Employee Paperwork Guide

Community Support Worker & Support Broker

This Employee Paperwork Guide provides descriptions, instructions and samples to assist with completing all forms that are necessary to enroll as a Community Support Worker and/or Support Broker in the Idaho Consumer Directed Community Supports program; My Voice, My Choice (Self-Directed Community Supports) and Family-Directed Services option.

Before the employee begins, it is important to note that a certain number of forms require several signatures by more than one individual. It is recommended that the employer of record and/or legal guardian be present when the employee begins his/her enrollment paperwork.

All completed paperwork can be sent via email, fax, or mail. For assistance, please email enrollment@acumen2.net.

Email: Enrollment@Acumen2.net
Fax: (855) 264-3290
5416 E Baseline Rd., Suite 200
Mesa, AZ 85206

Thank you for choosing Acumen Fiscal Agent, LLC. as your fiscal intermediary!

The Acumen Team

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)
EMPLOYEE	JANE	E	

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code
123 HAPPY VALLEY RD		ANYTOWN	AZ	55555

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number
01/01/1990	555555555	EMAIL@EXAMPLE.COM	(555) 555-5555

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.):

- [x] 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: EMPLOYEE SIGNATURE — Today's Date (mm/dd/yyyy): 08/0[illegible]/2023

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 the Instructions.

	List A	OR	List B	AND	List C
Document Title 1			DRIVER'S LICENSE		SOCIAL SECURITY CARD
Issuing Authority			ARIZONA DMV		SSA
Document Number (if any)			5555555A		555-55-5555
Expiration Date (if any)			05/05/2025		N/A
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

- [ ] Check here if you used an alternative procedure authorized by DHS to examine documents.

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

First Day of Employment (mm/dd/yyyy): 08/05/2023

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)
EMPLOYER, ELAINE - HOUSEHOLD EMPLOYER	EMPLOYER SIGNATURE	08/03/2023

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
ELAINE EMPLOYER	123 MAIN ST, ANYTOWN, AZ, 55555

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

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

Physical Address Required (No P.O. Box)

(a) First name and middle initial	Last name	(b) Social security number
Jane E.	Employee	123-45-6789

Address: 111 Main St Apt 2

City or town, state, and ZIP code: Anytown, State 12345

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*.

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

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

If applicable -->

(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

Required field even if "0".

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 $ 0

Multiply the number of other dependents by $500 . . . . . $ 0

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** $ 0

Step 4 (optional): Other Adjustments

Optional. Please refer to the instructions.

(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)** $

If filing exempt, leave Steps 2, 3 & 4 blank. Write EXEMPT here --->

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.

