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

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

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

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

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

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

_____ _____

Signature - Applicant | Date

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

Individual's Name	Employer Name

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

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

_____ _____

Signature - Employer | Date

Registry Check

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

_____ _____

Signature - Employer | Date

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

- ☐ Verbally (Only Option)
- ☐ ~~Encrypted email~~ (No longer an option)
- ☐ ~~Certified mail~~ (No longer an option)

_____
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

This form is required for all initial name-based search inquires. Agency shall retain tracking form for all name-based inquiries from audit to audit.

DPS Computerized Criminal History (CCH) Verification Form

Section 1: Applicant or Employee must acknowledge information. Signature & date required.

Applicant or Employee Name (Print):

(This is not a consent form but serves as information for the applicant)

I acknowledge that a Computerized Criminal History (CCH) check may be performed by accessing the Texas Department of Public Safety Secure Website and may be based on name and DOB identifiers. Authority for this agency to access an individual's criminal history data may be found in Texas Government Code 411, Subchapter F.

Name-based information is not an exact search and only fingerprint record searches represent true identification to criminal history record information (CHRI), therefore the organization conducting the criminal history check is not allowed to discuss with me any CHRI obtained using the name and DOB method. The agency may request that I also have a fingerprint search performed to clear any misidentification based on the result of the name and DOB search.

In order to complete the fingerprint process, I must make an appointment with the Fingerprint Applicant Services of Texas (FAST) as instructed online Crime Records General Information | Department of Public Safety (texas.gov) Review of Personal Criminal History - Employment Purposes or by calling the DPS Program Vendor at 1-888-467-2080, submit a full and complete set of fingerprints, request a copy be sent to the agency listed below, and pay a fee of $25.00 to the fingerprinting services company.

Once this process is completed the information on my fingerprint criminal history record may be discussed with me.

Applicant or Employee Signature:	Date:

Section 2: Agency use only.

Agency Name: Consumer Directed Services in Texas
Authorized User:
Signature of Authorized User:
Date of Name-Based CCH Search:

Section 3: For agency use only. CCH Tracking information. Check all that apply.

Purpose of CCH	☒ Employee ☐ Volunteer/Contractor ☐ Other:
CCH Storage	☒ No, CCH is not stored by agency. ☐ Yes, CCH is stored by agency.
Retention Period	☐ Temp Only ☐ Annual ☐ None in place ☒ Not Applicable ☐ Other:_____
Storage Method	☐ Physical/Printed ☐ Digital/Electronic ☒ Not Applicable
Retention Purpose	Explain: N/A
Date Destroyed	
Destruction Method of CCH	Explain: N/A

CJIS Launch Pad Link - CHRI & Audit Resources

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:

☐ **is** a subscriber of Texas Workers' Compensation through the Texas Department of Insurance, Division of Workers' Compensation.

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

Section II:

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

☐ I have made the following arrangement(s) for employee work-related injuries/illnesses:

- ☐ self-insurance;
- ☐ homeowner's personal liability insurance;
- ☐ renter's personal liability insurance;
- ☐ medical coverage insurance;
- ☐ risk pool insurance;
- ☐ other: _____

☐ 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
July 2024

Consumer Directed Services

Applicant Verification for Employees

Person's Name	Employer Name
Applicant's 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

☐ 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.

☐ 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.

☐ The applicant has the following educational qualifications if providing services for DBMD, Home and Community-based Services (HCS), MDCP, Texas Home Living (TxHmL) or Community First Choice (CFC):

- 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 who evidence the person's ability to provide a safe and healthy environment for the person.

☐ The applicant has the following qualifications if providing services for DBMD:

- is fluent in the communication methods used by the person, such as American Sign Language, tactile symbols, communication boards, pictures and gestures or has the ability to become fluent in the communication methods used by the person within three months after working with the person.

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 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	Designated Representative (DR) — if applicable
Applicant's Relationship to CDS Employer	Applicant's Relationship to DR

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

Section 2: All Programs

The applicant must answer the following questions.

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

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

** 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 05/31/2027

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 05/31/2027

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 05/31/2027

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

2025

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.)

