This packet is ONLY for prospective employees of a Member enrolled with My Choice Wisconsin.

This PDF document is optimized for use in Adobe Acrobat. Completion in a browser such as Chrome, Firefox, or Edge is not recommended.

This document is designed for double-sided paper printing.

CONSUMER DIRECT CARE NETWORK

CO-EMPLOYMENT

EMPLOYEE DATA FORM

Employee Information

Reset/clear all fields > Clear Form

Name: _____ _____ _____
First Middle Last

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

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

Phone #: Home _____ Cell _____

Do you consent to receiving text messages from Consumer Direct Care Network (CDCN)? ☐ Yes ☐ No

Email*: _____

Date of Birth: ___/___/_____ Social Security Number: _____-____-_____

Emergency Contact: _____ _____ _____
Name Phone Relationship

**Mandatory. The state of WI will send your unique ID for use with Electronic Visit Verification (EVV) to this email address. Email is also the most reliable and quickest way of communication between you and CDCN.*

Member/Authorizing Entity Information

Name of Member: _____

Name of Managing Party/Representative (if exists): _____

Name of MCO Authorizing the Member's Services: My Choice Wisconsin

Please Read Carefully: Neither the acceptance of employee paperwork nor entry into any type of employment relationship or employment agreement with a Member/Managing Party for the consideration of employment shall serve to create an actual or implied contract of employment with Consumer Direct Care Network Wisconsin (CDCN).

Employment is conditional until the criminal background check has been received and approved – the results of which may be shared with the approving entity (MCO) and/or the Member/Managing Party.

As the Employee, I understand that I cannot begin work until I receive an "Okay to Work" authorization letter from CDCN. This confirms the background check is complete, and all enrollment paperwork has been received and approved by CDCN.

CG Signature of Applicant: _____ Date: _____

When signing forms, look for these symbols next to signature lines.

Employee (Caregiver) signature

Member or Managing Party signature

CONSUMER DIRECT CARE NETWORK

CO-EMPLOYMENT

NEW EMPLOYEE CHECKLIST

Employee Name	Member Name	Managing Party Name

Welcome to Consumer Direct Care Network (CDCN)!

Please complete all the forms in the list below including this New Employee Checklist. Send originals to the CDCN Wisconsin office **before** the employee begins work. The Employee may not begin work until all forms are completed, and are received and **approved** by CDCN.

The Member/Managing Party should check each item as it is completed. The Member/Managing Party should keep a copy of each document and **send the originals to the CDCN Wisconsin office**.

Mandatory Forms - All New Employees:

1. ☐ Employee Data Form
2. ☐ New Employee Checklist (this form)
3. ☐ Equal Employment Opportunity Disclosure
4. ☐ I-9 - *Additional I-9 instructions are available on the CDCN Wisconsin website under the Forms tab*
5. ☐ W-4 (federal withholding certificate)
6. ☐ WT-4 (state withholding certificate)
7. ☐ Pay Selection Form - *Attachment may be required, see form instructions*
8. ☐ Wage Memo
9. ☐ Employment Agreement
10. ☐ Wisconsin Medicaid Program Provider Agreement
11. ☐ MCO Self Directed Supportive Home Care – TRAINING VERIFICATION FORM
12. ☐ Training Checklist
13. ☐ Electronic Visit Verification Live-in Worker Identification (return to CDCN only if applicable)
14. ☐ Background Information Disclosure
15. ☐ Employee Health Questionnaire
16. ☐ Hepatitis B Accept/Decline Form
17. ☐ HIPAA Quiz
18. ☐ Expected Weekly Hours (for internal use – please submit with packet)

Review and Discussions:

1. ☐ Employee Benefits Summary
2. ☐ Employee Handbook and appendix (located in the Managing Party Manual, online at www.consumerdirectwi.com or by calling 1-877-785-9991)
3. ☐ Reporting Requirements (abuse, neglect, fraud, injury)

I have reviewed and verified the above forms for completeness and all forms are readable.

For Office Use Only – Start Date: _____

CONSUMER DIRECT CARE NETWORK

EQUAL EMPLOYMENT OPPORTUNITY DISCLOSURE

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

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

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

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

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

-OR-

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

Decline Self Identification:

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

CG **Employee Signature**: _____ **Date**: _____

Staff Option:

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

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

Instructions for Completing Form I-9 Section 1

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

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

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

Employee (steps 1-9)

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

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

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

④ Print your Social Security Number.

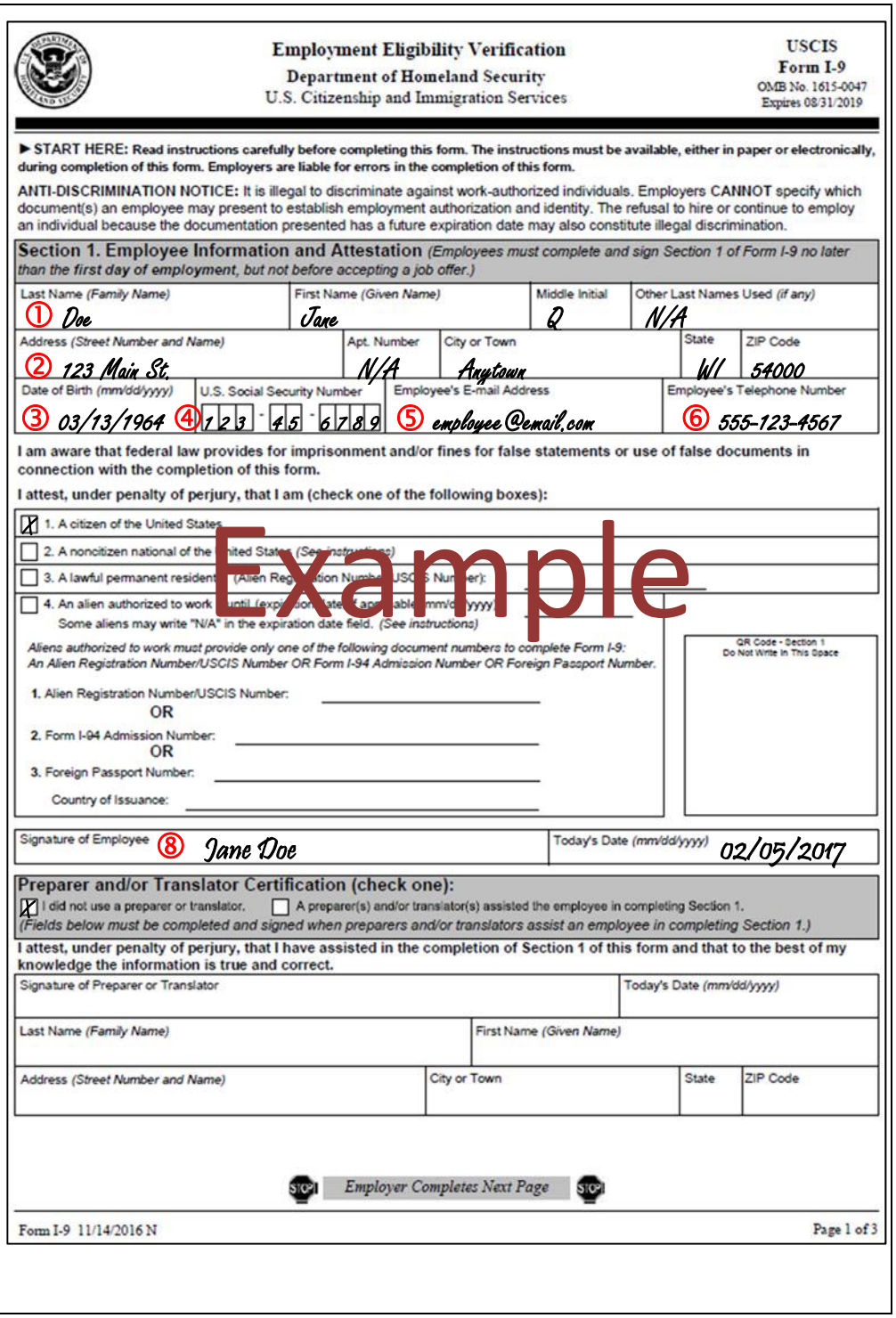
⑤ Print your email address or print "N/A" if you choose to not provide it.