Jane E. Employee

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

01/03/2024

Date

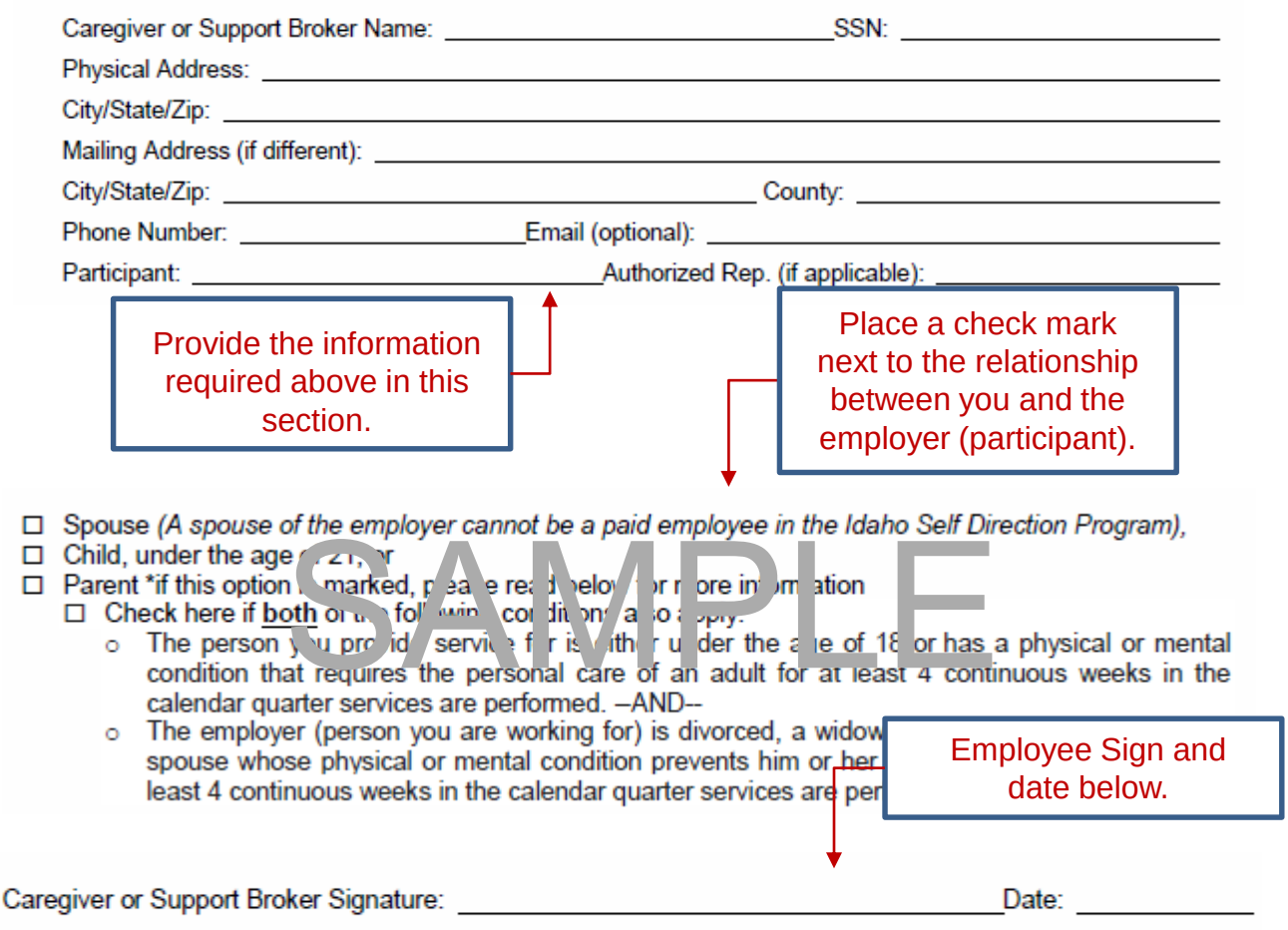
Employers Only

Employer Name Here

Employer's name and address	First date of employment	Employer identification number (EIN)
Employer Name 222 Main St Anytown, State 12345		

Employee Information Form

The Employee Information Form captures the type of relationship between the employee and the employer (Participant/EIN holder). In some cases an employee can be exempt from paying certain taxes due to the type of relationship he or she has between the employer. **The employee completes this form.**



Frequently Asked Questions

Q: What if none of the above relationships apply to me?
A: Do not mark any of the boxes if they do not apply to you.

Q: What if I am a parent of the participant, but I do not meet both of the conditions as a parent?
A: If you do not meet both conditions, do not select Parent.

Q: Can my employee work more than 40 hours in a work week?
A: This must be approved in your Spending Plan and the employee must qualify as an exempt employee. Refer to the Companionship or Live-In Exempt rules.

Pay Selection Options - Part One

The purpose of this form is to inform us how you, the employee, would like to receive your pay. You may need to provide additional information based on your selection; please read the instructions and return any necessary forms such as: a voided check and/or letter from the bank that includes your checking and/or savings account information.

I choose to receive my pay by (please check one box below):

Check ☐ Direct Deposit ☑ Pay Card ☐

Select a pay option.

If using direct deposit, complete this section with your bank information.

Primary Account Account Type: ☑ **Checking** (attach a voided check) ☐ **Savings** (attach routing & account information printout)	**Secondary Account** Account Type: ☐ **Checking** ☐ **Savings** (a
The Bank	
Financial Institution Name 11 Money Lane, Anytown, ID 12345 (optional)	Financial Institution Name
Financial Institution Address 123456789 (should always be 9 digits)	Financial Institution Address
Routing Number 1234	Routing Number
Account Number 100%	Account Number
% of check to be deposited	% of check to be deposited

