EMPLOYEE DATA FORM

Assistance with the hiring process: Any applicant who needs reasonable accommodation in any step of the hiring process should ask the Member/Managing Party.

Employee Contact Information

Name: _________________________ _________________________ _________________________
First Middle Last

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

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

Phone #: Home (____) __________ Cell (____) __________

Email: ____

Date of Birth: ________________ Social Security Number: _____ - ____ - _______

Emergency Contact: ____________________ ________________ ________________________
Name Phone Relationship

I want Consumer Direct to contact me by:

Phone: ☐ Yes ☐ No Email: ☐ Yes ☐ No Mail: ☐ Yes ☐ No

Have you ever had your driver's license in any state revoked or suspended? ☐ Yes ☐ No

In the past three years, have you had moving violations or motor vehicle accidents? ☐ Yes ☐ No

If yes, explain:

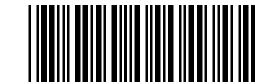
Please Read Carefully: Neither the acceptance of the employee paperwork nor entry into any type of employment relationship or employment agreement with a Member/Managing Party for the consideration of employment shall serve to create an actual or implied contract of employment with Consumer Direct for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

I authorize investigation of all statements provided to the Member/Managing Party or contained in the employee paperwork. I understand that misrepresentation or omission of facts called for is cause for dismissal at any time without notice. I hereby give the Member/Managing Party permission to contact schools, previous employers (unless otherwise indicated), references, and others, and hereby release the Member/Managing Party from any liability as a result of such contact.

I understand that employment remains conditional until the results of the criminal background check have been received and approved. I also understand that the results of the criminal background check or any future criminal background checks may be shared with the approving entity (MCO, county, etc.) and/or the Member/Managing Party I work with.

Signature of Applicant: ______________________________ Date: _______________

02219



CO-EMPLOYMENT

NEW EMPLOYEE CHECKLIST

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.*

Employee Name	Member Name	Managing Party Name

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. ☐ I-9 - *Additional I-9 instructions are available on the CDCN Wisconsin website under the Forms tab*
4. ☐ W-4
5. ☐ Pay Selection Form - *Attachment may be required, see form instructions*
6. ☐ Employee Agreement
7. ☐ Wisconsin Medicaid Program Provider Agreement
8. ☐ Documentation of Training – Supportive Home Care (SHC) / Respite
9. ☐ Training Checklist
10. ☐ Background Information Disclosure
11. ☐ Employee Health Questionnaire
12. ☐ Hepatitis B Accept/Decline Form
13. ☐ HIPAA Quiz
14. ☐ Job Description with Work Schedule

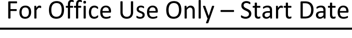
Review and Discussions:

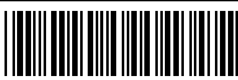
1. ☐ Employee Benefits Summary
2. ☐ Employee Handbook and appendix (located in the Managing Party Manual, online at www.consumerdirectwi.com or by calling 1-877-785-9991)
3. ☐ Reporting Requirements (abuse, neglect, fraud, injury)

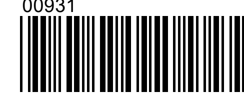
I have reviewed and verified the above forms for completeness and all forms are readable. As the Member/Managing Party, I understand that an applicant cannot be scheduled for work until all employment paperwork is approved, background checks are complete, and I have been notified by CDCN that the Employee is approved to begin work. As the Employee, I understand that I cannot begin work until I receive an "Okay to Work" authorization letter from CDCN.

Signatures:

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


For Office Use Only – Start 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)*

Example

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

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

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*
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 08/31/2019

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

1. Alien Registration Number/USCIS Number: ____________

OR

2. Form I-94 Admission Number: ____________

OR

3. Foreign Passport Number: ____________

Country of Issuance: ____________

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

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

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

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

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

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

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

03149

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

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

Section 2. Employer or Authorized Representative Review and Verification

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

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

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

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

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

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

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

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

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

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

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

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

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

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

03150

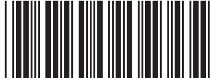
LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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. 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		**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		

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.



00540

Form W-4 (2018)

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

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

Exemption from withholding. You may claim exemption from withholding for 2018 if **both** of the following apply.

• For 2017 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**

• For 2018 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2018 expires February 15, 2019. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2018 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at ***www.irs.gov/W4App*** to determine your tax withholding more accurately. Consider using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2018. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

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

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

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Other Income Worksheet on page 3 or the calculator at *www.irs.gov/W4App* to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at *www.irs.gov/W4App* to find out if you should adjust your withholding on Form W-4 or W-4P.

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

Specific Instructions

Personal Allowances Worksheet

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

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

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

Line F. Credit for other dependents. When you file your tax return, you might be eligible to claim a credit for each of your dependents that don't qualify for the child tax credit, such as any dependent children age 17 and older. To learn more about this credit, see Pub. 505. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total income includes all of

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

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

Employee's Withholding Allowance Certificate

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

OMB No. 1545-0074

2018

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

5	Total number of allowances you're claiming (from the applicable worksheet on the following pages) . . .	5	
6	Additional amount, if any, you want withheld from each paycheck	6	$
7	I claim exemption from withholding for 2018, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here . . . . ►	7	

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

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

Date ►

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

For Privacy Act and Paperwork Reduction Act Notice, see page 4. Cat. No. 10220Q

your wages and other income, including income earned by a spouse, during the year.

Line G. Other credits. You might be able to reduce the tax withheld from your paycheck if you expect to claim other tax credits, such as the earned income tax credit and tax credits for education and child care expenses. If you do so, your paycheck will be larger but the amount of any refund that you receive when you file your tax return will be smaller. Follow the instructions for Worksheet 1-6 in Pub. 505 if you want to reduce your withholding to take these credits into account.

Deductions, Adjustments, and Additional Income Worksheet

Complete this worksheet to determine if you're able to reduce the tax withheld from your paycheck to account for your itemized deductions and other adjustments to income such as IRA contributions. If you do so, your refund at the end of the year will be smaller, but your paycheck will be larger. You're not required to complete this worksheet or reduce your withholding if you don't wish to do so.

You can also use this worksheet to figure out how much to increase the tax withheld from your paycheck if you have a large amount of nonwage income, such as interest or dividends.

Another option is to take these items into account and make your withholding more accurate by using the calculator at *www.irs.gov/W4App*. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Two-Earners/Multiple Jobs Worksheet

Complete this worksheet if you have more than one job at a time or are married filing jointly and have a working spouse. If you don't complete this worksheet, you might have too little tax withheld. If so, you will owe tax when you file your tax return and might be subject to a penalty.