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

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

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

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



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

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

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

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

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

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

Address (Street Number and Name)	Apt. Number	City or Town	State	ZIP Code
② 123 Main St.	N/A	Anytown	WI	54000

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

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

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

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

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

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

QR Code - Section 1
Do Not Write In This Space

Example

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

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

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

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

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

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

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

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

STOP Employer Completes Next Page STOP

Form I-9 11/14/2016 N — Page 1 of 3

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

Instructions for Completing Form I-9 Section 2

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

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

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

Employer (steps 1-10)

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

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

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

one document from List A

OR

one from List B and one from List C

Only accept unexpired, original documents (no photocopies).

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

⑤ Sign the form.

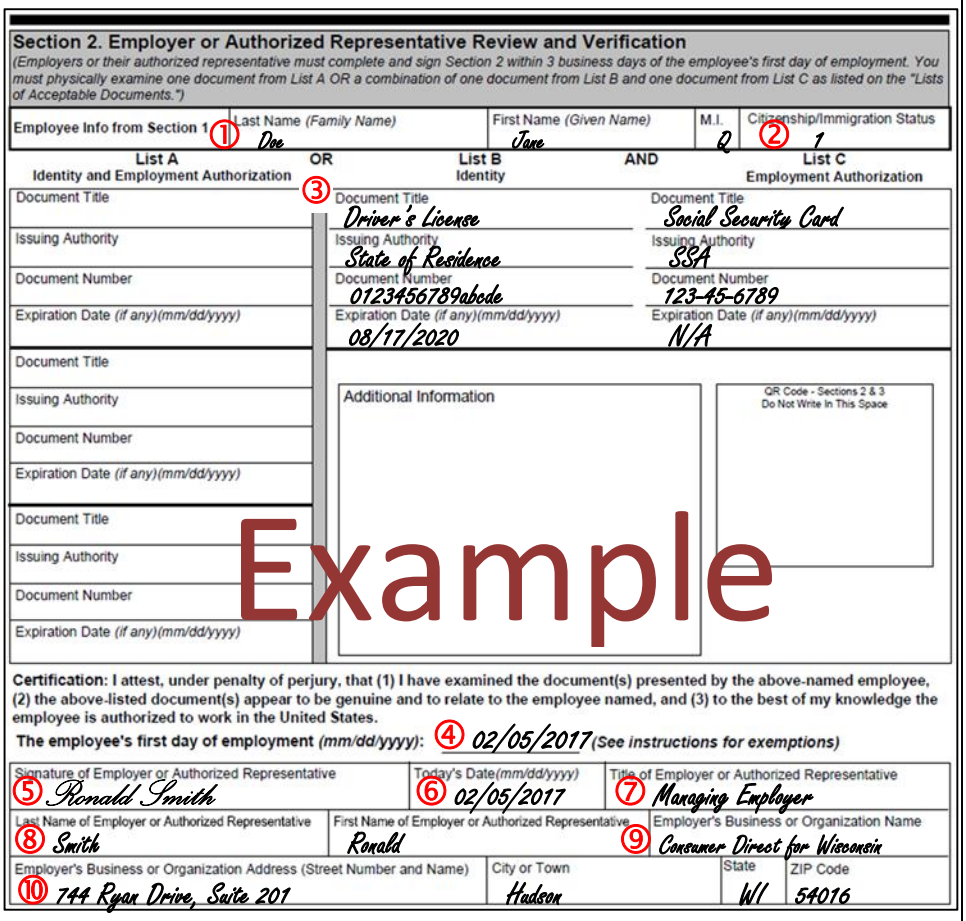
⑥ Print the date you signed the form. **Must be completed and signed within 3 days of employee's first day of work.**

⑦ Print "Managing Employer."

⑧ Print your last then first name.

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

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



Section 2. Employer or Authorized Representative Review and Verification

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

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

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

Example

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

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

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

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

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code
⑩ 744 Ryan Drive, Suite 201	Hudson	WI	54016

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

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

Employment Eligibility Verification

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

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

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

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

QR Code - Section 1
Do Not Write In This Space

CG

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

Preparer and/or Translator Certification (check one):

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

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

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

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

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

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

STOP *Employer Completes Next Page* STOP

03149

Employment Eligibility Verification

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

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

Section 2. Employer or Authorized Representative Review and Verification

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

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

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

Additional Information

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

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

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

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

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

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code
744 Ryan Drive, Suite 201	Hudson	WI	54016

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

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

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

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

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

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

M

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

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

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

Refer to the instructions for more information about acceptable receipts.

00540

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2023

Step 1: Enter Personal Information

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

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

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, other details, and privacy.

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Reserved for future use.

(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 . . . . . ☐

TIP: If you have self-employment income, see page 2.

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.

CG

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

Employers Only

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

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2023 if you meet both of the following conditions: you had no federal income tax liability in 2022 **and** you expect to have no federal income tax liability in 2023. You had no federal income tax liability in 2022 if (1) your total tax on line 24 on your 2022 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 2023 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2024.

Your privacy. If you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c).

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 income and self-employment taxes through withholding from your wages, you should enter the self-employment income on Step 4(a). Then compute your self-employment tax, divide that tax by the number of pay periods remaining in the year, and include that resulting amount per pay period on Step 4(c). You can also add half of the annual amount of self-employment tax to Step 4(b) as a deduction. To calculate self-employment tax, you generally multiply the self-employment income by 14.13% (this rate is a quick way to figure your self-employment tax and equals the sum of the 12.4% social security tax and the 2.9% Medicare tax multiplied by 0.9235). See Pub. 505 for more information, especially if the sum of self-employment income multiplied by 0.9235 and wages exceeds $160,200 for a given individual.

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.

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 roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

CAUTION

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 2023 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.

1	**Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3	**1**	$
2	**Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.		
	a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a	**2a**	$
	b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b	**2b**	$
	c Add the amounts from lines 2a and 2b and enter the result on line 2c	**2c**	$
3	Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc.	**3**	
4	**Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld)	**4**	$

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

1	Enter an estimate of your 2023 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income	**1**	$
2	Enter: { • $27,700 if you're married filing jointly or a qualifying surviving spouse • $20,800 if you're head of household • $13,850 if you're single or married filing separately }	**2**	$
3	If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-"	**3**	$
4	Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information	**4**	$
5	**Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4	**5**	$

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

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

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

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

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	$850	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,870
$10,000 - 19,999	0	930	1,850	2,000	2,200	2,220	2,220	2,220	2,220	2,220	3,200	4,070
$20,000 - 29,999	850	1,850	2,920	3,120	3,320	3,340	3,340	3,340	3,340	4,320	5,320	6,190
$30,000 - 39,999	850	2,000	3,120	3,320	3,520	3,540	3,540	3,540	4,520	5,520	6,520	7,390
$40,000 - 49,999	1,000	2,200	3,320	3,520	3,720	3,740	3,740	4,720	5,720	6,720	7,720	8,590
$50,000 - 59,999	1,020	2,220	3,340	3,540	3,740	3,760	4,750	5,750	6,750	7,750	8,750	9,610
$60,000 - 69,999	1,020	2,220	3,340	3,540	3,740	4,750	5,750	6,750	7,750	8,750	9,750	10,610
$70,000 - 79,999	1,020	2,220	3,340	3,540	4,720	5,750	6,750	7,750	8,750	9,750	10,750	11,610
$80,000 - 99,999	1,020	2,220	4,170	5,370	6,570	7,600	8,600	9,600	10,600	11,600	12,600	13,460
$100,000 - 149,999	1,870	4,070	6,190	7,390	8,590	9,610	10,610	11,660	12,860	14,060	15,260	16,330
$150,000 - 239,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
$240,000 - 259,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
$260,000 - 279,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	18,140
$280,000 - 299,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,870	17,870	19,740
$300,000 - 319,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,470	15,470	17,470	19,470	21,340
$320,000 - 364,999	2,040	4,440	6,760	8,550	10,750	12,770	14,770	16,770	18,770	20,770	22,770	24,640
$365,000 - 524,999	2,970	6,470	9,890	12,390	14,890	17,220	19,520	21,820	24,120	26,420	28,720	30,880
$525,000 and over	3,140	6,840	10,460	13,160	15,860	18,390	20,890	23,390	25,890	28,390	30,890	33,250

