



CO-EMPLOYMENT
EMPLOYEE DATA FORM

Employee Information

Name: _____
First Middle Last

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

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

Phone #: Home _____ Cell _____

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

Email*: _____

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

Gender ☐ Male ☐ Female (as identified by the Social Security Administration)

Emergency Contact: _____
Name Phone Relationship

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

Member/Authorizing Entity Information

Name of Member: _____

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

Name of MCO Authorizing the Member's Services: _____

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

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

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

Signature of Applicant: _____ Date: _____





Co-EMPLOYMENT
NEW EMPLOYEE CHECKLIST

Employee Name	Member Name	Managing Party Name

Welcome to Consumer Direct Care Network (CDCN)!

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

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

Mandatory Forms - All New Employees:

- ☐ Employee Data Form
- ☐ New Employee Checklist (this form)
- ☐ Equal Employment Opportunity Disclosure
- ☐ Employee-Member Live-in Determination
- ☐ Electronic Visit Verification Live-in Worker Identification (return to CDCN only if applicable)
- ☐ I-9 - *Additional I-9 instructions are available on the CDCN Wisconsin website under the Forms tab*
- ☐ W-4 (federal withholding certificate)
- ☐ WT-4 (state withholding certificate)
- ☐ Pay Selection Form - *Attachment may be required, see form instructions*
- ☐ Wage Memo
- ☐ Employment Agreement
- ☐ Wisconsin Medicaid Program Provider Agreement
- ☐ Documentation of Training – Supportive Home Care (SHC) / Respite
- ☐ Training Checklist
- ☐ Background Information Disclosure
- ☐ Employee Health Questionnaire
- ☐ Hepatitis B Accept/Decline Form
- ☐ Privacy Awareness Quiz and Confidentiality Agreement
- ☐ Expected Weekly Hours (for internal use – please submit with packet)

Review and Discussions:

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

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

For Office Use Only – Start Date: _____



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

 Employee (Caregiver) signature

 Member of Managing Party signature





EQUAL EMPLOYMENT OPPORTUNITY DISCLOSURE

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

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

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

☐ Male ☐ Female ☐ Undeclared

Race/Ethnic Identification:

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

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

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

Decline Self Identification:

☐ I do not wish to self-identify.

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

Employee Signature: _____ **Date:** _____

Staff Option:

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

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





EMPLOYEE-MEMBER LIVE-IN DETERMINATION

(Determine if employee is exempt from overtime pay and income tax)

Employee Name	Member (Employer of Record) Name

Domestic service workers may be exempt from overtime pay requirements and from paying income taxes. Consumer Direct Care Network (CDCN) will apply exemptions based on your answers below.

Employee-Member Live-in Status

Employee answers below with Yes or No

1. ☐ Yes ☐ No – Do you live permanently in the same home as the above-named Member?

If YES:

- Complete DHS form F-02717 and attach proof of residency documentation as instructed.
- You are exempt from submitting time through Electronic Visit Verification (EVV).

2. ☐ Yes ☐ No – Do you live temporarily, but for extended periods with the above-named Member (at least 120 hours per week or 5 consecutive days or nights per week)?

If YES to 1 or 2 above:

- Overtime hours worked are paid at the regular pay rate.
- Declare your Difficulty of Care income tax exemption status.
☐ Yes ☐ No – I declare under penalties of perjury that I am an individual care provider receiving payments under a state Medicaid Waiver program as defined in IRS Notice 2014-7. I provide care to the Member named above. The Member resides in my home. I am not required to report income earned under this Medicaid program. Federal and state income taxes should not be withheld from my pay. If non-taxable wages have been reported by CDCN in Box 1 of my Form W-2, I can deduct the nontaxable wages from my taxable income when I file my tax return. If I no longer qualify for IRS Notice 2014-7, I will notify CDCN. At that time, federal and state income tax withholding will resume. If the IRS deems I was not eligible for 2014-7 and taxes were not paid, I agree that I will be liable for any back taxes owed.

Note: IRS Notice 2014-7 directs that payments received under a Home and Community-based Medicaid Waiver program for providing Personal Care or Habilitation services are considered "Difficulty of Care" payments excludable from income taxation when the Medicaid recipient lives in the care provider's home. Respite and skilled services do not qualify. For more information please refer to <https://www.irs.gov/pub/irs-drop/n-14-07.pdf>.