Figure the total number of allowances you're entitled to claim and any additional amount of tax to withhold on all jobs using worksheets from only one Form W-4. Claim all allowances on the W-4 that you or your spouse file for the highest paying job in your family and claim zero allowances on Forms W-4 filed for all other jobs. For example, if you earn $60,000 per year and your spouse earns $20,000, you should complete the worksheets to determine what to enter on lines 5 and 6 of your Form W-4, and your spouse should enter zero ("-0-") on lines 5 and 6 of his or her Form W-4. See Pub. 505 for details.

Another option is to use the calculator at *www.irs.gov/W4App* to make your withholding more accurate.

Tip: If you have a working spouse and your incomes are similar, you can check the "Married, but withhold at higher Single rate" box instead of using this worksheet. If you choose this option, then each spouse should fill out the Personal Allowances Worksheet and check the "Married, but withhold at higher Single rate" box on Form W-4, but only one spouse should claim any allowances for credits or fill out the Deductions, Adjustments, and Additional Income Worksheet.

Instructions for Employer

Employees, do not complete box 8, 9, or 10. Your employer will complete these boxes if necessary.

New hire reporting. Employers are required by law to report new employees to a designated State Directory of New Hires. Employers may use Form W-4, boxes 8, 9, and 10 to comply with the new hire reporting requirement for a newly hired employee. A newly hired employee is an employee who hasn't previously been employed by the employer, or who was previously employed by the employer but has been separated from such prior employment for at least 60 consecutive days. Employers should contact the appropriate State Directory of New Hires to find out how to submit a copy of the completed Form W-4. For information and links to each designated State Directory of New Hires (including for U.S. territories), go to ***www.acf.hhs.gov/programs/css/employers***.

If an employer is sending a copy of Form W-4 to a designated State Directory of New Hires to comply with the new hire reporting requirement for a newly hired employee, complete boxes 8, 9, and 10 as follows.

Box 8. Enter the employer's name and address. If the employer is sending a copy of this form to a State Directory of New Hires, enter the address where child support agencies should send income withholding orders.

Box 9. If the employer is sending a copy of this form to a State Directory of New Hires, enter the employee's first date of employment, which is the date services for payment were first performed by the employee. If the employer rehired the employee after the employee had been separated from the employer's service for at least 60 days, enter the rehire date.

Box 10. Enter the employer's employer identification number (EIN).

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Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself	A	
B	Enter "1" if you will file as married filing jointly	B	
C	Enter "1" if you will file as head of household	C	
D	Enter "1" if: • You're single, or married filing separately, and have only one job; or • You're married filing jointly, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	D	
E	**Child tax credit.** See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $69,801 ($101,401 if married filing jointly), enter "4" for each eligible child. • If your total income will be from $69,801 to $175,550 ($101,401 to $339,000 if married filing jointly), enter "2" for each eligible child. • If your total income will be from $175,551 to $200,000 ($339,001 to $400,000 if married filing jointly), enter "1" for each eligible child. • If your total income will be higher than $200,000 ($400,000 if married filing jointly), enter "-0-"	E	
F	**Credit for other dependents.** • If your total income will be less than $69,801 ($101,401 if married filing jointly), enter "1" for each eligible dependent. • If your total income will be from $69,801 to $175,550 ($101,401 to $339,000 if married filing jointly), enter "1" for every two dependents (for example, "-0-" for one dependent, "1" if you have two or three dependents, and "2" if you have four dependents). • If your total income will be higher than $175,550 ($339,000 if married filing jointly), enter "-0-"	F	
G	**Other credits.** If you have other credits, see Worksheet 1-6 of Pub. 505 and enter the amount from that worksheet here	G	
H	Add lines A through G and enter the total here ►	H	

For accuracy, **complete all worksheets that apply.**

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, or if you have a large amount of nonwage income and want to increase your withholding, see the **Deductions, Adjustments, and Additional Income Worksheet** below.
- If you **have more than one job at a time** or are **married filing jointly and you and your spouse both work**, and the combined earnings from all jobs exceed $52,000 ($24,000 if married filing jointly), see the **Two-Earners/Multiple Jobs Worksheet** on page 4 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 above.

Deductions, Adjustments, and Additional Income Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income.

1	Enter an estimate of your 2018 itemized deductions. These 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. See Pub. 505 for details	1	$
2	Enter: $24,000 if you're married filing jointly or qualifying widow(er); $18,000 if you're head of household; $12,000 if you're single or married filing separately	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2018 adjustments to income and any additional standard deduction for age or blindness (see Pub. 505 for information about these items)	4	$
5	**Add** lines 3 and 4 and enter the total	5	$
6	Enter an estimate of your 2018 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero, enter "-0-". If less than zero, enter the amount in parentheses	7	$
8	**Divide** the amount on line 7 by $4,150 and enter the result here. If a negative amount, enter in parentheses. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H above	9	
10	**Add** lines 8 and 9 and enter the total here. If zero or less, enter "-0-". If you plan to use the **Two-Earners/ Multiple Jobs Worksheet,** also enter this total on line 1, page 4. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

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Two-Earners/Multiple Jobs Worksheet

Note: Use this worksheet *only* if the instructions under line H from the **Personal Allowances Worksheet** direct you here.

1 Enter the number from the **Personal Allowances Worksheet,** line H, page 3 (or, if you used the **Deductions, Adjustments, and Additional Income Worksheet** on page 3, the number from line 10 of that worksheet) . . . . . **1** ______

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you're married filing jointly and wages from the highest paying job are $75,000 or less and the combined wages for you and your spouse are $107,000 or less, don't enter more than "3" . . . . . **2** ______

3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet . . . . . **3** ______

Note: If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4 Enter the number from line 2 of this worksheet . . . . . **4** ______

5 Enter the number from line 1 of this worksheet . . . . . **5** ______

6 **Subtract** line 5 from line 4 . . . . . **6** ______

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . . . **7** $ ______

8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . . **8** $ ______

9 **Divide** line 8 by the number of pay periods remaining in 2018. For example, divide by 18 if you're paid every 2 weeks and you complete this form on a date in late April when there are 18 pay periods remaining in 2018. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck . . . . . **9** $ ______