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	$310	$890	$1,020	$1,020	$1,020	$1,860	$1,870	$1,870	$1,870	$1,870	$2,030	$2,040
$10,000 - 19,999	890	1,630	1,750	1,750	2,600	3,600	3,600	3,600	3,600	3,760	3,960	3,970
$20,000 - 29,999	1,020	1,750	1,880	2,720	3,720	4,720	4,730	4,730	4,890	5,090	5,290	5,300
$30,000 - 39,999	1,020	1,750	2,720	3,720	4,720	5,720	5,730	5,890	6,090	6,290	6,490	6,500
$40,000 - 59,999	1,710	3,450	4,570	5,570	6,570	7,700	7,910	8,110	8,310	8,510	8,710	8,720
$60,000 - 79,999	1,870	3,600	4,730	5,860	7,060	8,260	8,460	8,660	8,860	9,060	9,260	9,280
$80,000 - 99,999	1,870	3,730	5,060	6,260	7,460	8,660	8,860	9,060	9,260	9,460	10,430	11,240
$100,000 - 124,999	2,040	3,970	5,300	6,500	7,700	8,900	9,110	9,610	10,610	11,610	12,610	13,430
$125,000 - 149,999	2,040	3,970	5,300	6,500	7,700	9,610	10,610	11,610	12,610	13,610	14,900	16,020
$150,000 - 174,999	2,040	3,970	5,610	7,610	9,610	11,610	12,610	13,750	15,050	16,350	17,650	18,770
$175,000 - 199,999	2,720	5,450	7,580	9,580	11,580	13,870	15,180	16,480	17,780	19,080	20,380	21,490
$200,000 - 249,999	2,900	5,930	8,360	10,660	12,960	15,260	16,570	17,870	19,170	20,470	21,770	22,880
$250,000 - 399,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
$400,000 - 449,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
$450,000 and over	3,140	6,380	9,010	11,510	14,010	16,510	18,010	19,510	21,010	22,510	24,010	25,330

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	$620	$860	$1,020	$1,020	$1,020	$1,020	$1,650	$1,870	$1,870	$1,890	$2,040
$10,000 - 19,999	620	1,630	2,060	2,220	2,220	2,220	2,850	3,850	4,070	4,090	4,290	4,440
$20,000 - 29,999	860	2,060	2,490	2,650	2,650	3,280	4,280	5,280	5,520	5,720	5,920	6,070
$30,000 - 39,999	1,020	2,220	2,650	2,810	3,440	4,440	5,440	6,460	6,880	7,080	7,280	7,430
$40,000 - 59,999	1,020	2,220	3,130	4,290	5,290	6,290	7,480	8,680	9,100	9,300	9,500	9,650
$60,000 - 79,999	1,500	3,700	5,130	6,290	7,480	8,680	9,880	11,080	11,500	11,700	11,900	12,050
$80,000 - 99,999	1,870	4,070	5,690	7,050	8,250	9,450	10,650	11,850	12,260	12,460	12,870	13,820
$100,000 - 124,999	2,040	4,440	6,070	7,430	8,630	9,830	11,030	12,230	13,190	14,190	15,190	16,150
$125,000 - 149,999	2,040	4,440	6,070	7,430	8,630	9,980	11,980	13,980	15,190	16,190	17,270	18,530
$150,000 - 174,999	2,040	4,440	6,070	7,980	9,980	11,980	13,980	15,980	17,420	18,720	20,020	21,280
$175,000 - 199,999	2,190	5,390	7,820	9,980	11,980	14,060	16,360	18,660	20,170	21,470	22,770	24,030
$200,000 - 249,999	2,720	6,190	8,920	11,380	13,680	15,980	18,280	20,580	22,090	23,390	24,690	25,950
$250,000 - 449,999	2,970	6,470	9,200	11,660	13,960	16,260	18,560	20,860	22,380	23,680	24,980	26,230
$450,000 and over	3,140	6,840	9,770	12,430	14,930	17,430	19,930	22,430	24,150	25,650	27,150	28,600

Employee's Wisconsin Withholding Exemption Certificate/New Hire Reporting

WT-4

Employee's Section (Print clearly)

Employee's legal name *(first name, middle initial, last name)*			Social security number	☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note**: If married, but legally separated, check the Single box.
Employee's address *(number and street)*			Date of birth / /	
City	State	Zip code	Date of hire	

FIGURE YOUR TOTAL WITHHOLDING EXEMPTIONS BELOW

Complete Lines 1 through 3

1. (a) Exemption for yourself – enter 1 . . . . . _____
   (b) Exemption for your spouse – enter 1 . . . . . _____
   (c) Exemption(s) for dependent(s) – you are entitled to claim an exemption for each dependent . . . . . _____
   (d) Total – add lines (a) through (c) . . . . . _____
2. Additional amount per pay period you want deducted (if your employer agrees) . . . . . _____
3. I claim complete exemption from withholding (see instructions). Enter "Exempt" . . . . . _____

I CERTIFY that the number of withholding exemptions claimed on this certificate does not exceed the number to which I am entitled. If claiming complete exemption from withholding, I certify that I incurred no liability for Wisconsin income tax for last year and that I anticipate that I will incur no liability for Wisconsin income tax for this year.

CG Signature _____ Date Signed _____ , _____

EMPLOYEE INSTRUCTIONS:

- **WHO MUST COMPLETE:**
  Effective on or after January 1, 2020, every newly-hired employee is required to provide a completed Form WT-4 to each of their employers. Form WT-4 will be used by your employer to determine the amount of Wisconsin income tax to be withheld from your paychecks. If you have more than one employer, you should claim a smaller number or no exemptions on each Form WT-4 provided to employers other than your principal employer so that the total amount withheld will be closer to your actual income tax liability.

  You must complete and provide your employer a new Form WT-4 within 10 days if the number of exemptions previously claimed DECREASES.

  You may complete and provide to your employer a new Form WT-4 at any time if the number of your exemptions INCREASES.

  Your employer may also require you to complete this form to report your hiring to the Department of Workforce Development.

- **UNDER WITHHOLDING:**
  If sufficient tax is not withheld from your wages, you may incur additional interest charges under the tax laws. In general, 90% of the net tax shown on your income tax return should be withheld.

- **OVER WITHHOLDING:**
  If you are using Form WT-4 to claim the maximum number of exemptions to which you are entitled and your withholding exceeds your expected income tax liability, you may use Form WT-4A to minimize the over withholding.

WT-4 Instructions – Provide your information in the employee section.

- **LINE 1:**
  (a)-(c) Number of exemptions – Do not claim more than the correct number of exemptions. If you expect to owe more income tax for the year than will be withheld if you claim every exemption to which you are entitled, you may increase your withholding by claiming a smaller number of exemptions on lines 1(a)-(c) or you may enter into an agreement with your employer to have additional amounts withheld (see instruction for line 2).

  (c) Dependents – Those persons who qualify as your dependents for federal income tax purposes may also be claimed as dependents for Wisconsin purposes. The term "dependents" does not include you or your spouse. Indicate the number of dependents that you are claiming in the space provided.

- **LINE 2:**
  Additional withholding – If you have claimed "zero" exemptions on line 1, but still expect to have a balance due on your tax return for the year, you may wish to request your employer to withhold an additional amount of tax for each pay period. If your employer agrees to this additional withholding, enter the additional amount you want deducted from each of your paychecks on line 2.

- **LINE 3:**
  Exemption from withholding – You may claim exemption from withholding of Wisconsin income tax if you had no liability for income tax for last year, and you expect to incur no liability for income tax for this year. You may not claim exemption if your return shows tax liability before the allowance of any credit for income tax withheld. If you are exempt, your employer will not withhold Wisconsin income tax from your wages.

  You must revoke this exemption (1) within 10 days from the time you expect to incur income tax liability for the year or (2) on or before December 1 if you expect to incur Wisconsin income tax liabilities for the next year. If you want to stop or are required to revoke this exemption, you must complete and provide a new Form WT-4 to your employer showing the number of withholding exemptions you are entitled to claim. This certificate for exemption from withholding will expire on April 30 of next year unless a new Form WT-4 is completed and provided to your employer before that date.

Employer's Section

Employer's name				Federal Employer ID Number
Employer's payroll address *(number and street)*		City	State	Zip code
Completed by	Title	Phone number ( )	Email	

EMPLOYER INSTRUCTIONS for Department of Revenue:

- If you do not have a Federal Employer Identification Number (FEIN), contact the Internal Revenue Service to obtain a FEIN.
- If the employee has claimed more than 10 exemptions OR has claimed complete exemption from withholding and earns more than $200.00 a week or is believed to have claimed more exemptions than they are entitled to, mail a copy of this certificate to: Wisconsin Department of Revenue, Audit Bureau, PO Box 8906, Madison WI 53708 or fax (608) 267-0834.
- Keep a copy of this certificate with your records. If you have questions about the Department of Revenue requirements, call (608) 266-2772 or (608) 266-2776.