If NO to both 1 and 2 above :

- Overtime hours worked are paid at 1.5 times the regular pay rate.
- You must submit time worked through an approved EVV method.

Acknowledgement: The Employee and Employer agree the declaration(s) above are accurate. If living arrangements change, the Employee must notify CDCN. Regardless of overtime status identified above, working overtime requires prior approval.

CG

Employee Signature

Date

M

Member/Employer Signature

Date



ELECTRONIC VISIT VERIFICATION LIVE-IN WORKER IDENTIFICATION

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

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

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

5. Identification

For the purposes of EVV, a live-in worker is a worker who meets one of the following requirements. Check the box next to the statement that describes the worker's situation.

- ☐ The worker permanently resides in the same residence as the member or participant receiving services.
- ☐ The worker permanently resides in a two-residence dwelling (such as a duplex) where the member or participant receiving services lives in the other half of the dwelling **and** is a guardian or relative of the member or participant receiving services.
- ☐ The worker is one of the member's parents or guardians and the member resides with them at regularly scheduled intervals. Both parents or guardians are considered live-in workers for purposes of EVV compliance.

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

Note: The worker may submit two kinds of household bills (for example, they **may** submit a gas bill and an internet bill), but not two copies of the same type of bill (for example, they **may not** submit two gas bills).

Column A (Choose **One**)

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

Column B (Choose **Two**)

- ☐ Household bill from the last three months (for example, gas, electric, phone service, cable, internet, water, trash, or another similar bill)
- ☐ Current or previous month's bank statement
- ☐ Current or previous month's paycheck or paystub

6. Attestation

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

7. Name – Representative Verifying Live-In Status	8. SIGNATURE – Representative Verifying Live-In Status
9. Name – Agency Verifying Live-In Status	10. Date Signed (mm/dd/ccyy)



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 no later than your first day of work for pay. Print clearly. Sign and date when you are finished. Numbered explanations below are shown in the pictured example.

- ① Print your full legal name: Last, First and Middle Initial. Provide any other last names used, such as maiden name. Enter "N/A" if you have never had another name.
- ② Print your physical address. A PO Box is not allowed. Enter "N/A" if you have no apartment number.
- ③ Print your Date of Birth.
- 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 one box that describes your citizenship or immigration status in the United States. Enter additional information if you check box 3 or 4.
- ⑧ Sign and ⑨ date the form. **No later than first day of work for pay.**
- ⑩ Submit Supplement A (*Preparer and/or Translator Certification*) if a preparer or translator assisted you.

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

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) ① <i>Doe</i>		First Name (Given Name) <i>Jane</i>		Middle Initial (if any) <i>R</i>	Other Last Names Used (if any) <i>N/A</i>		
Address (Street Number and Name) ② <i>123 Main St.</i>			Apt. Number (if any) <i>N/A</i>	City or Town <i>Anytown</i>		State <i>WI</i>	ZIP Code <i>54001</i>
Date of Birth (mm/dd/yyyy) ③ <i>03/13/1964</i>		U.S. Social Security Number ④ <i>1 2 3 4 5 6 7 8 9</i>		Employee's Email Address ⑤ <i>employee@email.com</i>		Employee's Telephone Number ⑥ <i>555-123-4567</i>	
I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.		Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.): ⑦ ☒ 1. A citizen of the United States ☐ 2. A noncitizen national of the United States (See instructions) ☐ 3. A lawful permanent resident (Enter USCIS or A-Number) ☐ 4. A noncitizen (other than Item Numbers 2. and 3. above) authorized to work until (exp. date, if any) _____					
		If you check Item Number 4., enter one of these: USCIS A-Number _____ OR Form I-94 Admission Number _____ OR Foreign Passport Number and Country of Issuance _____					
Signature of Employee ⑧ <i>Jane Doe</i>				Today's Date (mm/dd/yyyy) ⑨ <i>09/15/2023</i>			
If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.							

Note: Refer to Form I-9 Instructions for detailed information.



Instructions for Completing Form I-9 Section 2

(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. See **LISTS OF ACCEPTABLE DOCUMENTS**.