TIP: Consider using the estimator at *www.irs.gov/W4App* to determine the most accurate withholding for the rest of the year if: you are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

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 the 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 unless otherwise noted.

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 2025 if you meet both of the following conditions: you had no federal income tax liability in 2024 **and** you expect to have no federal income tax liability in 2025. You had no federal income tax liability in 2024 if (1) your total tax on line 24 on your 2024 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 2025 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 17, 2026.

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. Are submitting this form after the beginning of the year;

2. Expect to work only part of the year;

3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;

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

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

TIP: Have your most recent pay stub(s) from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

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. Submit a separate Form W-4 for each job.

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 2025 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 2025 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:
- $30,000 if you're married filing jointly or a qualifying surviving spouse
- $22,500 if you're head of household
- $15,000 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	$700	$850	$910	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020
$10,000 - 19,999	0	700	1,700	1,910	2,110	2,220	2,220	2,220	2,220	2,220	2,220	3,220
$20,000 - 29,999	700	1,700	2,760	3,110	3,310	3,420	3,420	3,420	3,420	3,420	4,420	5,420
$30,000 - 39,999	850	1,910	3,110	3,460	3,660	3,770	3,770	3,770	3,770	4,770	5,770	6,770
$40,000 - 49,999	910	2,110	3,310	3,660	3,860	3,970	3,970	3,970	4,970	5,970	6,970	7,970
$50,000 - 59,999	1,020	2,220	3,420	3,770	3,970	4,080	4,080	5,080	6,080	7,080	8,080	9,080
$60,000 - 69,999	1,020	2,220	3,420	3,770	3,970	4,080	5,080	6,080	7,080	8,080	9,080	10,080
$70,000 - 79,999	1,020	2,220	3,420	3,770	3,970	5,080	6,080	7,080	8,080	9,080	10,080	11,080
$80,000 - 99,999	1,020	2,220	3,420	4,620	5,820	6,930	7,930	8,930	9,930	10,930	11,930	12,930
$100,000 - 149,999	1,870	4,070	6,270	7,620	8,820	9,930	10,930	11,930	12,930	14,010	15,210	16,410
$150,000 - 239,999	1,870	4,240	6,640	8,190	9,590	10,890	12,090	13,290	14,490	15,690	16,890	18,090
$240,000 - 259,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$260,000 - 279,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$280,000 - 299,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$300,000 - 319,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,170	19,170
$320,000 - 364,999	2,040	4,440	6,840	8,390	9,790	11,100	12,470	14,470	16,470	18,470	20,470	22,470
$365,000 - 524,999	2,790	6,290	9,790	12,440	14,940	17,350	19,650	21,950	24,250	26,550	28,850	31,150
$525,000 and over	3,140	6,840	10,540	13,390	16,090	18,700	21,200	23,700	26,200	28,700	31,200	33,700

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	$200	$850	$1,020	$1,020	$1,020	$1,370	$1,870	$1,870	$1,870	$1,870	$1,870	$2,040
$10,000 - 19,999	850	1,700	1,870	1,870	2,220	3,220	3,720	3,720	3,720	3,720	3,890	4,090
$20,000 - 29,999	1,020	1,870	2,040	2,390	3,390	4,390	4,890	4,890	4,890	5,060	5,260	5,460
$30,000 - 39,999	1,020	1,870	2,390	3,390	4,390	5,390	5,890	5,890	6,060	6,260	6,460	6,660
$40,000 - 59,999	1,220	3,070	4,240	5,240	6,240	7,240	7,880	8,080	8,280	8,480	8,680	8,880
$60,000 - 79,999	1,870	3,720	4,890	5,890	7,030	8,230	8,930	9,130	9,330	9,530	9,730	9,930
$80,000 - 99,999	1,870	3,720	5,030	6,230	7,430	8,630	9,330	9,530	9,730	9,930	10,130	10,580
$100,000 - 124,999	2,040	4,090	5,460	6,660	7,860	9,060	9,760	9,960	10,160	10,950	11,950	12,950
$125,000 - 149,999	2,040	4,090	5,460	6,660	7,860	9,060	9,950	10,950	11,950	12,950	13,950	14,950
$150,000 - 174,999	2,040	4,090	5,460	6,660	8,450	10,450	11,950	12,950	13,950	15,080	16,380	17,680
$175,000 - 199,999	2,040	4,290	6,450	8,450	10,450	12,450	13,950	15,230	16,530	17,830	19,130	20,430
$200,000 - 249,999	2,720	5,570	7,900	10,200	12,500	14,800	16,600	17,900	19,200	20,500	21,800	23,100
$250,000 - 399,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$400,000 - 449,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$450,000 and over	3,140	6,490	9,160	11,660	14,160	16,660	18,660	20,160	21,660	23,160	24,660	26,160