EMPLOYER INSTRUCTIONS for New Hire Reporting:

- This report contains the required information for reporting a New Hire to Wisconsin. If you are reporting new hires electronically, you do not need to forward a copy of this report to the Department of Workforce Development. Visit https://dwd.wi.gov/uinh/ to report new hires.
- If you do not report new hires electronically, mail the original form to the Department of Workforce Development, New Hire Reporting, PO Box 14431, Madison WI 53708-0431 or fax toll free to 1-800-277-8075.
- If you have questions about New Hire requirements, call toll free (888) 300-HIRE (888-300-4473). Visit dwd.wi.gov/uinh/ for more information.

CONSUMER DIRECT CARE NETWORK

PAY SELECTION FORM

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

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

Please check one pay option below.

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

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

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

The Name of my bank is: _____

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

AN ATTACHMENT IS REQUIRED.

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

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

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

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

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

CG

_____ _____

Employee Signature *Date*

Sign up for the Wisely® Pay card today!

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

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

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

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

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

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

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

WiselyCard_Poster_V4 Rev. Aug 2020

CONSUMER DIRECT CARE NETWORK

WAGE MEMO

Employee Name	Member Name	Member CDCN ID #

MCO/Authorizing Entity: My Choice Wisconsin

Authorized Services:

Service Code	Wage or Reimbursement	Rate
	$_____	☐ hour ☐ session ☐ day ☐ mile
	$_____	☐ hour ☐ session ☐ day ☐ mile
	$_____	☐ hour ☐ session ☐ day ☐ mile
	$_____	☐ hour ☐ session ☐ day ☐ mile
	$_____	☐ hour ☐ session ☐ day ☐ mile
	$_____	☐ hour ☐ session ☐ day ☐ mile

Overtime: ☐ Allowed ☐ Not Allowed

Effective Date:

CG

Employee Signature *Date*

CDCN Representative Name *CDCN Representative Signature* *Date*

CONSUMER DIRECT CARE NETWORK

CO-EMPLOYMENT

EMPLOYEE AGREEMENT

I, _____, agree to and acknowledge the following:
(Employee Print Name)

_____ has elected to hire me to perform care services for the Member
(Member or Managing Party Print Name)

according to Wisconsin's self-directed services program.

The "Approving Entity" authorizing the Member's services is My Choice Wisconsin.
(Managed Care Organization)

1. **Enrollment**
   I will complete the Employee Packet and associated pre-hire trainings. Mandatory trainings include:
   - Employee handbook.
   - Bloodborne Pathogens protocols.
   - Abuse, Neglect and Exploitation Reporting Requirements.
   - HIPAA regulations and Privacy.
   - Lifting and Moving.
   - Employee and Member Harassment.

2. **Co-Employment Service Model**
   Under the co-employment service model, the Member/Managing Party (MP) is my Managing Employer. They select, schedule, manage and dismiss caregivers. Consumer Direct Care Network Wisconsin (CDCN) is my legal Employer of Record. They provide administrative and payroll services. CDCN can terminate a caregiver's CDCN employment without the Member's permission. I acknowledge while employed by CDCN, I may be offered the opportunity to work for other Members.

3. **Effective Date**
   I can begin work when CDCN approves my enrollment materials and I receive an *Okay to Work* letter from CDCN.

4. **Payment**
   - I am paid at an hourly rate as defined in the wage memo. My pay is subject to applicable tax withholding.
   - CDCN offers two direct deposit pay options. I can specify a bank account or choose a pay card. If I change my direct deposit option, I must submit a new *Pay Selection Form*.
   - CDCN issues pay every two weeks. CDCN sends pay stubs (summary of pay) and W-2s by first class mail to my address on file or electronically.
   - I agree to use an approved Electronic Visit Verification (EVV) method to record each shift worked. I must also submit weekly paper or online time records, due by midnight on Monday following the work week. If submitted late, pay may be delayed.
   - CDCN reserves the right to withhold wages for overpayment or alleged misrepresentation on time submitted.

5. My Responsibilities

- Provide services according to authorized tasks and hours outlined in the Member's care plan. If a reasonable accommodation is needed to perform job duties, notify the Member/MP and CDCN.
- Work the agreed upon schedule as set by the Member/MP.
- Program compliance.
- Confidentiality of Member information.
- Use appropriate safeguards and universal health precautions to not spread communicable disease.
- Not working more than forty (40) hours a week without written permission from CDCN.
- Ensure any car used to provide services has auto insurance that meets the State's minimum guidelines.
- Perform job duties in an ethical manner and respect the Member's rights and dignity.
- Understand and accept the roles and responsibilities of the Member/MP and CDCN as defined in this Agreement.

6. Member/MP Responsibilities

- Refer employees to be hired by CDCN:
  - Assist each employee to complete an Employee Packet and associated pre-hire trainings.
  - Use the *Employee Training Checklist* to document completion of mandatory pre-hire trainings.
- Manage and schedule employees to provide authorized tasks and hours outlined in the Member's care plan.
- Ensure continued employee trainings are completed, as needed.
- Evaluate employee's job performance. Notify CDCN if dissatisfied with an employee's services.
- Approve employee work-time records through EVV and paper timesheet/web portal.
- Dismiss employees from providing services. Dismissing an employee does not terminate their CDCN employment.
  - Member/MP must provide CDCN with the reason for the dismissal so CDCN can appropriately respond to unemployment compensation requests.
- Instruct employees on necessary medical administration procedures.
- Provide a safe work environment according to federal and state laws.

7. CDCN Responsibilities

- Serve as the employee's Legal Employer or Record.
- Provide employee and Member/MP with hiring documents, training materials, CDCN policies, and benefits information.

- Process work-time records, apply tax and benefit withholdings, and issue employee paychecks.
- Provide a contact person to ensure compliance with laws and regulations and assist with questions about services. The Member/MP and employees can contact a CDCN Service Coordinator at 1-877-785-9991.

8. Reporting Requirements

- Employee must report:
  - Work-place injuries to the CDCN Injury Hotline at 1-888-541-1701 within twenty-four (24) hours.
  - Possible Member neglect, abuse or exploitation to the county Adult or Elder Abuse reporting line.
- Member/MP or employee must report suspected Medicaid Fraud to CDCN or the appropriate authority. Reporting contact information is available on our website under the Resources/Fraud Prevention tab.

9. Conclusion

This Agreement is not a contract/guarantee of employment. CDCN reserves the right, with or without cause, to refuse to hire any person as an employee and can terminate an employee's employment at any time.

CG _____ _____ M _____ _____

Employee Signature *Date* *Member/Managing Party Signature* *Date*

DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-00180C (07/2017)

STATE OF WISCONSIN
42 CFR 431.107 & 42 CFR 438.602(b)

WISCONSIN MEDICAID PROGRAM PROVIDER AGREEMENT AND ACKNOWLEDGEMENT OF TERMS OF PARTICIPATION

FOR WAIVER SERVICE PROVIDER AGENCIES OR INDIVIDUALS

Completion of this form is required under Federal Law by the Centers for Medicare & Medicaid Services, Department of Health and Human Services, under the Code of Federal Regulations 42 CFR 431.107.

Name of Provider (Typed or Printed—Must exactly match name used on all other documents)		Phone Number	
Address – Street	City	State	Zip Code

The above-referenced provider of home and community-based waiver services under Wisconsin's Medicaid program, hereinafter referred to as the provider, hereby agrees and acknowledges as follows:

1. To provide only the items or services authorized by the managed care organization or IRIS program.
2. To accept the payment issued by the managed care organization or IRIS program as payment in full for provided items or services.
3. To make no additional claims or charges for provided items or services.
4. To refund any overpayment to the managed care organization or IRIS program.
5. To keep any records necessary to disclose the extent of services provided consistent with the provider's business type.
6. To provide, upon request by the managed care organization, the IRIS program, or the Department of Health Services (DHS) or its designee, information regarding the items or services provided.
7. To comply with all other applicable federal and state laws, regulations, and policies relating to providing home and community-based waiver services under Wisconsin's Medicaid program including the caregiver background check law.
8. Medicaid Confidentiality Policies and Procedures: To maintain the confidentiality of all records or other information relating to each participant's status as a waiver participant and items or services the participant receives from the Provider.
9. To respect and comply with the waiver participant's right to refuse medication and treatment and other rights granted the participant under federal and state law.
10. Medicaid Fraud Prevention Policies and Procedures (including records retention): To keep records necessary to disclose the extent of services provided to waiver participants **for a period of ten (10) years** and to furnish upon request to the DHS, the federal Department of Health and Human Services, or the state Medicaid Fraud Control Unit, any information regarding services provided and payments claimed by the Provider for furnishing services under the Wisconsin Medicaid Program. This requirement includes retaining all records and documents according to the terms provided by Wis. Admin. Code § DHS 106.02(a)-(d); (f)-(g).
11. The provider agrees to comply with the disclosure requirements of 42 CFR Part 455, Subpart B, as now in effect or as may be amended. To meet those requirements and address real or potential conflict of interest that may influence service provision, among other things the provider shall furnish to the managed care organization and upon request, to the Department in writing:

    a) The names and addresses of all vendors of drugs, medical supplies or transportation, or other providers in which it has a controlling interest or ownership;

    b) The names and addresses of all persons who have a controlling interest in the provider;

c) Whether any of the persons named in compliance with (a) and (b) above are related to any owner or to a person with a controlling interest as spouse, parent, child or sibling;

d) The names and addresses of any subcontractors who have had business transactions with the provider;

e) The identity of any person named in compliance with (a) and (b) above, who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX services programs since the inception of those programs.