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $5,000	0	$0 - $7,000	0
5,001 - 9,500	1	7,001 - 12,500	1
9,501 - 19,000	2	12,501 - 24,500	2
19,001 - 26,500	3	24,501 - 31,500	3
26,501 - 37,000	4	31,501 - 39,000	4
37,001 - 43,500	5	39,001 - 55,000	5
43,501 - 55,000	6	55,001 - 70,000	6
55,001 - 60,000	7	70,001 - 85,000	7
60,001 - 70,000	8	85,001 - 90,000	8
70,001 - 75,000	9	90,001 - 100,000	9
75,001 - 85,000	10	100,001 - 105,000	10
85,001 - 95,000	11	105,001 - 115,000	11
95,001 - 130,000	12	115,001 - 120,000	12
130,001 - 150,000	13	120,001 - 130,000	13
150,001 - 160,000	14	130,001 - 145,000	14
160,001 - 170,000	15	145,001 - 155,000	15
170,001 - 180,000	16	155,001 - 185,000	16
180,001 - 190,000	17	185,001 and over	17
190,001 - 200,000	18		
200,001 and over	19		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $24,375	$420	$0 - $7,000	$420
24,376 - 82,725	500	7,001 - 36,175	500
82,726 - 170,325	910	36,176 - 79,975	910
170,326 - 320,325	1,000	79,976 - 154,975	1,000
320,326 - 405,325	1,330	154,976 - 197,475	1,330
405,326 - 605,325	1,450	197,476 - 497,475	1,450
605,326 and over	1,540	497,476 and over	1,540

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 who claims no withholding allowances; 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 possessions 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 aren't required to provide the information requested on a form that's 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.

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Employee Name: ______________________________
(please print)

Consumer Direct Care Network (CDCN) recommends every employee select direct deposit, either to a Visa debit card issued through US Bank or to another account you specify. Direct deposits avoid all possible delays associated with delivery of mail - and that helps you access your pay on pay day. Your pay stub (summary of your pay) will be sent by first class mail to your address on file. First class mail terms and limitations apply.

CDCN offers the following pay options. Please select one option below.

☐ **US Bank Focus Card Direct Deposit** – I authorize CDCN to issue me a US Bank Focus Card using my Social Security Number and other identification on file and to initiate payroll deposits to my card account. You should receive your debit card in approximately two weeks.

☐ **Bank or Credit Union Direct Deposit** – I authorize CDCN to initiate payroll deposits to (name of bank or financial institution): ______________________________

Account Type (check one): ☐ Checking ☐ Savings

For Checking Accounts:

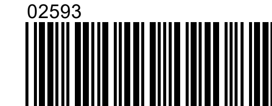
Attach (tape) a voided check here

Do not attach a deposit slip.

For Savings Accounts: provide a document from your bank with exact numbers to process direct deposits to your account. If the document is larger than a standard-sized check, please provide a separate document. Do not attach a deposit slip because it does not have all the necessary numbers.

I authorize CDCN to process my selected method of pay as indicated above. In the event that funds are deposited mistakenly to my account, I authorize CDCN to debit my account to correct the error. It is my responsibility to confirm that each deposit has occurred and to pay any fees caused by overdrafts on my account. Deposits will be made on each payday unless I notify my employer, in writing, of my request to stop direct deposits. I understand that CDCN reserves the right to refuse any direct deposit request, that all direct deposits are made through an Automated Clearing House (ACH), and that the processing is subject to ACH terms and limitations, as well as those of my financial institution. **I understand that I may still receive a paper check while my selected method of pay is being set up**.

______________________________ ______________________
Signature *Date*



FASTER. SAFER. EASIER.

With the U.S. Bank Focus Card™ Your Funds Are:

Immediately loaded to your card on payday | **Available to use** right away | **Protected** if lost or stolen[1]

About the Focus Card

It is a Visa® prepaid debit card that is a convenient alternative to receiving paper checks. Your payments will automatically be direct deposited to your card each payday. You have access to your funds right away and you can use it to make purchases or get cash wherever Visa debit cards are accepted. It's that simple!

MAKE PURCHASES | RELOAD | GET CASH
PAY BILLS | TRACK SPENDING

Getting Started is Easy

1. Sign up today.
2. Your pay will be automatically deposited to your card. Go online to check your balance.
3. Use your card anywhere Visa debit cards are accepted!

Sign Up!

No cost to sign up.

No credit check or bank account required.[2]

And Save!

Keep more of your money. No fees to cash a paycheck.

No waiting for your paycheck or extra trips to the bank.

To enroll, please select the US Bank Focus Card Direct Deposit option on your Consumer Direct Care Network Pay Selection Form.

[1] The Visa Zero Liability Policy protects you against unauthorized purchases. U.S.-issued cards only. This does not apply to ATM transactions or to PIN transactions not processed by Visa. You must immediately report any unauthorized use.
[2] Successful identity verification required. To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. If necessary, we may also ask to see your driver's license or other identifying documents.

Getting Started

focus

For security, your card comes in a plain white windowed envelope.

Follow the activation instructions that accompany your card.

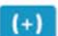
Features

Cash Back Rewards

For purchases at certain retail and restaurant locations.

Savings Account

Create an interest-bearing savings account without ever going to a bank.



Cash Reload Networks[5]

In addition to payroll deposits, there are a variety of ways to add cash to your Focus Card account.

Text and Email Alerts[4]

Instant notification when money is added or your card balance gets low.

Mobile Banking App[4]

Quickly see your account balance and transaction history.

Track Spending

Online | Phone | Email | Text[4] | Mobile App

Fee Schedule

Activity		Cost		
Monthly Account Maintenance		Free		
Purchases at Point-of-Sale (Domestic)		Free		
Cash Back with Purchases (Domestic)		Free		
ATM Transactions		Cash Withdrawal	Declined Withdrawal	Balance Inquiry
The owner of any Non-U.S. Bank or Non-MoneyPass ATM may assess an additional surcharge fee for any ATM transaction that you complete.	U.S. Bank ATM	Free	Free	Free
	MoneyPass® ATM	Free	Free	Free
	Allpoint® ATM	Free	Free	Free
	Other ATM	$2.00	$0.50	$1.00
	International ATM	$3.00	$0.50	$1.00
Teller Cash Withdrawal		Free		
Teller Cash Withdrawal Decline		$0.00		
Customer Service Automated Phone Service, Online, Live Phone Representative		Free		
Text or Email Alerts[4]		Free		
Inactivity After 90 consecutive days. Not assessed if balance is $0.00.		$2.00 Per Month		
Monthly Paper Statement		If requested – $2.00		
Card Replacement				
Non-Personalized Issued by employer (If applicable to your program)		$5.00		
Personalized		Standard $5.00; Expedited $15.00; Overnight $25.00		
ChekToday Convenience Checks (If applicable to your program)	Check Authorization	Free		
	Check Order	Free; Expedited $35.00		
	Check Return	$25.00		
	Stop Payment	$25.00		
	Lost/Stolen Check	$25.00		
	Void Check	Free		
	Check Reversal	$25.00		
	Check Copy	$10.00		
Foreign Transaction		Up to 3% of transaction amount		

Transaction Limits	Count	Amount
Maximum Card Balance	N/A	$40,000
Purchases (includes cash back)	20 per day	$4,000 per day
Cash Loads (If applicable to your program)	3 per day	$950 per day
Teller Cash Withdrawal	5 per day	$2,525 per day
ATM Withdrawal	5 per day	$1,525 per day; $1,025 max transaction
Loads or Deposits	10 per day	$20,000 per day
Signature-based POS returns	4 per day	N/A
Pending ACH Credits	5 per day	$5,000 per day
ACH Loads	5 per day	$20,000 per day

We reserve the right to change the above fee schedule upon written notification to you as required by applicable law.