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	$450	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,870	$1,870	$1,870	$1,890
$10,000 - 19,999	450	1,450	2,000	2,200	2,220	2,220	2,220	3,180	4,070	4,070	4,090	4,290
$20,000 - 29,999	850	2,000	2,600	2,800	2,820	2,820	3,780	4,780	5,670	5,690	5,890	6,090
$30,000 - 39,999	1,000	2,200	2,800	3,000	3,020	3,980	4,980	5,980	6,890	7,090	7,290	7,490
$40,000 - 59,999	1,020	2,220	2,820	3,830	4,850	5,850	6,850	8,050	9,130	9,330	9,530	9,730
$60,000 - 79,999	1,020	3,030	4,630	5,830	6,850	8,050	9,250	10,450	11,530	11,730	11,930	12,130
$80,000 - 99,999	1,870	4,070	5,670	7,060	8,280	9,480	10,680	11,880	12,970	13,170	13,370	13,570
$100,000 - 124,999	1,950	4,350	6,150	7,550	8,770	9,970	11,170	12,370	13,450	13,650	14,650	15,650
$125,000 - 149,999	2,040	4,440	6,240	7,640	8,860	10,060	11,260	12,860	14,740	15,740	16,740	17,740
$150,000 - 174,999	2,040	4,440	6,240	7,640	8,860	10,860	12,860	14,860	16,740	17,740	18,940	20,240
$175,000 - 199,999	2,040	4,440	6,640	8,840	10,860	12,860	14,860	16,910	19,090	20,390	21,690	22,990
$200,000 - 249,999	2,720	5,920	8,520	10,960	13,280	15,580	17,880	20,180	22,360	23,660	24,960	26,260
$250,000 - 449,999	2,970	6,470	9,370	11,870	14,190	16,490	18,790	21,090	23,280	24,580	25,880	27,180
$450,000 and over	3,140	6,840	9,940	12,640	15,160	17,660	20,160	22,660	25,050	26,550	28,050	29,550

TEXAS
Health and Human Services

Form 1731
January 2007-E

Consumer Directed Services

Employee Work Schedule and Assigned Tasks

Employee Name: _____

Purpose of Form:
- ☐ Initial
- ☐ Change

Activity Involved:
- ☐ Tasks
- ☐ Schedule

Effective Date: _____

Schedule I

Day	Time In	Time Out	Time In	Time Out	Time In	Time Out	Total Hours
Sunday							
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							
Schedule may vary depending on need.					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

Day	Time In	Time Out	Time In	Time Out	Time In	Time Out	Total Hours
Sunday							
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							
Schedule may vary depending on need.					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.)*

_____ **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.)*

_____ **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: _____ Employer Name: _____

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

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

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

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

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

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

I, _____, have read and understand the above notification.

_____ _____
Signature Date

TEXAS
Health and Human Services

Form 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.