12. To provide to the DHS identifying information, including name, specialty, date of birth, Social Security number, national provider identifier, (NPI) (if eligible for an NPI), Federal taxpayer identification number, and State license or certification for purposes of enrollment with the State Medicaid program.

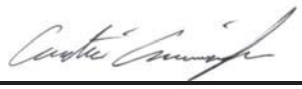
13. To include its NPI (if eligible for an NPI) on all claims submitted under the Medicaid program.

14. To comply with the advance directives requirements specified in 42 CFR Part 489, Subpart I.

Modifications to this agreement cannot and will not be agreed to. Altering this agreement in any way voids the Department of Health Services' signature. This agreement is not transferable or assignable.

Name – Provider (Typed or Printed)

SIGNATURE – Provider	Date Signed
CG	

FOR DMS USE ONLY (DO NOT WRITE BELOW THIS LINE)	
SIGNATURE – Department of Health Services	Date Signed
	8/14/17

MCO Self Directed Supportive Home Care

TRAINING VERIFICATION FORM

Service Description: Supportive Home Care (SHC) is the provision of a range of services for members who require assistance to meet their daily living needs, ensure adequate functioning in their home and permit safe access to the community. SHC includes personal services such as activities of daily living, assistance in the use of adaptive equipment, mobility and communication aids and accompanying the member to appointments. It may also include assisting the member follow through on treatment plans. Household services may include performing household tasks and home maintenance activities such as meal preparation, shopping, laundry and house cleaning.

Employee/Care provider:

Address:

Phone:

Employer/Member:

Personal Assistance and Household/Chore Services
Required Minimum Training and Qualified Provider Standards

Providers of supportive home care and personal assistance services must meet the following DHS required minimum training and qualified provider standards to deliver services and receive payments using Medicaid funding. **Each member/employer is responsible for providing information and training to their on specific care needs.**

1. Policies, Procedures

Including HIPPA compliance and other confidentiality requirements, ethical standards, including respecting personal property, safely providing services to members, scheduling and procedure/ notice for needed time off and initiating back up services as needed.

2. Billing and payment processes and relevant contact information

Record keeping, reporting, and contact information including the name and contact information of the primary contact information of the member and Fiscal/employer agent or co-employment agency

3. Recognizing & Responding to Emergencies

Protocols for contacting local emergency response systems prompt notification to primary member contact, MCO team and Fiscal Employer Agent.
Examples: emergency contact numbers, when to call 911, fire/tornado plan, prompt notification to support team, etc.

4. Member/Employer Specific Information

Member individual needs, medical conditions, strengths, abilities, preferences/rules; expectations for providing care needs safely.
Examples: wearing gloves, washing hands, handling equipment, transfers, transportation, grooming preferences, how to use adaptive/mobility aids, preparation of foods, preferences for assistance with daily living and abilities.

5. General Target Information

Any general information that might apply to the care of the member
Example: info on working with elderly, people with physical or cognitive disabilities, or mental health challenges

6. Providing Quality Homemaking/Household Services (if provided)

Understanding good nutrition, special diets, meal planning and preparation. Understanding and maintaining a clean, safe & healthy environment. Respecting member preferences in housekeeping tasks and shopping
Examples: how to run the washer/dryer, washing dishes, preparing meals, etc.

7. Working Effectively with Employee/Participant

Understanding and respecting member self-direction, individuality, independence and rights. Procedures for handling conflict and complaints, cultural differences and family relationships and behavioral supports (if needed).

OVER for SIGNATURES

Exemption and Waiver from Training Requirements

Prior to employment, the employer/member may exempt a prospective service provider from the personal service and household chore service training requirements when it is determined that the provider already has sufficient comparable knowledge or experience.

Exemption: Due to a licensure or Credential, the following professions may be exempted from the training requirements: Certified Nursing Assistant (CNA), Licensed Practical Nurse (LPN), Registered Nurse (RN), Physical or Occupational Therapist (PT, OT) or certified Physical or Occupational Assistant (CPTA or COTA). When an exemption is granted, the employee/provider must still document the license or certification. ***The employer/member ensure the worker performing medically oriented tasks such as tube feedings, wound care or tracheotomy care is competent in performing those tasks specific to the employer/member.***

❑ ***This provider is exempt due to licensure or certification as***

- ❑ Licensed Practical Nurse (LPN)
- ❑ Certified Nursing Assistant (CNA)
- ❑ Physical or Occupational Assistant
- ❑ Registered Nurse (RN)
- ❑ Physical or Occupational Therapist

Waiver: Some or all of the required training may be waived based on knowledge and skills attained through prior experience (e.g., personal care worker with a certified personal care agency). When a waiver is granted, ***the employer/member ensure the worker performing medically oriented tasks such as tube feedings, wound care or tracheotomy care is competent in performing those tasks specific to the employer/member.***

❑ ***This provider is waived from specific training due to prior training and/or experience.***

LIST Prior Experience/Training

SIGNATURES

By signing below, I attest I meet the minimum training and qualified provider standards in order to provide Supported Home Care to my employer/member. As the Employer, I attest the above person meets all provider standards and training requirements set by DHS as explained.

CG	**Employee/care provider**	Date
M	**Employer/ Representative Signature**	Date

Return Form to: **Consumer Direct Care Network WI**
744 Ryan Drive, Suite 201
Hudson, WI 54016-7984
Phone: 877-785-9991 (toll free)
Fax: 877-785-9992 (toll free)
Email: infoCDWI@consumerdirectcare.com

CONSUMER DIRECT CARE NETWORK

CO-EMPLOYMENT

EMPLOYEE TRAINING CHECKLIST

Employee Name	Member Name	Managing Party Name

Please complete the following trainings and include the date each training module was completed.

Date Completed

___/___/___ Employee has read and agrees to follow the policies including those outlined in the Employee Handbook and Appendix. I understand that a copy of the handbook is found in the Managing Party Manual, online at www.consumerdirectwi.com or one can be obtained by calling 1-877-785-9991. These policies include, but are not limited to:

- Corporate Compliance
  - Federal Fraud and Abuse
  - Wisconsin Medicaid
- Drug Free Workplace
- Exposure Control Plan
- Safe Driving Program
- Employee Injury Reporting (Injury Hotline: 1- 888-541-1701)
- Harassment-free workplace environment

___/___/___ Employee reviewed and understands the "Lifting and Moving" booklet training.

___/___/___ Employee reviewed and understands the "Infection Control Guidelines" booklet training.

___/___/___ Employee reviewed and understands the "HIPAA Guide" training information.

___/___/___ Employee reviewed and understands the "Abuse, Neglect & Exploitation" training information.

___/___/___ Employee has received orientation to the Member by the Managing Party.

Signatures:
Both Employee and Member/Managing Party sign below to acknowledge training was completed on the dates listed above.

CG _____ _____ M _____ _____

Employee Signature *Date* *Member or Managing Party Signature* *Date*

DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-02717 (02/2022)

STATE OF WISCONSIN

ELECTRONIC VISIT VERIFICATION LIVE-IN WORKER IDENTIFICATION

INSTRUCTIONS: Type or print clearly. This form documents live-in worker identification. Refer to the Electronic Visit Verification Live-In Worker Identification Instructions, F-02717A, for more information on completing this form. Fee-for-service agencies must submit this form and supporting documentation with their prior authorization request. This form may also be used by program payers if they do not require electronic visit verification (EVV) for live-in workers. Completed forms should be kept according to program document retention requirements.