[4]US Bank does not charge a fee for mobile banking. Standard messaging and data rates may apply through your mobile carrier.

[5]Businesses performing your reload may charge a fee. Cash reload services are provided by unaffiliated third parties.

EMPLOYMENT AGREEMENT

This Employment Agreement ("Agreement") is made between ________________________________ ("Managing Party"), __________________________________ ("Employee"), an individual, and Consumer Direct for Wisconsin, LLC, doing business as Consumer Direct Care Network Wisconsin (CDCN) a Wisconsin Fiscal Support Entity ("Legal Employer of Record").

RECITALS

A. ____________________________________ is an individual ("Member") and who receives services through ____ , an Approving Entity.

B. The Approving Entity has contracted with CDCN to perform certain administrative functions on behalf of Managing Party including acting as the Legal Employer of Record of employees who provide care for the Member. The Approving Entity approves the services to be provided to the Member by the Employee.

C. Managing Party wishes to refer a potential Employee to the Legal Employer of Record for consideration for employment, and Employee wishes to be employed by the Legal Employer of Record, to provide assistance to the Managing Party by performing certain approved services for the Member.

D. The Legal Employer of Record has agreed to provide administrative support, including payroll services, to the Managing Party and the Employee.

As described in this Agreement, the parties (Managing Party, Employee, and the Legal Employer of Record) agree as follows:

1. **Compensation.**
   a. The Legal Employer of Record agrees to pay the Employee an hourly rate as established in its contract with the Approving Entity as compensation for services provided to the Member:
      i. $_______ per hour for _____________ Service Code
      ii. $_______ per hour for _____________ Service Code
      iii. $_______ per mile for transportation services* _____________Service Code
      *If included on the approved budget

   b. Overtime pay is subject to prior written approval of the Employer of Record in consultation with the Managing Party and is contingent on the availability of sufficient funds in the Member's budget. The Employee will receive overtime pay for any work performed over 40 hours in a workweek Overtime pay rates are calculated according to the number of normal and respite hours of work performed during the workweek. Overtime pay that includes both normal and respite hours will be calculated on a weighted average hourly rate.

   c. The Legal Employer of Record will issue payment to the Employee on a biweekly basis following submission of accurate online time entries (or paper time sheets, by special authorization only) which must be received by midnight on Monday of each week. All compensation is subject to applicable withholding. Submittal of work-time records after this deadline may experience a

delay in payment, in which case payment will be issued on the following scheduled pay date. Anytime there is a misrepresentation on the time sheet the Legal Employer of Record has the right to withhold future payment.

d. As the Legal Employer of Record CDCN wants each of its employees to be paid in a timely and consistent manner. CDCN offers two direct deposit pay options, either to a debit card through US Bank, or to a bank account specified by you. Pay stubs (a summary of your pay) are sent first class mail to your address on file.

2. **Employment.**

a. Employment will be effective upon notice from CDCN that the Employee Packet and associated training modules have been received and approved. I must receive an "Okay to Work Form" before I can begin work.

b. The Employee recognizes and agrees that CDCN is their Legal Employer of Record.

c. The Managing Party agrees to schedule and monitor the job performance of the Employee and to assist the Member by performing the other duties specified in this Agreement.

d. The Employee understands and accepts the roles and responsibilities of the Managing Party and the Legal Employer of Record as defined in the terms and conditions of this Employment Agreement.

e. CDCN, as the Legal Employer of Record, reserves the right to terminate the employment of the Employee at any time. Such termination decisions are not subject to the approval of the Managing Party.

3. **Job Assignment**.

a. Managing Party has developed a recommended written job description for the Employee and submitted it to the Legal Employer of Record for approval. The Managing Party may periodically recommend changes to the job description. Any recommended changes must be discussed with the Employee and submitted in writing to the Legal Employer of Record prior to implementation.

b. The Managing Party agrees to provide direction to the Employee and arrange agreed upon times with the Employee to provide the services approved by the Approving Entity.

c. The Employee is required to perform his or her duties in an ethical manner, preserving and respecting the rights and dignity of the Member.

d. Hours of work may vary from week to week and will be established by the Managing Party. The Employee is not authorized and agrees not to work in excess of 40 hours per week (or a lesser number as established by the Managing Party) without prior written permission from the Legal Employer of Record.

e. Employee agrees to perform his or her duties in accordance with the terms of the job description, the instructions of the Managing Party and the terms of this Agreement.

f. The Employee will utilize all appropriate safeguards and universal health precautions, assuming at all times the possible presence of communicable disease.

g. Employee represents and warrants that he or she is able to perform the essential functions of the job with or without reasonable accommodation and that he or she will advise the Managing Party and the Legal Employer of Record if accommodation is needed.

h. The Managing Party and the Employee agree to maintain adequate vehicle insurance on any and all vehicles used to provide services under this Agreement, and agree that any vehicles used to provide services will be operated in a lawful manner.

4. **Monitoring.**

a. The Managing Party will monitor and assume responsibility for the quality of the services delivered by the Employee.

b. The Managing Party will promptly notify Legal Employer of Record of any dissatisfaction with the employee. The Legal Employer of Record shall have the sole power to make employment termination decisions with respect to Employee's employment. However, the Managing Party shall determine whether the Individual will be dismissed from providing services to Member. As the Legal Employer of Record CDCN will determine if the employee is terminated from employment by CDCN.

c. The Employee agrees and acknowledges that the Managing Party is responsible for and will ensure that the Employee is provided a safe working environment in accordance with applicable federal and state laws and regulations.

d. Any harassment of any kind experienced by, or suspected on the part of, the Employee must be immediately reported to the Managing Party and the Legal Employer of Record.

