completes Section II below if this option applies.)

**Section II:**

**CHOOSE ONE**

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

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

**Acknowledgement by Employer and Applicant for Employment**

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

\_\_\_\_\_  
Signature – Employer  
(Must be signed by the employer)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature – Applicant for Employment

\_\_\_\_\_  
Date

→ Participant Name: \_\_\_\_\_

→ Employee Name: \_\_\_\_\_



### Informed Choice Related to Hepatitis B Vaccination

**Employee Statement** — Check one statement below. ←

- I **agree** to receive the Hepatitis B vaccination and will be reimbursed by my employer within 30 days of presenting a paid receipt for each dose. I understand that I will only be reimbursed for doses received while employed by the employer.
- I **agree** to receive the Hepatitis B vaccination and the employer and I have agreed to the following arrangement(s) related to covering the cost of the vaccination:  
  
\_\_\_\_\_  
  
\_\_\_\_\_

- I **decline** the Hepatitis B vaccination at this time because I have previously received the Hepatitis B vaccination.
- I **decline** the Hepatitis B vaccination.

**\* I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine at this time. However, I decline the Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.**

Federal Register: 61 FR 5507, February 13, 1996  
\*OSHA 1910.1030 App A – *Mandatory Declination Statement*

#### Certification by Employee:

I, \_\_\_\_\_, the **employee**, acknowledge and certify that I have received information on occupational exposure to bloodborne pathogens, universal precautions, Hepatitis B and Hepatitis B vaccination. I have been provided the opportunity to ask questions and to seek additional information. I have made my choice (as documented above) related to the Hepatitis B vaccination based on informed choice.

\* I may decide in the future to request and accept the vaccination at no charge to me.

**Employee:**

→

Printed Name

→

Signature

→

Date

**Employer:**

→

Printed Name

→

Signature

→

Date

Participant Name: \_\_\_\_\_

### Employee Work Schedule and Assigned Tasks

→ **Employee Name:** \_\_\_\_\_ **Veteran Name:** \_\_\_\_\_

**Purpose of Form:**

**Activity Involved:**

- Initial
- Change

- Tasks
- Schedule

**Effective Date:** \_\_\_\_\_

**LIST WORK SCHEDULE; IT MAY CHANGE WITHOUT NOTICE TO CDS**

**Schedule I**

→ **Schedule I – Tasks** ↓

Day	Time In	Time Out	Time In	Time Out	Time In	Time Out	Total Hours
Sunday							
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							
<b>Weekly Total Hours</b>							

Check those that apply - refer to your care plan

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

**Must have a schedule listed above**

**Schedule II (OPTIONAL)**

**Schedule II – Tasks**

Day	Time In	Time Out	Time In	Time Out	Time In	Time Out	Total Hours
Sunday							
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							
<b>Weekly Total Hours</b>							

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

→ \_\_\_\_\_ → \_\_\_\_\_ → \_\_\_\_\_ → \_\_\_\_\_  
**Signature – Employer**                      **Date**                      **Signature – Employee**                      **Date**



**Criminal Conviction History and Registry Checks**

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

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

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

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

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

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

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

\_\_\_\_\_  
Signature - Applicant

\_\_\_\_\_  
Date

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

Individual's Name	Employer Name
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**Criminal Conviction History Check (Check each box to certify agreement):**

- I request that my FMSA obtain a **current** Criminal Conviction History Check of the applicant from DPS. I authorize the FMSA to be reimbursed for the cost of obtaining the DPS Criminal Conviction History Check and if I request the report, the cost of sending the report from my budgeted funds.
- I understand that if I request the report, the FMSA must send it to me through a secure method, DPS approved encrypted software or certified mail.
- I understand that all criminal records and reports obtained by my FMSA, and the information they contain, are confidential information.
- I understand all DPS criminal history information reports must be destroyed five days after I make the hiring decision. Paper records need to be shredded, pulped or burned. For electronic records, destroying the media or using specialized software to copy over the data are acceptable methods.
- I understand that sharing of criminal history information with any person or agency may be prosecuted as a Class A Misdemeanor.
- I understand I may not allow the applicant to begin delivering services until the FMSA and I confirm the applicant meets all qualifications to be hired.

\_\_\_\_\_  
Signature - Employer

\_\_\_\_\_  
Date

**Registry Check**

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

\_\_\_\_\_  
Signature - Employer

\_\_\_\_\_  
Date

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

- Verbally
- Encrypted email
- Certified mail

\_\_\_\_\_  
Date of Employer Request

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

**DPS Criminal Conviction Criminal History Check**

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

Date of DPS Check	Time (specify a.m. or p.m.)
Obtained By	Convictions: <input type="checkbox"/> Yes <input type="checkbox"/> No
DPS approved dissemination method used to inform employer of results: <input type="checkbox"/> Verbally <input type="checkbox"/> Encrypted email <input type="checkbox"/> Certified mail <input type="checkbox"/> Did not specify method	
Date FMSA staff notified employer: _____ FMSA staff: <div style="border: 1px solid black; height: 40px; width: 100%; margin-top: 5px;"></div>	
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)? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Within five calendar days after the hiring decision, the FMSA must destroy the criminal history record information obtained from DPS whether or not hired or retained by the employer or designated representative. Date report was destroyed: _____ Date employer notified FMSA of hiring decision: _____	

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

Date of Registry Checks	Time (specify a.m. or p.m.)	Obtained By	<input type="checkbox"/> Employer <input type="checkbox"/> FMSA Representative
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**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**