Employer: Examine and record the documents your employee provides. The employee must be present while you examine them. Numbered explanations below are shown in the pictured example.

- ① Examine each document. Print the details in the appropriate List column(s). Only accept unexpired, original documents (no photocopies).
You may accept one document from List A **OR** one from List B and one from List C.
- ② Print the date of the employee's first day of work.
- ③ Print your last name, first name and title. Title is "Managing Employer."
- ④ Sign and ⑤ date the form. **Must be completed and signed within 3 days of employee's first day of work.**
- ⑥ If not pre-populated, print CDCN's business name (Consumer Direct for Wisconsin).
- ⑦ If not pre-populated, print CDCN's office address (744 Ryan Drive, Suite 201, Hudson WI 54016).

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS , documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.			
List A		OR	List B AND List C
Document Title 1		①	Driver's License
Issuing Authority			State of Residence
Document Number (if any)			0123456789abode
Expiration Date (if any)			08/17/2027
Document Title 2 (if any)			Social Security Card
Issuing Authority			SSA
Document Number (if any)			123-45-6789
Expiration Date (if any)			N/A
Document Title 3 (if any)		Additional Information	
Issuing Authority		Example ⚡ Do not check. You must physically examine documents. ☐ Check here if you used an alternative procedure authorized by DHS to examine documents.	
Document Number (if any)			
Expiration Date (if any)			
Document Title 3 (if any)			
Issuing Authority			
Document Number (if any)			
Expiration Date (if any)			
Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.			First Day of Employment (mm/dd/yyyy): ② 09/15/2023
Last Name, First Name and Title of Employer or Authorized Representative ③ Smith, Ronald Managing Employer		Signature of Employer or Authorized Representative ④ Ronald Smith	Today's Date (mm/dd/yyyy) ⑤ 09/15/2023
Employer's Business or Organization Name ⑥ Consumer Direct for Wisconsin		Employer's Business or Organization Address, City or Town, State, ZIP Code ⑦ 744 Ryan Drive, Suite 201, Hudson WI 54016	

For reverification or rehire, complete [Supplement B, Reverification and Rehire](#) on Page 4.

Note: Refer to 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 07/31/2026

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

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

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

Last Name (Family Name)		First Name (Given Name)		Middle Initial (if any)	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number (if any)	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number		Employee's Email Address			Employee's Telephone Number
I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.		Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):				
		☐ 1. A citizen of the United States				
		☐ 2. A noncitizen national of the United States (See Instructions.)				
		☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)				
		☐ 4. A noncitizen (other than Item Numbers 2. and 3. above) authorized to work until (exp. date, if any)				
		If you check Item Number 4. , enter one of these:				
		USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance
Signature of Employee				Today's Date (mm/dd/yyyy)		

CG

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

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

List A		OR	List B	AND	List C	
Document Title 1						
Issuing Authority						
Document Number (if any)						
Expiration Date (if any)						
Document Title 2 (if any)		Additional Information				
Issuing Authority						
Document Number (if any)						
Expiration Date (if any)						
Document Title 3 (if any)		☐ Check here if you used an alternative procedure authorized by DHS to examine documents.				
Issuing Authority						
Document Number (if any)						
Expiration Date (if any)						
Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.					First Day of Employment (mm/dd/yyyy):	
Last Name, First Name and Title of Employer or Authorized Representative			Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)	
Employer's Business or Organization Name			Employer's Business or Organization Address, City or Town, State, ZIP Code			

For reverification or rehire, complete [Supplement B, Reverification and Rehire](#) on Page 4.



LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.

* Documents extended by the issuing authority are considered unexpired.

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

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 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		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 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 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 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	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. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 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. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security For examples, see Section 7 and Section 13 of the M-274 on uscis.gov/i-9-central. The Form I-766, Employment Authorization Document, is a List A, Item Number 4. document, not a List C document.
Acceptable Receipts May be presented in lieu of a document listed above for a temporary period. For receipt validity dates, see the M-274.			
• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	OR	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

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





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

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

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

Last Name (<i>Family Name</i>) from Section 1 .	First Name (<i>Given Name</i>) from Section 1 .	Middle initial (if any) from Section 1 .
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Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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

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

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

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

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

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

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

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



Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2024

Step 1:
Enter Personal Information

(a) First name and middle initialLast name

Address

City or town, state, and ZIP code

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

(b) Social security number

Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov.