5. **Employment Status.**

a. This Agreement between the Employee, Managing Party and CDCN is not a contract/guarantee of employment for the Employee. Employment is considered employment at-will. Notwithstanding the foregoing or any provision to the contrary in this Agreement, as the Legal Employer of Record CDCN reserves the right, with or without cause, to refuse to hire a person as an Employee or to terminate the employment of an Employee by CDCN at any time.

b. The Employee acknowledges that while employed by CDCN he or she may be offered the opportunity to provide services to other Members even though he or she was referred for employment by the Managing Party to provide services to a specific individual Member.

6. **Benefits.** As per the Benefits Summary and eligibility criteria, the Legal Employer of Record will provide its employees with the following employee benefits: Workers' Compensation Insurance coverage; the option to participate in the company sponsored 401(k) retirement plan; the company's separate Medical Savings Account and Child Care Saving Account Flexible Spending Plans; and the option to enroll in the company sponsored Supplemental Vision Plan and Life Insurance Policy. Benefits are subject to change.

7. **Unemployment Insurance.** The Legal Employer of Record will arrange and pay for Unemployment Insurance benefits for the Employee in the event of lay-off or termination. The Managing Party agrees to provide the Legal Employer of Record information documenting the rationale for dismissing an employee from providing service to the Member, which leads to a decision by the Legal Employer of Record to terminate the Employee, in order to respond appropriately to unemployment compensation requests.

8. **Policy Information.** The Legal Employer of Record will provide training materials to the Managing Party regarding employer and employee responsibilities and procedures. These materials will include information on Corporate Compliance / Reporting Medicaid Fraud, Blood borne Pathogens protocols, Abuse, Neglect and Exploitation Reporting Requirements, Data Practices Act and HIPAA regulations, Lift and Moving, and harassment of employees and members. The Managing Party will obtain written confirmation of the receipt and review of these materials by the potential Employee. The Managing Party has the duty to review the materials with each potential employee. The Legal Employer of Record will not employ any potential Employee who has not completed the company's required training as documented by the Managing Party.

9. **Reporting Requirements.**
   a. The employee must immediately report all incidents, accidents and work place injuries involving the Employee or the Member. Incidents and accidents should be reported immediately to the Managing Party. Work place injuries must be reported to the CDCN Injury Hotline at 1-888-541-1701.

   b. The Employee must report possible neglect, abuse or exploitation of a Member to their County Adult or Elder Abuse reporting line.

   c. Suspected Medicaid Fraud must be reported to CDCN's Fraud Hotline 1-877-532-8530.

10. **Medical Administration Procedures.** The Employee will learn all medical administration procedures required in the performance of his or her job duties. Instructions for those procedures will come from the Managing Party or the Managing Party's designee.

11. **Contact Person.** The Employee has been recruited and referred for employment by, and will receive orientation and direction from, the Managing Party who shall control the Employee's workplace activities. In addition to acting as Legal Employer or Record CDCN acts as a consultant to the Managing Party in connection with a number of services that are intended to ensure compliance with applicable laws and regulations. Both the Employee and the Managing Party have access to CDCN staff for information and clarification. The person at CDCN to be contacted is the Program Coordinator at 1-877-785-9991.

12. **Entire Agreement.** This Agreement constitutes the entire agreement between the parties and there are no other oral or written agreements, understandings, or other representations between the parties relating to the terms of employment of the Employee. This Agreement supersedes all prior agreements, understandings, discussions, or negotiations relating to this subject matter.

13. **Severability.** If any provision of this Agreement shall be held to be invalid or unenforceable for any reason, the remaining provisions shall continue to be valid and enforceable. If a court finds that any provision of this Agreement is invalid or unenforceable, but that by limiting such provision it would become valid or enforceable, then such provision shall be deemed to be written, construed and enforced as so limited.
14. **Amendment.** This Agreement may be modified or amended if the amendment is made in writing and is signed by the parties to this Agreement.
15. **Waiver.** The failure of either party to enforce any provision of this Agreement shall not be construed as a waiver or limitation of that party's right to subsequently enforce and compel strict compliance with every provision of this Agreement.
16. **Applicable Law.** This Agreement, the construction of its terms and the interpretation of the parties' rights and duties, shall be governed by and construed under the laws of the State of Wisconsin unless federal law controls the issue in question.

EMPLOYEE:		**MANAGING PARTY:**	
Print Name		*Print Name*	
Signature	*Date*	*Signature*	*Date*

CONSUMER DIRECT FOR WISCONSIN, LLC (Legal Employer of Record):

Print Name

Signature *Date*

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

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

05296

DOCUMENTATION OF TRAINING – SUPPORTIVE HOME CARE (SHC) / RESPITE

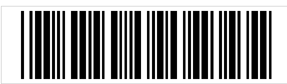
This is a voluntary form. If this form is not used, you must ensure that the information requested is on file in another format.

Name – County Waiver Agency	
Name –	Date – Initial Employment
Name – Employer (SHC Agency or Participant)	

The following information outlines the required minimum training to be completed by the person providing SHC/Respite services, based on the actual services to be provided. Check the appropriate box(s) to indicate training that was completed for the applicable services.

☐ **Personal Services – Required Training** 1. Orientation to County and SHC Agency Policies 2. Safe Provision of Services 3. Recognizing and Responding to Emergencies 4. Participant Specific Information 5. General Target Group Information 6. Working Effectively with Participants 7. Homemaking/Household Services	☐ **Required Training Completed (1, 2, 3, 4)** Date: ☐ **Training Completed (5, 6, 7)** Date: ☐ **Training Exempted (5, 6, 7)—**Provider has previous/ comparable experience. List and attach documentation.
☐ **Household/Chore Services – Required Training** 1. Orientation to County and SHC Agency Policies 2. Safe Provision of Services 3. Recognizing and Responding to Emergencies 4. Participant Specific Information	☐ **Required Training Completed (1, 2, 3, 4)** Date:
☐ **Respite Services – Required Training** 1. Orientation to County and SHC Agency Policies 2. Safe Provision of Services 3. Recognizing and Responding to Emergencies 4. Participant Specific Information 5. General Target Group Information 6. Working Effectively with Participants 7. Homemaking/Household Services (if provided)	☐ **Required Training Completed (1, 2, 3, 4)** Date: ☐ **Training Completed (5, 6, 7)** Date: ☐ **Training Exempted (5, 6, 7)—**Provider has previous/ comparable experience. List and attach documentation.