1. Name – Member (Last, First, Middle Initial)	2. Member Medicaid ID Number
3. Name – Live-In Worker (Last, First, Middle Initial)	4. Live-In Worker ForwardHealth ID Number

Note: The live-in worker's name must match both the name entered on the ForwardHealth Portal and the name on the proof submitted.

5. Identification

For the purposes of EVV, a live-in worker is a worker who meets one of the following requirements:

- The worker permanently resides in the same residence as the member or participant receiving services.
- The worker permanently resides in a two-residence dwelling (such as a duplex) where the member or participant receiving services lives in the other half of the dwelling **and** is a relative of the member or participant receiving services. A relative is defined as a person related, of any degree, by blood, adoption, or marriage, to the member or participant.

Permanent residency is determined by the worker being able to produce documentation that shows the worker's name and current residential address. The address must satisfy the requirements for a live-in worker listed above. The worker may use one document from Column A or two types of documents from Column B. Check the box(es) next to the document(s) being submitted as proof of residence.

Column A (Choose **One**)

- ☐ Current and valid State of Wisconsin driver's license or state ID card
- ☐ Other official ID card or license issued by a Wisconsin governmental body or unit
- ☐ Real estate tax bill or receipt for the current year
- ☐ Residential lease for current year
- ☐ Check or other document issued by a unit of government within the last three months

Column B (Choose **Two**)

- ☐ Current or previous month's gas, electric, or phone service statement
- ☐ Current or previous month's bank statement
- ☐ Current or previous month's paycheck or paystub

6. Attestation

☐ I have examined the documentation indicated above and attest the worker meets all the requirements of a live-in worker as defined on this form.

7. Name – Representative Verifying Live-In Status	8. **SIGNATURE** – Representative Verifying Live-In Status
9. Name – Agency Verifying Live-In Status Consumer Direct Care Network Wisconsin	10. Date Signed

DEPARTMENT OF HEALTH SERVICES
Division of Quality Assurance
F-82064A (01/2022)

STATE OF WISCONSIN
Wis. Stat. § 50.065
Wis. Admin. Code § DHS 12.05(4)

BACKGROUND INFORMATION DISCLOSURE (BID) FOR ENTITY EMPLOYEES AND CONTRACTORS: INSTRUCTIONS

PURPOSE

- The *Background Information Disclosure for Employees and Contractors* (form F-82064) gathers information required by Wis. Stat. § 50.065 and Wis. Admin. Code ch. DHS 12 for entities to conduct caregiver background checks for prospective and existing employees and contractors. This form may also be used by entities to conduct background checks for students and volunteers that are expected to have regular and direct contact with clients.
- **NOTE:** Form F-82064 should not be used by applicants for *entity operator approval* or by entities requesting approval for an individual to reside in entity facilities as a *non-client resident*. Applicants for *entity operator approval* or for a *non-client resident* background check must request an *entity* background check from the Division of Quality Assurance.

CAREGIVER BACKGROUND CHECK LAW

Entities must conduct background checks to verify initial and renewal eligibility of employees and contractors to serve as *caregivers*. Pursuant to Wis. Stat. § 50.065 and Wis. Admin. Code ch. DHS 12, an entity may not employ or contract with an individual to serve as a "caregiver," if the individual has certain governmental findings or criminal convictions affecting eligibility. See Offenses Affecting Eligibility for Employment or Contract in Roles with Client Contact.

APPLICATION

Caregiver Background Checks are required for prospective and existing employees and contractors of entities. The term *entity* includes, but is not limited to:

- Adult Day Care Centers
- Adult Family Homes
- Alcohol and Other Drug Abuse Treatment Programs
- Ambulance Service Providers
- AODA Services
- Community Based-Residential Facilities
- Community Mental Health Programs
- Community Support Programs
- Comprehensive Community Services
- Corporate Guardianships
- Facilities Serving People with Developmental Disabilities
- Emergency Mental Health Service Programs
- Home Health Agencies
- Hospices
- Hospitals
- Mental Health Day Treatment Services for Children
- Nursing Homes
- Outpatient Mental Health Clinics
- Personal Care Agencies
- Residential Care Apartment Complexes
- Rural Medical Centers
- Youth Crisis Stabilization Facilities
- Programs regulated by ch. DHS 75

FAIR EMPLOYMENT ACT & ELIGIBILITY REQUIREMENTS

Wisconsin Stat. §§ 111.31 – 111.395, prohibits discrimination because of a criminal record or pending charge. However, it is not discrimination to decline to hire or license a person based on the person's arrest or conviction record if the arrest or conviction is substantially related to the circumstances of the particular job or licensed activity. In addition, Wisconsin law establishes conditions of eligibility for employment or contract to work in roles with regular and direct client/patient contact.

Wis. Stat. § 50.065(4m)(b) reads:
Notwithstanding s. 111.335, and except as provided in sub. (5), an entity may not employ or contract with a caregiver or permit to reside at the entity a nonclient resident, if the entity knows or should have known any of the following:

1. That the person has been convicted of a serious crime.
2. That a unit of government or a state agency, as defined in s. 16.61 (2) (d), has made a finding that the person has abused or neglected any client or misappropriated the property of any client.
3. That a final determination has been made under s. 48.981 (3) (c) 5m. or, if a contested case hearing is held on such a determination, a final decision has been made under s. 48.981 (3) (c) 5p. that the person has abused or neglected a child.
4. That, in the case of a position for which the person must be credentialed by the department of safety and professional services, the person's credential is not current or is limited so as to restrict the person from providing adequate care to a client.

See Offenses Affecting Eligibility for guidance.

DEPARTMENT OF HEALTH SERVICES
Division of Quality Assurance
F-82064 (01/2022)

STATE OF WISCONSIN
Wis. Stat. § 50.065
Wis. Admin. Code § DHS 12.05(4)

BACKGROUND INFORMATION DISCLOSURE (BID) FOR ENTITY EMPLOYEES AND CONTRACTORS

- **PENALTY:** A person who provides false information on this form may be subject to forfeiture and sanctions, as provided in Wis. Stat. § 50.065(6)(c) and Wis. Admin Code § DHS 12.05(4).
- Completion of this form to verify your eligibility for employment/service as a "caregiver" is required by Wis. Stat. § 50.065 and Wis. Admin Code ch. DHS 12. Failure to complete this form may result in denial or termination of your employment, contract or service agreement.

Refer to DQA form F-82064A, *Instructions*, for additional information.

Check the box that applies to you.

☑ Applicant / Employee ☐ Student / Volunteer
☐ Contractor ☐ Other – Specify:

NOTE: This form should NOT be used by applicants for *entity operator approval* (license, certification, registration or other DHS approval) or by entities requesting approval for an individual to reside in entity facilities as a *non-client resident*. Applicants for *entity operator approval* or for a *non-client resident* background check must request an *entity* background check from the Division of Quality Assurance.

Full Legal Name – *First*	*Middle*	*Last*

Other Names (including prior to marriage)

Position Title (applied for or existing)	Birth Date *(MM/DD/YYYY)*	Sex
Caregiver		☐ Male ☐ Female

Home Address	City	State	Zip Code

Business Name and Address – Employer (Entity)
Consumer Direct for Wisconsin, LLC, 744 Ryan Drive, Suite 201, Hudson, WI 54016

Answering "NO" to all questions does not guarantee employment, a contract, or service agreement.
If more space is required, attach additional documentation to this form and indicate "see attached" in your answer.

SECTION A – DISCLOSURES

1. Do you have any criminal charges pending against you, including in federal, state, local, military, and tribal courts?
   If **Yes**, list each charge, when it occurred or the date of the charge, and the city and state where the court is located.
   You may be asked to supply additional information, including a copy of the criminal complaint or any other relevant court or police documents.
   Yes ☐ No ☐

2. Were you ever convicted of any crime anywhere, including in federal, state, local, military, and tribal courts?
   If **Yes**, list each crime, when it occurred or the date of the conviction, and the city and state where the court is located.
   You may be asked to supply additional information including a certified copy of the judgment of conviction, a copy of the criminal complaint, or any other relevant court or police documents.
   Yes ☐ No ☐

3. Please note that Wis. Stat. § 48.981, *Abused or neglected children and abused unborn children*, may apply to information concerning findings of child abuse and neglect.
   Has any government or regulatory agency (other than the police) ever found that you committed **child** abuse or neglect?
   Provide an explanation below, including when and where the incident(s) occurred.
   Yes ☐ No ☐

4. Has any government or regulatory agency (other than the police) ever found that you abused or neglected **any person or client**?
   If **Yes,** explain, including when and where it happened.
   Yes ☐ No ☐

5. Has any government or regulatory agency (other than the police) ever found that you misappropriated (improperly took or used) the property of a person or client? Yes ☐ No ☐
   If **Yes**, explain, including when and where it happened.