Are you the account holder for the account(s) listed above? ☑ **Yes** ☐ **No**

If "no," what is the name of the account holder? _____

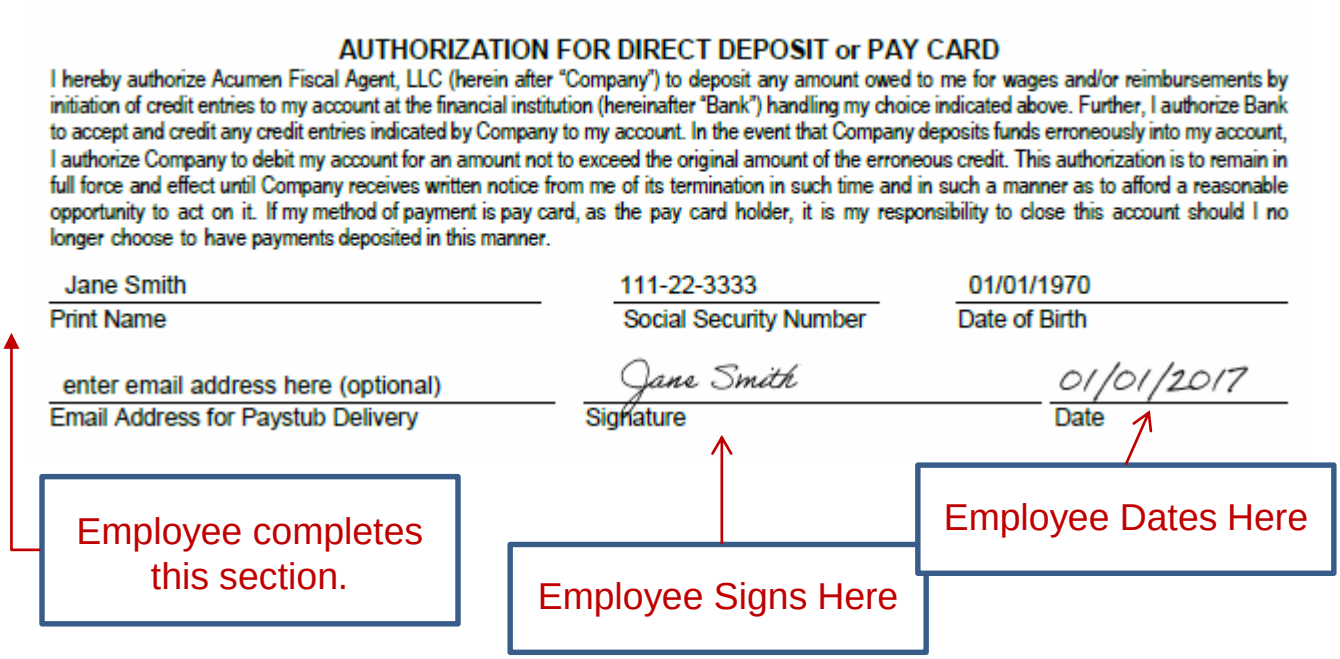
If "no," employee agrees to have their funds deposited into this account._____

Employee Signature

If for some reason you require your payment to be deposited into someone else's account, please complete this section.

Pay Selection Options - Part Two

If you have selected **Direct Deposit or Pay Card**, complete this portion.



AUTHORIZATION FOR DIRECT DEPOSIT or PAY CARD

I hereby authorize Acumen Fiscal Agent, LLC (herein after "Company") to deposit any amount owed to me for wages and/or reimbursements by initiation of credit entries to my account at the financial institution (hereinafter "Bank") handling my choice indicated above. Further, I authorize Bank to accept and credit any credit entries indicated by Company to my account. In the event that Company deposits funds erroneously into my account, I authorize Company to debit my account for an amount not to exceed the original amount of the erroneous credit. This authorization is to remain in full force and effect until Company receives written notice from me of its termination in such time and in such a manner as to afford a reasonable opportunity to act on it. If my method of payment is pay card, as the pay card holder, it is my responsibility to close this account should I no longer choose to have payments deposited in this manner.

Jane Smith	111-22-3333	01/01/1970
Print Name	Social Security Number	Date of Birth
enter email address here (optional)	Jane Smith	01/01/2017
Email Address for Paystub Delivery	Signature	Date

Frequently Asked Questions

Q: Can I select more than one pay option?
A: You may select only one of the available options. However, if you select direct deposit, you can have more than one direct deposit account. For example, you can deposit a portion of your pay into a checking account, and the remainder into another checking or savings account. If you do not select either direct deposit or pay card, you will receive a paper check by mail.