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

Step 2:
Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.
Do **only one** of the following.
(a) Use the estimator at www.irs.gov/W4App for most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**
(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**
(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate ☐

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

Step 3:
Claim Dependent and Other Credits

If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly):
Multiply the number of qualifying children under age 17 by \$2,000 \$ _____
Multiply the number of other dependents by \$500 \$ _____
Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here

3 \$

Step 4 (optional):
Other Adjustments

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

4(a) \$

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

4(b) \$

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

4(c) \$

Step 5:
Sign Here

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

CG

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

Date

Employers Only

Employer's name and address

First date of employment

Employer identification number (EIN)

For Privacy Act and Paperwork Reduction Act Notice, see page 3.

Cat. No. 10220Q

Form **W-4** (2024)

02227

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

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

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

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

1. Expect to work only part of the year;
2. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or
3. Prefer the most accurate withholding for multiple job situations.

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

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

Specific Instructions

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

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

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

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



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

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

Step 4 (optional).

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

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

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



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



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

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

1

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

1

\$

2

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

a

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

2a

\$

b

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

2b

\$

c

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

2c

\$

3

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

3

4

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

4

\$

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



1

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

1

\$

2

Enter:

• \$29,200 if you're married filing jointly or a qualifying surviving spouse

• \$21,900 if you're head of household

• \$14,600 if you're single or married filing separately

2

\$

3

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

3

\$

4

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

4

\$

5

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

5

\$

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

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

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

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



Married Filing Jointly or Qualifying Surviving Spouse

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

Single or Married Filing Separately

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

Head of Household

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



Employee's Wisconsin Withholding Exemption Certificate/New Hire Reporting

WT-4

Employee's Section (Print clearly)

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

FIGURE YOUR TOTAL WITHHOLDING EXEMPTIONS BELOW

Complete Lines 1 through 3

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

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

CG

Signature _____ Date Signed _____

EMPLOYEE INSTRUCTIONS:

• WHO MUST COMPLETE:

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

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

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

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

• UNDER WITHHOLDING:

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

• OVER WITHHOLDING:

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

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

• LINE 1:

(a)-(c) Number of exemptions – Do not claim more than the correct number of exemptions. If you expect to owe more income tax for the year than will

be withheld if you claim every exemption to which you are entitled, you may increase your withholding by claiming a smaller number of exemptions on lines 1(a)-(c) or you may enter into an agreement with your employer to have additional amounts withheld (see instruction for line 2).

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

• LINE 2:

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

• LINE 3:

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

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

Employer's Section

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

EMPLOYER INSTRUCTIONS for Department of Revenue:

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

EMPLOYER INSTRUCTIONS for New Hire Reporting:

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





PAY SELECTION FORM

Employee Name: _____

Date of Birth: _____

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

Please check one pay option below.

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

- ☐ **Direct Deposit to a Wisely Pay Card Account.** I authorize CDCN to issue me a Wisely Pay card. The card will be tied to my identification on file. CDCN will make payroll deposits to my card account. I will receive the card in 7 to 10 business days after initial processing.
- ☐ **Direct Deposit to an Existing Checking, Savings or Pay Card Account.** I authorize CDCN to initiate payroll deposits to my bank or financial institution.

The Name of my bank is: _____

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

AN ATTACHMENT IS REQUIRED.

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

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

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

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

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

CG

Employee Signature

Date





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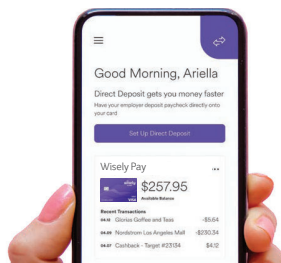


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² You must log in to the myWisely app or mywisely.com to opt-in to early direct deposit. Early direct deposit of funds is not guaranteed and is subject to the timing of payor's payment instruction. Faster funding claim is based on a comparison of our policy of making funds available upon our receipt of payment instruction with the typical banking practice of posting funds at settlement. Please see full disclosures on mywisely.com or the myWisely app. If you have a Wisely Pay or Wisely Cash card (see back of your card), this feature requires an upgrade which may not be available to all cardholders. Please allow up to 3 weeks after your initial setup of direct deposit for your pay to start loading to your card.