☐ _____

☐ _____

☐ _____

☐ _____

☐ _____

☐ _____

☐ _____

☐ _____

☐ _____

☐ _____

☐ _____

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☐ _____

☐ _____

☐ _____

TEXAS Health and Human Services

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,** _____ ☐ an individual or

☐ an entity, located at (Address) _____ ,

_____; Telephone _____ Fax _____

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 _____ , doing business in _____ , 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.*

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

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

EMPLOYEE DIRECT DEPOSIT AUTHORIZATION

Employee Name:	**Effective Date:**
Address:	**City / State / Zip:**
Birth Date:	**Social Security Number:**
Phone:	**Email:**

CHOOSE YOUR METHOD OF DIRECT DEPOSIT:

☐ **I request my payroll deduction / direct deposit be placed in the following account(s):**

BANK / CREDIT UNION	BANK ABA#	ACCOUNT#	DEDUCTION AMOUNT / NET PAY	TYPE OF ACCOUNT
	#	#	☐ $ _____ or ☐ _____%	☐ Savings ☐ Checking
	#	#	☐ $ _____ or ☐ _____%	☐ Savings ☐ Checking

PLEASE PROVIDE A VOIDED CHECK FOR EACH CHECKING ACCOUNT LISTED ABOVE.

AND / OR:

☐ **rapid! PayCard Issuance Authorization Form**

Financial Institution Name: MetaBank®

Routing Number: **124085244**

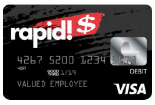
Direct Deposit Account Number: **353** ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
(Card ID on front of envelope)

To be assigned and entered by CDS in Texas

DEDUCTION AMOUNT / NET PAY

☐ $ _____

or ☐ 100%



The rapid! PayCard® Visa® Prepaid card is issued by MetaBank®, Member FDIC, pursuant to a license from Visa U.S.A. Inc.

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.

I authorize CDS in Texas to withhold the indicated amount(s), if available, from my pay, and deposit directly into the account(s) shown and/or I hereby authorize CDS in Texas to assign a rapid! PayCard and initiate credit entries and any correcting entries to my assigned rapid! PayCard account. The direct deposit(s) will be made on each payday, unless I notify CDS in Texas in writing of my intent to cancel. Upon CDS in Texas' receipt of a request to cancel a direct deposit authorization, it shall become effective after a reasonable opportunity to act upon it.

In the event funds are deposited erroneously into my account, I authorize CDS in Texas to debit my account(s) not to exceed the original amount of the credit.

I understand that CDS in Texas reserves the right to refuse any direct deposit request. I also understand that all direct deposits are made through the Automated Clearing House (ACH), and that funds availability is subject to the terms and limitations of the ACH as well as my financial institution.

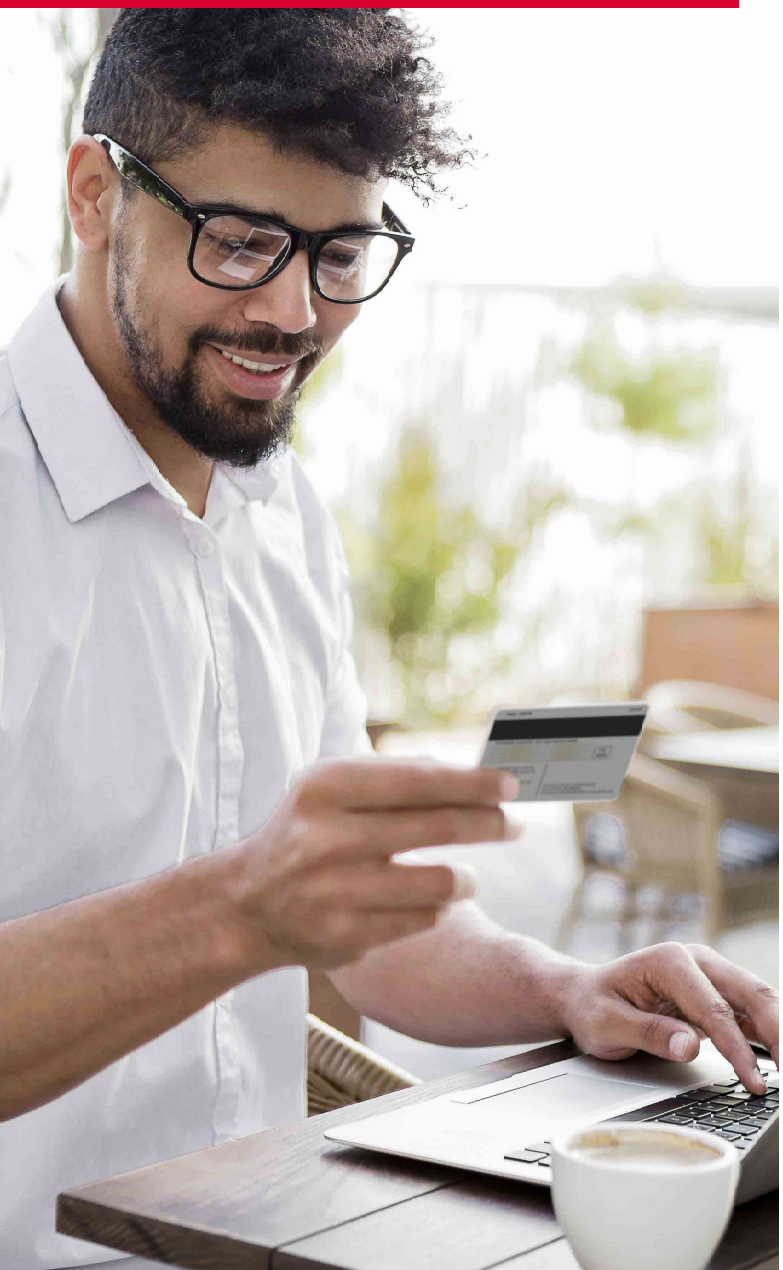
Note: If sending this form electronically, please type your initials and the last 4 digits of your social security number in the signature field. If sending or faxing a paper copy, please print out and sign your name(s) in the signature box.