6. Has any government or regulatory agency (other than the police) ever found that you abused an **elderly person**? Yes ☐ No ☐
   If **Yes**, explain, including when and where it happened.

7. Do you have a government issued credential that is not current or is limited so as to restrict you from providing care to clients? Yes ☐ No ☐
   If **Yes**, explain, including credential name, limitations or restrictions, and time period.

SECTION B – OTHER REQUIRED INFORMATION

1. Has any government or regulatory agency ever limited, denied, or revoked your license, certification, or registration to provide care, treatment, or educational services? Yes ☐ No ☐
   If **Yes,** explain, including when and where it happened.

2. Has any government or regulatory agency ever denied you permission or restricted your ability to live on the premises of a care providing facility? Yes ☐ No ☐
   If **Yes,** explain, including when and where it happened and the reason.

3. Have you been discharged from a branch of the US Armed Forces, including any reserve component? Yes ☐ No ☐
   If **Yes**, indicate the year of discharge:
   Attach a copy of your DD214, if you were discharged within the last three (3) years.

4. Have you resided outside of Wisconsin in the last three (3) years? Yes ☐ No ☐
   If **Yes**, list each state and the dates you resided there.

5. If you are employed by or applying for the State of Wisconsin, have you resided outside of Wisconsin in the last seven (7) years? Yes ☐ No ☐
   If **Yes**, list each state and the dates you resided there.

6. Have you had a caregiver background check done within the last four (4) years? Yes ☐ No ☐
   If **Yes**, list the date of each check, and the name, address, and phone number of the person, facility, or government agency that conducted each check.

7. Have you ever requested a rehabilitation review with the Wisconsin Department of Health Services, a county department, a private child placing agency, school board, or DHS-designated tribe? Yes ☐ No ☐
   If **Yes**, list the review date and the review result. You may be asked to provide a copy of the review decision.

Read and initial the following statement.

CG I have completed and reviewed this form (F-82064, BID) and affirm that the information is true and correct as of today's date.

NAME – Person Completing This Form	Date Submitted

CONSUMER DIRECT CARE NETWORK

EMPLOYEE HEALTH QUESTIONNAIRE

Employee Name: _____
(please print)

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

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

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

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

CONSUMER DIRECT CARE NETWORK

EMPLOYEE HEALTH QUESTIONNAIRE

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

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

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

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

CG *Employee Signature:* _____ Date: _____/_____/_____

Office Use Only

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

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

05095

CONSUMER DIRECT CARE NETWORK

HEPATITIS B VACCINATION AUTHORIZATION/DECLINATION FORM

Employee Name: _____
(please print)

ACCEPT/DECLINE 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 the Hepatitis B virus (HBV) infection. I have the opportunity to be vaccinated with Hepatitis B vaccine, and have the cost reimbursed by Consumer Direct Care Network (CDCN). I understand that if I decline this vaccine, I will be at risk of acquiring Hepatitis B, a serious disease. I understand if I decline the vaccine at this time, I continue to have the opportunity to receive the vaccine in the future while employed with CDCN.

☐ **I decline the Hepatitis B vaccination**

☐ **I choose to receive the Hepatitis B vaccination**

Signature:

CG _____ _____
Employee Signature *Date*

INSTRUCTIONS FOR RECEIVING THE VACCINATION SERIES

If you choose to be vaccinated, make an appointment as soon as possible to receive the first of the three part series at your local Health Department. Afterwards, you will need to schedule appointments for the remaining two parts of the series.

CDCN will reimburse after the full Hepatitis B series is complete. **Be sure to keep your receipts.** Submit your receipts from all three parts of the vaccination series for reimbursement. CDCN cannot reimburse for lost or missing receipts. Likewise, reimbursable immunization shots must occur at the Health Department and while you are employed with CDCN.

Please submit your reimbursement request to:

Consumer Direct Care Network Wisconsin
744 Ryan Drive, Suite 201
Hudson, WI 54016-7984
Phone: 1-877-785-9991
Fax: 1-877-785-9992

CONSUMER DIRECT CARE NETWORK

HIPAA QUIZ AND CONFIDENTIALITY AGREEMENT

Employee Name	Member Name	Score (minimum 80%)

Employee: Review the HIPAA Training Guide, ask questions as required, complete the HIPAA Quiz below, and review and sign the confidentiality agreement.

1. HIPAA stands for:
   a. Health Insurance Protection and Accuracy
   b. Health Insurance Portability and Accountability Act
   c. Help Insurance company Profits - Always Applicable
2. PHI stands for: P_____ H_____ I_____
3. Under HIPAA, patients are generally not allowed to see their medical information:
   a. True b. False
4. If a patient requests information from their medical record, you should:
   a. Run to Kinko's, make a copy, & give it to the patient
   b. Answer that the information is not available, sorry
   c. Refer the request to a Program Manager or Privacy Officer
5. HIPAA law includes penalties for non-compliance of (mark all that apply):
   a. $100 civil penalty up to a maximum of $25,000 per year for each standard violated
   b. A criminal penalty for knowingly disclosing PHI up to a maximum of $250,000
   c. Revocation of your driving license
6. If you get a question from a patient about how their PHI is used and disclosed, you should:
   a. Inform them that a sign has been posted on the door
   b. Say everything is written in invisible ink to protect the information
   c. Refer the patient to a Program Manager or Privacy Officer
7. Patients will not be told of their rights under HIPAA, but rather have to look up information on a government web site:
   a. True b. False
8. The HIPAA Privacy Rule (the law) took effect on: _____

Confidentiality Agreement: By signing below, I acknowledge that the disclosure of confidential information obtained through my employment with the Member and this Consumer Direct Care Network program is **PROHIBITED!** Furthermore, I understand that any information concerning a Member's illness, family, financial condition, or personal details is considered to be strictly confidential. When a Member's history or condition is reviewed, it must be done in private where only those persons involved with the care of the Member are present. Any information known by me concerning any Member, employee, or other person, is also considered confidential. I acknowledge that confidentiality is an important part of the job and that I will not release confidential information. Failure to follow confidentiality requirement is cause for termination.

Signatures:

CG _____ _____ M _____ _____

Employee Signature *Date* *Member or Managing Party Signature* *Date*

CONSUMER DIRECT CARE NETWORK

EXPECTED WEEKLY HOURS - NEW HIRE

CAREGIVER/NURSE
(Non-FEA)

Employee Name: _____

Entity: CDWI

Email Address: _____

-- Office Use Only --

Hire Date: _____

Anticipated Weekly Hours:

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

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

Comments:

CDCN Representative Name: _____

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

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

Always Designing for People™

Work Opportunity Tax Credits - Consumer Direct Care Network

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

Applicant Instructions

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

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

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

IVR CODE: 410849

CONSUMER DIRECT CARE NETWORK

2023 Benefits Summary
WI Caregivers

Benefit	Eligibility Requirements	Enrollment	Important Details
Dependent Care Flexible Spending Account (FSA)	10+ Hours per week	First of the month following 30 days of employment	Employees can defer up to $5,000 per calendar year in pre-tax dollars to use for daycare or disabled adult dependent care expenses. Unused funds are forfeited at the end of the year.
Vision Insurance	10+ Hours per week	First of the month following 30 days of employment	Plan participants receive a free annual eye exam with in-network providers, and can choose between new lenses or frames with $20 copay OR free contacts (within allowance). Additional discounts available.
Voluntary Dental Insurance	10+ Hours per week	First month following 30 days of employment	FREE preventative care (cleanings). Additional services subject to $50 deductible and $1,000 maximum benefit per year.
Basic Life/AD&D Insurance	10+ Hours per week	**Automatic:** First of the month following 30 days of employment	In the event of an employee's death, this company paid plan pays their beneficiary a benefit equal to $10,000. Life and AD&D Benefits reduce to 65% at age 65 and to 45% at age 80.
Voluntary Supplemental Life Insurance	10+ Hours per week	First of the month following 30 days of employment	Employees can elect amounts in $10,000 increments, up to the lesser of $300,000 or 5 times your annual earnings. Verification may be required in certain circumstances. Life Benefits reduce to 65% at age 65 and to 45% at age 80.
Unum Supplemental Insurances	10+ Hours per week	First of the month following 30 days of employment	Coverages Available: Critical Illness, Accident and Hospital Insurance

Employee Assistance Program (EAP)	No hours requirement	**Automatic:** All employees and eligible family members	The EAP offers free and confidential counseling and assistance resolving situations that may inpact your personal or professional life. Employees are given 3 counseling sessions per issue.
401(k) Retirement Plan	No hours requirement Must be age 18 or older	First of the month following 90 days of employment	Employees can defer pre-tax dollars into the company's 401(k) plan.
Pet Insurance	No hours requirement	No waiting period	MetLife Pet Insurance offers assistance to pay for your pet's medical care, including check-ups, testing, surgery, and hospitalization. Contact MetLife at www.metlife.com/getpetquote or 800-438-6388.