³ Amounts transferred to your savings envelope will no longer appear in your available balance. You can transfer money from your savings envelope back to your available balance at any time using the myWisely app or at mywisely.com.

⁴ The number of fee-free ATM transactions may be limited. Please log in to the myWisely app or mywisely.com and see your cardholder agreement and list of all fees for more information.

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WAGE MEMO

Employee Name	Member Name	Member CDCN ID #

MCO/Authorizing Entity:

Authorized Services:

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

Overtime: ☐ Allowed ☐ Not Allowed

Effective Date:

Employee Signature

Date

CDCN Representative Name

CDCN Representative Signature

Date

**CLTS per unit wages are subject to Employer taxes per DHS program guideline.*





**CO-EMPLOYMENT
EMPLOYEE AGREEMENT**

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

_____ has elected to hire me to perform care services for the Member
(Member or Managing Party Print Name)
according to Wisconsin's self-directed services program.

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

1. Enrollment

I will complete the Employee Packet and associated pre-hire trainings. Mandatory trainings include:

- Employee handbook.
- Bloodborne Pathogens protocols.
- Abuse, Neglect and Exploitation Reporting Requirements.
- HIPAA regulations and Privacy.
- Lifting and Moving.
- Employee and Member Harassment.

2. Co-Employment Service Model

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

3. Effective Date

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

4. Payment

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





5. My Responsibilities

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

6. Member/MP Responsibilities

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

7. CDCN Responsibilities

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





**CO-EMPLOYMENT
EMPLOYEE AGREEMENT**

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

8. Reporting Requirements

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

9. Conclusion

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

CG

Employee Signature

Date

M

Member/Managing Party 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;



DEPARTMENT OF HEALTH SERVICES

Division of Medicaid Services
F-00180C (03/2023)

STATE OF WISCONSIN

42 CFR 431.107 & 42 CFR 438.602(b)

- 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.
 15. To refrain from influencing an individual to either not enroll in or to disenroll from another managed care organization or the IRIS program.

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

Date Signed



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

CG

SIGNATURE – SHC Agency Supervisor

Date Signed

SIGNATURE – Participant as Employer

Date Signed

M

SIGNATURE – County Agency Care Manager

Date Signed



09530





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:

- Federal and State False Claims Laws
- 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 “Privacy Awareness Guide” training information.

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

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

Signatures:

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

CG

Employee Signature

Date

M

Member or Managing Party Signature

Date



DEPARTMENT OF HEALTH SERVICES

Division of Quality Assurance
F-82064A (01/2022)

STATE OF WISCONSIN

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

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

PURPOSE

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

CAREGIVER BACKGROUND CHECK LAW

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

APPLICATION

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

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

FAIR EMPLOYMENT ACT & ELIGIBILITY REQUIREMENTS

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

Wis. Stat. § 50.065(4m)(b) reads:

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

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

See [Offenses Affecting Eligibility](#) for guidance.



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DEPARTMENT OF HEALTH SERVICES

Division of Quality Assurance

F-82064 (01/2022)

STATE OF WISCONSIN

Wis. Stat. § 50.065

Wis. Admin. Code § DHS 12.05(4)

Page 1 of 2

BACKGROUND INFORMATION DISCLOSURE (BID) FOR ENTITY EMPLOYEES AND CONTRACTORS

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

Refer to DQA form [F-82064A, Instructions](#), for additional information.**Check the box that applies to you.**

- | | |
|--|---|
| ☐ Applicant / Employee
☐ Contractor | ☐ Student / Volunteer
☐ Other – Specify: |
|--|---|

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

Full Legal Name – <i>First</i>	<i>Middle</i>	<i>Last</i>
--------------------------------	---------------	-------------

Other Names (including prior to marriage)

Position Title (applied for or existing)	Birth Date (<i>MM/DD/YYYY</i>)	Sex ☐ Male ☐ Female
---	----------------------------------	--

Home Address	City	State	Zip Code
--------------	------	-------	----------

Business Name and Address – Employer (Entity)

Answering “NO” to all questions does not guarantee employment, a contract, or service agreement.