Employee Signature: _____ Date: _____

For Official Use Only	
Entered By: _____	Date: _____

rapid! PAYCARD

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.

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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.

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rapid! Customer Support
1.888.727.4314

CDS in Texas Bi-Weekly 2025 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	12/08/2024	12/21/2024	12/23/2024		01/03/2025
2	12/22/2024	01/04/2025	01/06/2025		01/17/2025
3	01/05/2025	01/18/2025	01/20/2025		01/31/2025
4	01/19/2025	02/01/2025	02/03/2025		02/14/2025
5	02/02/2025	02/15/2025	02/17/2025		02/28/2025
6	02/16/2025	03/01/2025	03/03/2025		03/14/2025
7	03/02/2025	03/15/2025	03/17/2025		03/28/2025
8	03/16/2025	03/29/2025	03/31/2025		04/11/2025
9	03/30/2025	04/12/2025	04/14/2025		04/25/2025
10	04/13/2025	04/26/2025	04/28/2025		05/09/2025
11	04/27/2025	05/10/2025	05/12/2025		05/23/2025
12	05/11/2025	05/24/2025	05/26/2025		06/06/2025
13	05/25/2025	06/07/2025	06/09/2025		06/20/2025
14	06/08/2025	06/21/2025	06/23/2025		07/03/2025
15	06/22/2025	07/05/2025	07/07/2025		07/18/2025
16	07/06/2025	07/19/2025	07/21/2025		08/01/2025
17	07/20/2025	08/02/2025	08/04/2025		08/15/2025
18	08/03/2025	08/16/2025	08/18/2025		08/29/2025
19	08/17/2025	08/30/2025	09/01/2025		09/12/2025
20	08/31/2025	09/13/2025	09/15/2025		09/26/2025
21	09/14/2025	09/27/2025	09/29/2025		10/10/2025
22	09/28/2025	10/11/2025	10/13/2025		10/24/2025
23	10/12/2025	10/25/2025	10/27/2025		11/07/2025
24	10/26/2025	11/08/2025	11/10/2025		11/21/2025
25	11/09/2025	11/22/2025	11/24/2025		12/05/2025
26	11/23/2025	12/06/2025	12/08/2025		12/19/2025
1	12/07/2025	12/20/2025	12/22/2025		01/02/2026

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 Documentation of Tasks worked

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

You now have another way to upload your timesheet. 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 your 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 forms: www.cdsintexas.com