☐ Required Caregiver Background Check completed (if applicable)	Date Completed
SIGNATURE – SHC / Respite Provider	Date Signed
SIGNATURE – SHC Agency Supervisor	Date Signed
SIGNATURE – Participant as Employer	Date Signed
SIGNATURE – County Agency Care Manager	Date Signed



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 (CDCN Fraud Hotline 1-877-532-8530)
  - 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.

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

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DEPARTMENT OF HEALTH SERVICES
Division of Quality Assurance
F-82064A (07/2018)

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

BACKGROUND INFORMATION DISCLOSURE (BID) INSTRUCTIONS

- The *Background Information Disclosure* (form F-82064) gathers information as required by the Wisconsin Caregiver Background Check Law to help employers and governmental regulatory agencies make employment, contract, residency, and regulatory decisions.
- Complete and return the entire form and attach explanations as specified by employer or governmental regulatory agency.
- **NOTE:** If you are an owner, operator, board member, or non-client resident of a facility regulated by the Division of Quality Assurance (DQA), complete the *BID*, F-82064, and the *BID Appendix,* F-82069, and submit both forms to the address noted in the *BID Appendix Instructions*.

CAREGIVER BACKGROUND CHECK LAW

In accordance with the provisions of Wis. Stat. § 50.065, for persons who have been convicted of certain acts, crimes, or offenses:

1. The Department of Health Services (DHS) may not license, certify, or register the person or entity.
   **Note: Employers and Care Providers are referred to as "entities."*
2. An entity may not employ, contract with, or permit persons to reside at the entity.

The list of offenses affecting caregiver eligibility that require rehabilitation review is available from the regulatory agencies or through the Internet at https://www.dhs.wisconsin.gov/caregiver/statutes.htm.

The Caregiver Law covers the following EMPLOYERS / CARE PROVIDERS (aka ENTITIES) regulated under Wis. Stat. §§ 50, 51, and 146:

- Adult Family Homes (3-4 Bed)
- Ambulance Service Providers
- AODA Services
- Community Based-Residential Facilities
- Community Mental Health Programs
- Community Support Programs (CSP)
- Developmental Disabilities
- Emergency Mental Health Service Programs
- Intermediate Care Facility for Individuals with Intellectual Disabilities
- Home Health Agencies, including those that provide personal care services
- Hospices
- Hospitals
- Mental Health Day Treatment Services for Children
- Nursing Homes
- Residential Care Apartment Complexes
- Rural Medical Centers

The Caregiver Law covers the following PERSONS:

- Anyone employed by or contracting with a covered entity who has access to the clients served, except if the access is infrequent or sporadic and service is not directly related to care of the client. Exception: Emergency medical technicians and first responders are not covered under the Caregiver Law.
- Anyone who lives on the premises of a covered entity and is 10 years old or over, but is not a client ("non-client resident").
- Anyone who is licensed by DHS.
- Anyone certified by DHS.
- Anyone registered by DHS.
- Anyone who is a board member or corporate officer who has access to the clients served.

FAIR EMPLOYMENT ACT

Wisconsin's Fair Employment Law, Wis. 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.

PERSONALLY IDENTIFIABLE INFORMATION

This information is used to obtain relevant data as required by the provisions set forth by the Wisconsin Caregiver Background Check Law. Providing your social security number is voluntary; however, your social security number is one of the unique identifiers used to prevent incorrect matches. For example, the Department of Justice uses social security numbers, names, gender, race, and date of birth to prevent incorrect matches of persons with criminal convictions. The Department of Health Services' Caregiver Misconduct Registry uses social security numbers as one identifier to prevent incorrect matches of persons with findings of abuse or neglect of a client or misappropriation of a client's property.

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BACKGROUND INFORMATION DISCLOSURE (BID)

- **PENALTY: Knowingly providing false information or omitting information may result in a forfeiture of up to $1,000 and other sanctions as provided in Wis. Admin. Code § DHS 12.05(4).**
- Completion of this form is required under the provisions of Wis. Stat. § 50.065. Failure to comply may result in a denial or revocation of your license, certification, or registration, or denial or termination of your employment or contract.
- Refer to DQA form F-82064A, *BID Instructions,* for additional information.
- Providing your social security number is voluntary; however, your social security number is one of the unique identifiers used to prevent incorrect matches.
- **PRINT OR TYPE YOUR ANSWERS.**

Check the box that applies to you.

☐ Employee / Contractor (including new applicant) ☐ Household member (lives on premises, but is not a client)

☐ Applicant for a license, certification, or registration (including continuation or renewal) ☐ Other – Specify: ____________

NOTE: If you are an owner, operator, board member, or non-client resident of a facility regulated by the Division of Quality Assurance (DQA), complete the BID, F-82064 and the Appendix, F-82069, and submit both forms to the address noted in the Appendix Instructions.

Full Legal Name – *First*	*Middle*	*Last*	
Position Title (Complete only if a prospective or current employee or contractor.)		Birth Date *(MM/dd/yyyy)*	Sex ☐ Male ☐ Female
Any Other Names By Which You Have Been Known (Including Maiden Name)			
Race / Ethnicity (Check ONLY one.) ☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander ☐ Black ☐ White ☐ Unknown			Social Security Number
Home Address	City	State	Zip Code
Business Name and Address – Employer or Care Provider (Entity)			

A "NO" answer to all questions does not guarantee employment, residency, a contract, or regulatory approval.

SECTION A – ACTS, CRIMES, AND OFFENSES THAT MAY ACT AS A BAR OR RESTRICTION

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. **IMPORTANT: Read before completing item 3.**

Wis. Stat. § 48.981 Abused and neglected children and abused unborn children. (7)(a) CONFIDENTIALITY. "All reports made under this section, notices provided under sub. (3) (bm), and records maintained by an agency and other persons, officials, and institutions shall be confidential." Reports and records may be disclosed only to the persons identified in this section.

☐ **If you are the employer or prospective employer of the person completing this form and are entitled to obtain this information per the above, check this box.**

Has any government or regulatory agency (other than the police) ever found that you committed child abuse or neglect? Yes ☐ No ☐

If the above box has been checked, provide an explanation below, including when and where the incident(s) occurred.

4. Has any government or regulatory agency (other than the police) ever found that you abused or neglected any person or client? Yes ☐ No ☐

If **Yes,** explain, including when and where it happened.

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.

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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?

   If **Yes,** explain, including when and where it happened.

   Yes ☐ No ☐

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?

   If **Yes,** explain, including when and where it happened and the reason.