If more space is required, attach additional documentation to this form and indicate “see attached” in your answer.

SECTION A – DISCLOSURES

- 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
☐	☐
- 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
☐	☐
- Please note that Wis. Stat. § 48.981, *Abused or neglected children and abused unborn children*, may apply to information concerning findings of child abuse and neglect.
Has any government or regulatory agency (other than the police) ever found that you committed **child** abuse or neglect?
Provide an explanation below, including when and where the incident(s) occurred.

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

Yes	No
☐	☐



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- | | | |
|--|--------------------------|--------------------------|
| 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?
If Yes , explain, including when and where it happened. | Yes | No |
| | ☐ | ☐ |
-
- | | | |
|--|--------------------------|--------------------------|
| 6. Has any government or regulatory agency (other than the police) ever found that you abused an elderly person ?
If Yes , explain, including when and where it happened. | Yes | No |
| | ☐ | ☐ |
-
- | | | |
|--|--------------------------|--------------------------|
| 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?
If Yes , explain, including credential name, limitations or restrictions, and time period. | Yes | No |
| | ☐ | ☐ |

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?
If Yes , list the review date and the review result. You may be asked to provide a copy of the review decision. | Yes | No |
| | ☐ | ☐ |

Read and initial the following statement.

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

NAME – Person Completing This Form

Date Submitted





EMPLOYEE HEALTH QUESTIONNAIRE

Employee Name: _____
(please print)

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

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

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

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



EMPLOYEE HEALTH QUESTIONNAIRE

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

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

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

[illegible]

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

CG Employee Signature: _____ Date: ____/____/____

Office Use Only	
Reviewed by: [] Date ____/____/____	Date sent to Risk Mgr: ____/____/____
State Office/Location: _____	Risk Mgr Review: [] Date ____/____/____





HEPATITIS B VACCINATION AUTHORIZATION/DECLINATION FORM

Employee Name: _____
(please print)

ACCEPT/DECLINE HEPATITIS B VACCINATION

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring the Hepatitis B virus (HBV) infection. I have the opportunity to be vaccinated with Hepatitis B vaccine, and have the cost reimbursed by Consumer Direct Care Network (CDCN). I understand that if I decline this vaccine, I will be at risk of acquiring Hepatitis B, a serious disease. I understand if I decline the vaccine at this time, I continue to have the opportunity to receive the vaccine in the future while employed with CDCN.

- ☐ I decline the Hepatitis B vaccination
- ☐ I choose to receive the Hepatitis B vaccination

Signature:

CG

Employee Signature

Date

INSTRUCTIONS FOR RECEIVING THE VACCINATION SERIES

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

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

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





PRIVACY AWARENESS QUIZ AND CONFIDENTIALITY AGREEMENT

Employee Name: _____
(please print)

Office Use Only

Score: _____ (min. 80%)

Reference Material: Consumer Direct Care Network (CDCN) *Privacy Awareness Guide – Caregivers*.

1. What does “HIPAA” stand for?
 - a. Health Insurance Portability and Accountability Act
 - b. Healthcare Industry Privacy and Accountability Act
 - c. Health Insurance Privacy and Administration Act
 - d. None of the above

2. Which example is considered an unauthorized disclosure?
 - a. Bringing a third party to a service recipient’s home.
 - b. Speaking to a service recipient about their condition.
 - c. Mentioning a caregiver’s name to another person.
 - d. Talking to a CDCN Representative about working with the service recipient.

3. CDCN employees must adhere to privacy laws in their individual state, as well as HIPAA federal regulations.
 - a. True
 - b. False

4. Which of the following are considered PII/PHI? (select all that apply)
 - a. Full Address
 - b. Medical history
 - c. Doctor’s Office Location
 - d. First and Last Name
 - e. Social Security Number
 - f. Mother’s Maiden Name
 - g. Name of City of Residence
 - h. Medical Diagnosis
 - i. Medication History

5. In which situation(s) are CDCN employees required to comply with HIPAA privacy standards?
 - a. At home with employee’s family.
 - b. In a service recipient’s house.
 - c. To another caregiver who works for a different service recipient.
 - d. All of the above.