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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

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

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name	4. Employer Identification Number (EIN)
Consumer Direct for Wisconsin	26-2202984
5. Employer address 100 Consumer Direct Way	6. Employer phone number 844.360.4747

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

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

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

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

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

Regular status employees working at least 30 hours/week

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

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

☐ We do not offer coverage.

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

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

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

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

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

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

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

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

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

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

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

CONSUMER DIRECT CARE NETWORK

2023 Payroll Calendar

Symbol Key: □ Time Due ○ Pay Day △ Postal and Bank Holiday

JANUARY

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	△2	3	4	5	6	7
8	□9	10	11	12	○13	14
15	△16	17	18	19	20	21
22	□23	24	25	26	○27	28
29	□30	31				

FEBRUARY

Sun	Mon	Tue	Wed	Thu	Fri	Sat
			1	2	3	4
5	□6	7	8	9	○10	11
12	□13	14	15	16	17	18
19	△20	21	22	23	○24	25
26	□27	28				

MARCH

Sun	Mon	Tue	Wed	Thu	Fri	Sat
			1	2	3	4
5	□6	7	8	9	○10	11
12	□13	14	15	16	17	18
19	□20	21	22	23	○24	25
26	□27	28	29	30	31	

APRIL

Sun	Mon	Tue	Wed	Thu	Fri	Sat
						1
2	□3	4	5	6	○7	8
9	□10	11	12	13	14	15
16	□17	18	19	20	○21	22
23	□24	25	26	27	28	29
30						

MAY

Sun	Mon	Tue	Wed	Thu	Fri	Sat
	□1	2	3	4	○5	6
7	□8	9	10	11	12	13
14	□15	16	17	18	○19	20
21	□22	23	24	25	26	27
28	△29	30	31			

JUNE

Sun	Mon	Tue	Wed	Thu	Fri	Sat
				1	○2	3
4	□5	6	7	8	9	10
11	□12	13	14	15	○16	17
18	△19	20	21	22	23	24
25	□26	27	28	29	○30	

JULY

Sun	Mon	Tue	Wed	Thu	Fri	Sat
						1
2	□3	△4	5	6	7	8
9	□10	11	12	13	○14	15
16	□17	18	19	20	21	22
23	□24	25	26	27	○28	29
30	□31					

AUGUST

Sun	Mon	Tue	Wed	Thu	Fri	Sat
		1	2	3	4	5
6	□7	8	9	10	○11	12
13	□14	15	16	17	18	19
20	□21	22	23	24	○25	26
27	□28	29	30	31		

SEPTEMBER

Sun	Mon	Tue	Wed	Thu	Fri	Sat
					1	2
3	△4	5	6	7	○8	9
10	□11	12	13	14	15	16
17	□18	19	20	21	○22	23
24	□25	26	27	28	29	30

OCTOBER

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	□2	3	4	5	○6	7
8	△9	10	11	12	13	14
15	□16	17	18	19	○20	21
22	□23	24	25	26	27	28
29	□30	31				

NOVEMBER

Sun	Mon	Tue	Wed	Thu	Fri	Sat
			1	2	○3	4
5	□6	7	8	9	△10	11
12	□13	14	15	16	○17	18
19	□20	21	22	△23	24	25
26	□27	28	29	30		

DECEMBER

Sun	Mon	Tue	Wed	Thu	Fri	Sat
					○1	2
3	□4	5	6	7	8	9
10	□11	12	13	14	○15	16
17	□18	19	20	21	22	23
24	△25	26	27	28	○29	30
31						

2023 Bank & Post Office Holidays

*Consumer Direct Care Network office closures

*__New Year's Day__ - Monday, January 2

*__Martin Luther King, Jr. Day__ - Monday, January 16

__Presidents Day__ - Monday, February 20

*__Memorial Day__ - Monday, May 29

*__Juneteenth__ - Monday, June 19

*__Independence Day__ - Tuesday, July 4

*__Labor Day__ - Monday, September 4

__Columbus Day__ - Monday, October 9

*__Veterans Day__ - Friday, November 10

*__Thanksgiving Day__ - Thursday, November 23

*__Christmas Day__ - Monday, December 25

CONSUMER DIRECT CARE NETWORK

Each pay period consists of two Sunday through Saturday work weeks. Paper timesheets or web portal time is due Monday by midnight following each work week. You must also clock-in and clock-out for each shift using an approved Electronic Visit Verification (EVV) method. Late time or time with mistakes may result in late pay. Thank you!

Work Week 1 Sunday through Saturday	**Timesheet Due** Monday	**Work Week 2** Sunday through Saturday	**Timesheet Due** Monday	**Pay Date**
12/18/22 to 12/24/22	12/26/22	12/25/22 to 12/31/22	1/2/23	1/13/2023
1/1/23 to 1/7/2023	1/9/23	1/8/23 to 1/14/23	1/16/23	1/27/2023
1/15/23 to 1/21/23	1/23/23	1/22/23 to 1/28/23	1/30/23	2/10/2023
1/29/23 to 2/4/23	2/6/23	2/5/23 to 2/11/23	2/13/23	2/24/2023
2/12/23 to 2/18/23	2/20/23	2/19/23 to 2/25/23	2/27/23	3/10/2023
2/26/23 to 3/4/23	3/6/23	3/5/23 to 3/11/23	3/13/23	3/24/2023
3/12/23 to 3/18/23	3/20/23	3/19/23 to 3/25/23	3/27/23	4/7/2023
3/26/23 to 4/1/23	4/3/23	4/2/23 to 4/8/23	4/10/23	4/21/2023
4/9/23 to 4/15/23	4/17/23	4/16/23 to 4/22/23	4/24/23	5/5/2023
4/23/23 to 4/29/23	5/1/23	4/30/23 to 5/6/23	5/8/23	5/19/2023
5/7/23 to 5/13/23	5/15/23	5/14/23 to 5/20/23	5/22/23	6/2/2023
5/21/23 to 5/27/23	5/29/23	5/28/23 to 6/3/23	6/5/23	6/16/2023
6/4/23 to 6/10/23	6/12/23	6/11/23 to 6/17/23	6/19/23	6/30/2023
6/18/23 to 6/24/23	6/26/23	6/25/23 to 7/1/23	7/3/23	7/14/2023
7/2/23 to 7/8/23	7/10/23	7/9/23 to 7/15/23	7/17/23	7/28/2023
7/16/23 to 7/22/23	7/24/23	7/23/23 to 7/29/23	7/31/23	8/11/2023
7/30/23 to 8/5/23	8/7/23	8/6/23 to 8/12/23	8/14/23	8/25/2023
8/13/23 to 8/19/23	8/21/23	8/20/23 to 8/26/23	8/28/23	9/8/2023
8/27/23 to 9/2/23	9/4/23	9/3/23 to 9/9/23	9/11/23	9/22/2023
9/10/23 to 9/16/23	9/18/23	9/17/23 to 9/23/23	9/25/23	10/6/2023
9/24/23 to 9/30/23	10/2/23	10/1/23 to 10/7/23	10/9/23	10/20/2023
10/8/23 to 10/14/23	10/16/23	10/15/23 to 10/21/23	10/23/23	11/3/2023
10/22/23 to 10/28/23	10/30/23	10/29/23 to 11/4/23	11/6/23	11/17/2023
11/5/23 to 11/11/23	11/13/23	11/12/23 to 11/18/23	11/20/23	12/1/2023
11/19/23 to 11/25/23	11/27/23	11/26/23 to 12/2/23	12/4/23	12/15/2023
12/3/23 to 12/9/23	12/11/23	12/10/23 to 12/16/23	12/18/23	12/29/2023
12/17/23 to 12/23/23	12/25/23	12/24/23 to 12/30/23	1/1/24	1/12/2024

CDWITimesheets@ConsumerDirectCare.com

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