   Yes ☐ No ☐

3. Have you been discharged from a branch of the US Armed Forces, including any reserve component?

   If **Yes**, indicate the year of discharge: __________

   Attach a copy of your DD214, if you were discharged within the last three (3) years.

   Yes ☐ No ☐

4. Have you resided outside of Wisconsin in the last three (3) years?

   If **Yes**, list each state and the dates you resided there.

   Yes ☐ No ☐

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?

   If **Yes**, list each state and the dates you resided there.

   Yes ☐ No ☐

6. Have you had a caregiver background check done within the last four (4) years?

   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.

   Yes ☐ No ☐

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.

________ 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

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EMPLOYEE HEALTH QUESTIONNAIRE

Employee Name: ___________________________________
(please print)

Background: At this point in the employment process, you have been conditionally hired by a Consumer/Member/ Representative/Individual ("Employer") as an Employee. Your position involves delivering services for the Employer. Your duties will vary according to the needs and authorized services of the Employer, but will require you to perform tasks of a physical nature, which have physical demand requirements. The purpose of this Health Questionnaire is to obtain information about 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 to physical activity. **Please explain each "Yes" answer on the reverse of this form, and attach additional information as necessary.**

Return this completed form, with the 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 Strain or 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	Allergies		
32	Other Current Problems, Diseases, Conditions		
33	Have you ever been hospitalized or undergone surgery, other than for childbirth?		
34	Have you ever refused a recommended surgical procedure?		
35	Are you currently taking any medication or drugs, whether by prescription or not, that could impair your judgment?		

EMPLOYEE HEALTH QUESTIONNAIRE

Employee Name: ___________________________________
(please print)

Do you currently have, or have you ever been told by a health care professional that you have, any physical limitations in reference 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 retention policies or practices against persons who have, in good faith, filed a claim for or received benefits pursuant to State Workers' Compensation Laws.

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:

____

____

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I hereby certify that I have answered the above questions to the best of my knowledge, and that my answers are true and complete. I understand that misrepresentation or omission of facts is cause for dismissal and may result in denial of workers' compensation benefits.

Employee Signature: ______________________________________ Date: _____/_____/__________

Office Use Only

Reviewed by: [________] Date _______/_______/_______ Date sent to Risk Mgr: _______/_______/_______

State Office/Location: ____________________________ Risk Mgr Review: [________] Date ______/______/______

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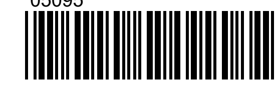


HEPATITIS B VACCINATION AUTHORIZATION/DECLINATION FORM

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:

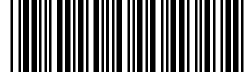
________________________________ ______________
Employee Signature *Date*

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



HIPAA QUIZ & CONFIDENTIALITY AGREEMENT

Employee Name	Member Name	Score (minimum 85%)

Employee: Review the HIPAA Training Guide, ask questions as required, complete the HIPAA Quiz below, and review & 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, and 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

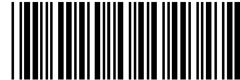
8. The HIPAA Privacy Rule (the law) took effect on: _______________________

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:

_________________________________ ___________ _________________________________ ___________

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



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EMPLOYEE JOB DESCRIPTION

Employee Name	Position Title	Managing Party/Member Name

Write a description of job with responsibilities the employee will be required to perform in the following categories that apply. Leave each category that does not apply to your staff blank.

Recreational/Leisure/Socialization:

____

____

____

Mobility/Transportation:

____

____

____

Independent Living Skills:

____

____

____

Dressing:

____

____

____

Bathing/Assisting in the bathroom:

____

____

____

Housekeeping/Laundry:

____

____

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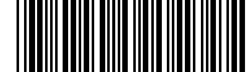

Shopping:

____

____

____

Meal Preparation:

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Other:

____

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____

Work Schedule:
Include bi-weekly schedule, not exceeding authorized staffing hours.

Week 1		Week 2	
Sunday	____________	Sunday	____________
Monday	____________	Monday	____________
Tuesday	____________	Tuesday	____________
Wednesday	____________	Wednesday	____________
Thursday	____________	Thursday	____________
Friday	____________	Friday	____________
Saturday	____________	Saturday	____________

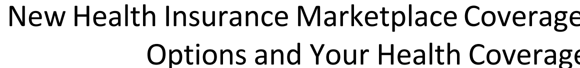
Signatures:
I have reviewed and agree to the responsibilities of the job.

____________________________	__________	____________________________	__________
Employee Signature	*Date*	*Managing Party Signature*	*Date*

2018 Benefits Summary
Direct Care Staff
Wisconsin

Benefit	Provider	Contact	Eligibility Requirements	Enrollment	Important Details
Please note: Part I of this summary EXCLUDES all caregivers working for the MCO "Community Link, Inc" (formerly ContinuUs) and the MCO "Community Care, Inc."					
Part I					
Dependent Care Flexible Spending Account (FSA)	PacificSource Plan# G0035039	PacificSource Administrators 800.422.7038	Working 10 hours per week	**New Hires**: First of the month following 60 days, **Others**: Open Enrollment or Qualifying Event	$5,000 maximum per calendar year. Unused funds at the end of the year will be forfeited. Pre-tax account used for daycare or disabled adult dependent care expenses.
Vision Insurance	VSP Plan# 30043269	VSP 800.877.7195	Working 10 hours per week	**New Hires**: First of the month following 60 days, **Others**: Open Enrollment or Qualifying Event	Get a free in-network annual eye exam. Choose between new lenses or frames with $20 copay OR free contacts (within allowance). Additional discounts available.
Basic Life/AD&D Insurance	LifeMap Plan# LM0598283	CDCN HR Department	Working 10 hours per week	Automatic: First of the month following 60 days of employment	**Company-paid**. In the event of your death, this plan pays your 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	LifeMap Plan# LM0598283	CDCN HR Department	Working 10 hours per week	**New Hires**: First of the month following 60 days, **Others**: Open Enrollment or Qualifying Event	**Employee-paid.** If you enroll when you are first eligible, you are guaranteed up to $250,000 of employee life insurance coverage. You can elect amounts in $5,000 increments, up to the lesser of $300,000 or 5 times your annual earnings, whichever is less. Voluntary Life Benefits reduce to 65% at age 65 and to 45% at age 80.
Part II					
Employee Assistance Program (EAP)	Reliant Behavioral Health	Reliant Behavioral Health 866.750.1327	Available at time of hire	All employees and eligible family members automatically covered	The EAP offers free and confidential counseling and assistance in resolving situations that may inpact your personal or professional life. **www.myrbh.com PASSWORD: LifeMap**
Aflac Supplemental Insurances	Aflac Plan# PL216	Jeff Hill 406.544.9579 (cell) 406.721.3000 ext 1023 donald_hill@us.aflac.com		Following 60 days of employment, enroll at any time	Enroll anytime after 60 days of employment
	Coverages Available: Hospital, Accident/Disability, Short Term Disability, Long Term Care, Dental Insurance, Cancer Insurance, Life Insurance & more.				
401(k) Retirement Plan	Fidelity Plan# 12648	Fidelity 800.835.5097	Must be age 18 or older	First of the month following 90 days of employment	Pre-tax payroll deduction. Employee-only contributions. Enroll anytime after 90 days by calling Fidelity to request an enrollment packet at **800.835.5097**.
Family Medical Leave Act (FMLA)	CDCN	CDCN HR Department	Employed 12 months & worked 1250 hours in previous 12 months	Employee-initiated	Apply to receive up to 12 weeks of **unpaid** job and benefits protected leave per 12-month period.