PRIVACY AWARENESS QUIZ AND CONFIDENTIALITY AGREEMENT

6. What should you do if you're concerned about a possible unauthorized disclosure of PII/PHI?
 - a. Keep quiet and see if anything bad happens before reporting it.
 - b. Call the police.
 - c. Notify your Service Coordinator.
 - d. All of the above.

7. Which of the following could possibly cause an unauthorized HIPAA disclosure?
 - a. Talking to CDCN about a service recipient.
 - b. Leaving paperwork out that contains PHI where others can view it.
 - c. Shredding any paper documents with service recipient information.
 - d. Talking to a service recipient about their condition and care.

8. Penalties for unauthorized disclosure can be applied to CDCN and the employee.
 - a. True
 - b. False

9. Only employees taking care of service recipients with medication need to worry about HIPAA.
 - a. True
 - b. False

Confidentiality Agreement: By signing below, I acknowledge that the disclosure of confidential information obtained through my employment with the Member (service recipient) and CDCN is **Prohibited!** Furthermore, I understand that any information concerning the Member's diagnosis, personal care services, and their personal details are 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. I acknowledge that confidentiality is an important part of the job, and that failure to follow confidentiality requirement is cause for termination.

CG

Employee Signature

Date



EXPECTED WEEKLY HOURS - NEW HIRE

CAREGIVER/NURSE (Non-FEA)

Employee Name: _____

Entity: _____

Email Address: _____

-- Office Use Only --

Hire Date: _____

Anticipated Weekly Hours:

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

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

Comments:

CDCN Representative Name: _____

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

****Employees marked “variable” will not be offered benefits upon hire.***





Work Opportunity Tax Credits - Consumer Direct Care Network

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

Applicant Instructions

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

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

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

IVR CODE: 410849



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00540 - Delete





2024 Benefits Summary
WI Caregivers

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

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

For additional assistance, please contact Health Advocate at answers@healthadvocate.com or by calling 866-695-8622.





Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

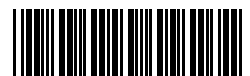
Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%¹ of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.^{1,2}

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

¹ Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2023.

² An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.



When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/> for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact the Human Resources Department

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.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. This information is numbered to correspond to the Marketplace application.

3. Employer name Consumer Direct for Wisconsin		4. Employer Identification Number (EIN) 26-2202984	
5. Employer address 100 Consumer Direct Way		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 InfoBenefits@consumerdirectcare.com	

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

- As your employer, we offer a health plan to:
☐ All employees. Eligible employees are:

- ☒ Some employees. Eligible employees are:

Regular status employees working at least 30 hours/week

- With respect to dependents:
☒ We do offer coverage. Eligible dependents are:

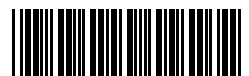
Spouse or domestic partner, child(ren) up to age 26

- ☐ We do not offer coverage.

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

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

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.



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

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

☒ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$ 20.03

b. How often? ☐ Weekly ☐ Every 2 weeks ☒ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

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

16. What change will the employer make for the new plan year? _____

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

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





2024 Payroll Calendar

Symbol Key:



Pay Day



Postal and Bank Holiday

JANUARY							FEBRUARY							MARCH						
Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat
	1	2	3	4	5	6					1	2	3						1	2
7	8	9	10	11	12	13	4	5	6	7	8	9	10	3	4	5	6	7	8	9
14	15	16	17	18	19	20	11	12	13	14	15	16	17	10	11	12	13	14	15	16
21	22	23	24	25	26	27	18	19	20	21	22	23	24	17	18	19	20	21	22	23
28	29	30	31				25	26	27	28	29			24	25	26	27	28	29	30
														31						
APRIL							MAY							JUNE						
Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat
	1	2	3	4	5	6				1	2	3	4							1
7	8	9	10	11	12	13	5	6	7	8	9	10	11	2	3	4	5	6	7	8
14	15	16	17	18	19	20	12	13	14	15	16	17	18	9	10	11	12	13	14	15
21	22	23	24	25	26	27	19	20	21	22	23	24	25	16	17	18	19	20	21	22
28	29	30					26	27	28	29	30	31		23	24	25	26	27	28	29
														30						
JULY							AUGUST							SEPTEMBER						
Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat
	1	2	3	4	5	6					1	2	3	1	2	3	4	5	6	7
7	8	9	10	11	12	13	4	5	6	7	8	9	10	8	9	10	11	12	13	14
14	15	16	17	18	19	20	11	12	13	14	15	16	17	15	16	17	18	19	20	21
21	22	23	24	25	26	27	18	19	20	21	22	23	24	22	23	24	25	26	27	28
28	29	30	31				25	26	27	28	29	30	31	29	30					
OCTOBER							NOVEMBER							DECEMBER						
Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat
		1	2	3	4	5						1	2	1	2	3	4	5	6	7
6	7	8	9	10	11	12	3	4	5	6	7	8	9	8	9	10	11	12	13	14
13	14	15	16	17	18	19	10	11	12	13	14	15	16	15	16	17	18	19	20	21
20	21	22	23	24	25	26	17	18	19	20	21	22	23	22	23	24	25	26	27	28
27	28	29	30	31			24	25	26	27	28	29	30	29	30	31				