For additional assistance please contact Human Resources at InfoHR@consumerdirectcare.com, or a Benefit Advocate at 1.800.542.3737 (6am-6pm PST), by email at askgbs-wa@ajg.com, or online at www.GBSwa.com



Plan Year 2018

Dear Consumer Direct for Wisconsin Caregiver,

The following is a notice regarding the *Affordable Care Act* related Health Insurance Marketplace. Our company is required by federal law to provide this notice to all employees. If you have any questions about healthcare reform or the online application process, please contact the Health Insurance Marketplace Call Center at 1-800-318-2596.

Thank you,
Human Resources Department
Consumer Direct Care Network

Notice of Health Care Marketplace

PART A: General Information

When the health care law took effect in 2014, this created 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 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 tax credit that lowers your monthly premium.

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 will lose the employer contribution to the employer-offered coverage (if offered) as well as the pre-tax benefit of paying your health insurance premiums through payroll deduction. Your payments for coverage through the Marketplace are *not* tax-deductible, payments are included as income for Federal State income tax purposes.

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.

How Can I Get More Information?

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please call 1.800.318.2596 or 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.

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.

The information below is numbered to match questions on the online application.

3. Employer name: **Consumer Direct for Wisconsin, LLC**		4. Employer Identification Number: **26-2202984**
5. Employer address: **100 Consumer Direct Way, Suite 120**		6. Employer phone number: **844.360.4747**
7. City: **Missoula**	8. State: **MT**	9. ZIP code: **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: **infohr@consumerdirectcare.com**

You are **not eligible** for health insurance through this employer. You and your family may be able to obtain health coverage through the Marketplace, with a tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.

For answers to any questions you have about the Affordable Care Act Health Insurance Marketplace call 1.800.318.2596 for further assistance.

2018 Payroll Calendar

Symbol Key: ☐ Time Due ○ Pay Day △ Postal & 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					

2018 Bank & Post Office Holidays

*__New Year's Day__ - Monday, January 1
*__Martin Luther King, Jr. Day__ - Monday, January 15
President's Day - Monday, February 19
*__Memorial Day__ - Monday, May 28
*__Independence Day__ - Wednesday, July 4
*__Labor Day__ - Monday, September 3
Columbus Day - Monday, October 8
Veterans Day - Monday, November 12
*__Thanksgiving Day__ - Thursday, November 22
*__Christmas Day__ - Tuesday, December 25

*Consumer Direct holidays and office closures

Work weeks are Sundays through Saturdays. Time must be submitted by MONDAY at MIDNIGHT. Late time or time with mistakes may result in late pay. Thank you!

Pay Period - Week 1 Sunday through Saturday	**Pay Period - Week 2** Sunday through Saturday	**Pay Date**
11/26/2017 to 12/02/2017	12/03/2017 to 12/09/2017	12/22/2017
12/10/2017 to 12/16/2017	12/17/2017 to 12/23/2017	01/05/2018
12/24/2017 to 12/30/2017	12/31/2017 to 01/06/2018	01/19/2018
01/07/2018 to 01/13/2018	01/14/2018 to 01/20/2018	02/02/2018
01/21/2018 to 01/27/2018	01/28/2018 to 02/03/2018	02/16/2018
02/04/2018 to 02/10/2018	02/11/2018 to 02/17/2018	03/02/2018
02/18/2018 to 02/24/2018	02/25/2018 to 03/03/2018	03/16/2018
03/04/2018 to 03/10/2018	03/11/2018 to 03/17/2018	03/30/2018
03/18/2018 to 03/24/2018	03/25/2018 to 03/31/2018	04/13/2018
04/01/2018 to 04/07/2018	04/08/2018 to 04/14/2018	04/27/2018
04/15/2018 to 04/21/2018	04/22/2018 to 04/28/2018	05/11/2018
04/29/2018 to 05/05/2018	05/06/2018 to 05/12/2018	05/25/2018
05/13/2018 to 05/19/2018	05/20/2018 to 05/26/2018	06/08/2018
05/27/2018 to 06/02/2018	06/03/2018 to 06/09/2018	06/22/2018
06/10/2018 to 06/16/2018	06/17/2018 to 06/23/2018	07/06/2018
06/24/2018 to 06/30/2018	07/01/2018 to 07/07/2018	07/20/2018
07/08/2018 to 07/14/2018	07/15/2018 to 07/21/2018	08/03/2018
07/22/2018 to 07/28/2018	07/29/2018 to 08/04/2018	08/17/2018
08/05/2018 to 08/11/2018	08/12/2018 to 08/18/2018	08/31/2018
08/19/2018 to 08/25/2018	08/26/2018 to 09/01/2018	09/14/2018
09/02/2018 to 09/08/2018	09/09/2018 to 09/15/2018	09/28/2018
09/16/2018 to 09/22/2018	09/23/2018 to 09/29/2018	10/12/2018
09/30/2018 to 10/06/2018	10/07/2018 to 10/13/2018	10/26/2018
10/14/2018 to 10/20/2018	10/21/2018 to 10/27/2018	11/09/2018
10/28/2018 to 11/03/2018	11/04/2018 to 11/10/2018	11/21/2018
11/11/2018 to 11/17/2018	11/18/2018 to 11/24/2018	12/07/2018
11/25/2018 to 12/01/2018	12/02/2018 to 12/08/2018	12/21/2018
12/09/2018 to 12/15/2018	12/16/2018 to 12/22/2018	01/04/2019
12/23/2018 to 12/29/2018	12/30/2018 to 01/05/2019	01/18/2019

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