2024 Bank & Post Office Holidays

*Consumer Direct Care Network office closures

*New Year's Day - Monday, January 1

*Martin Luther King, Jr. Day - Monday, January 15

Presidents Day - Monday, February 19

*Memorial Day - Monday, May 27

*Juneteenth - Wednesday, June 19

*Independence Day - Thursday, July 4

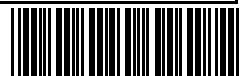
*Labor Day - Monday, September 2

Columbus Day - Monday, October 14

*Veterans Day - Monday, November 11

*Thanksgiving Day - Thursday, November 28

*Christmas Day - Wednesday, December 25





Work weeks are Sunday through Saturday. You must submit time daily using Electronic Visit Verification (EVV). Corrections are due by the correction deadline. Late time or time with mistakes may result in late pay. Thank you!

Two Week Pay Period		EVV Time Correction	
Start Date	End Date	Deadline	Pay Date
Sunday	Saturday	Monday	Friday
12/17/2023	12/30/2023	1/1/2024	1/12/2024
12/31/2023	1/13/2024	1/15/2024	1/26/2024
1/14/2024	1/27/2024	1/29/2024	2/9/2024
1/28/2024	2/10/2024	2/12/2024	2/23/2024
2/11/2024	2/24/2024	2/26/2024	3/8/2024
2/25/2024	3/9/2024	3/11/2024	3/22/2024
3/10/2024	3/23/2024	3/25/2024	4/5/2024
3/24/2024	4/6/2024	4/8/2024	4/19/2024
4/7/2024	4/20/2024	4/22/2024	5/3/2024
4/21/2024	5/4/2024	5/6/2024	5/17/2024
5/5/2024	5/18/2024	5/20/2024	5/31/2024
5/19/2024	6/1/2024	6/3/2024	6/14/2024
6/2/2024	6/15/2024	6/17/2024	6/28/2024
6/16/2024	6/29/2024	7/1/2024	7/12/2024
6/30/2024	7/13/2024	7/15/2024	7/26/2024
7/14/2024	7/27/2024	7/29/2024	8/9/2024
7/28/2024	8/10/2024	8/12/2024	8/23/2024
8/11/2024	8/24/2024	8/26/2024	9/6/2024
8/25/2024	9/7/2024	9/9/2024	9/20/2024
9/8/2024	9/21/2024	9/23/2024	10/4/2024
9/22/2024	10/5/2024	10/7/2024	10/18/2024
10/6/2024	10/19/2024	10/21/2024	11/1/2024
10/20/2024	11/2/2024	11/4/2024	11/15/2024
11/3/2024	11/16/2024	11/18/2024	11/27/2024 (Wed.)
11/17/2024	11/30/2024	12/2/2024	12/13/2024
12/1/2024	12/14/2024	12/16/2024	12/27/2024
12/15/2024	12/28/2024	12/30/2024	1/10/2025
12/29/2024	1/11/2025	1/13/2025	1/24/2025

Consumer Direct Care Network Wisconsin
744 Ryan Drive, Suite 201
Hudson, WI 54016-7984

Phone: 877-785-9991

Fax: 877-785-9992

Email: infoCDWI@ConsumerDirectCare.com

Web: www.ConsumerDirectWI.com