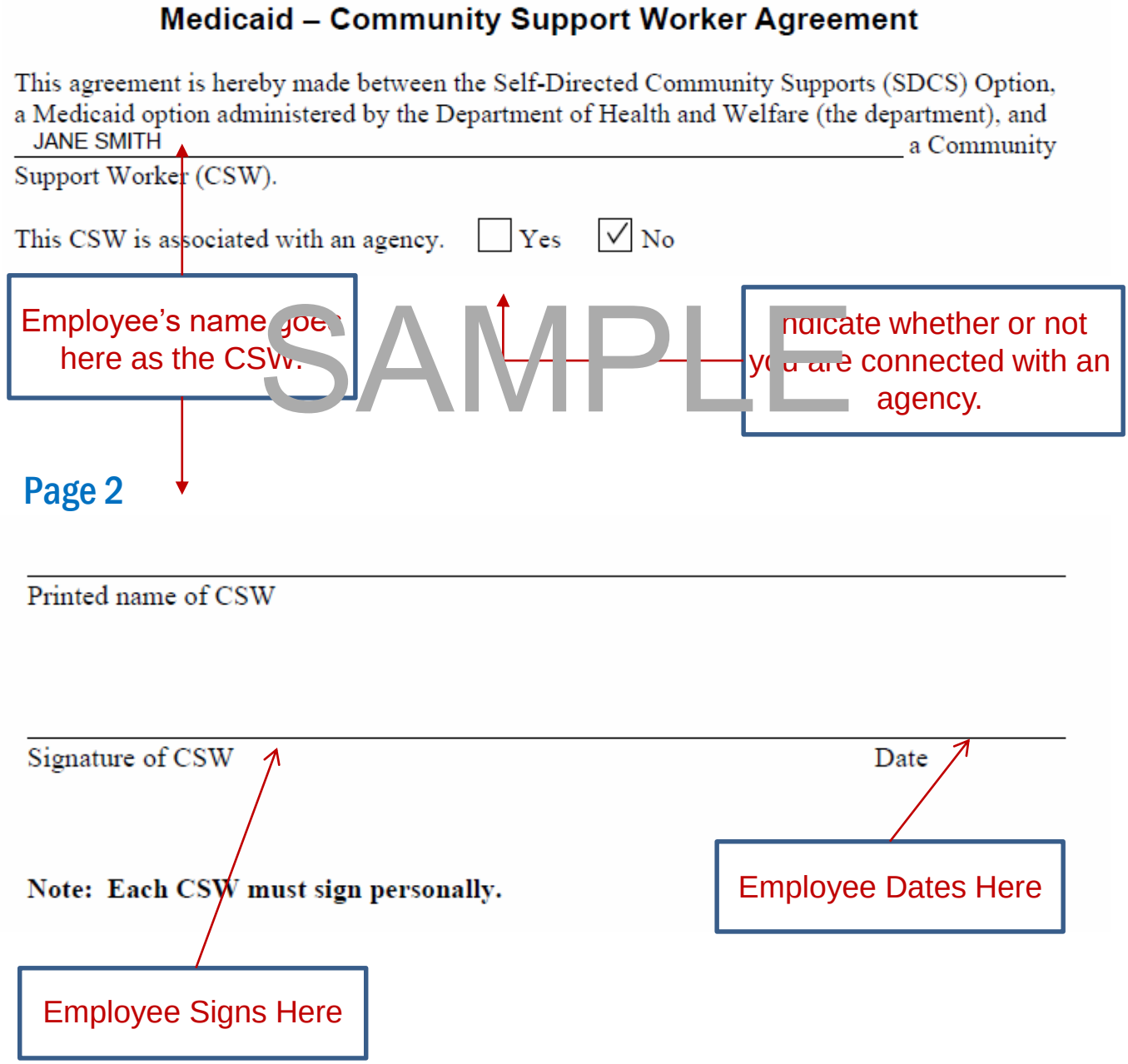
Q: If I select direct deposit, what additional forms will I need to send?
A: A copy of a voided check or a letter from the bank that provides your routing and account number for each account you would like to have payments deposited into.

Q: If I select a pay card, what additional forms will I need to send?
A: There are no additional forms required. Acumen will order your pay card through Money Network, Money Network will provide further information and instructions for activating your card. After you activate your card through Money Network, contact our customer service team and notify them that your Pay Card is activated.

Medicaid–Community Support Worker Agreement

Page 1

Employee Instructions: This agreement is completed by the employee who is considered to be a Community Support Worker (CSW). This agreement is a State form between you, the CSW and the State. You must complete this form to enroll as a Participant's employee. You agree that the Participant will only pay you for work done in accordance with program rules and this agreement.



Medicaid – Community Support Worker Agreement

This agreement is hereby made between the Self-Directed Community Supports (SDCS) Option, a Medicaid option administered by the Department of Health and Welfare (the department), and JANE SMITH a Community Support Worker (CSW).

This CSW is associated with an agency. ☐ Yes ☑ No

Employee's name goes here as the CSW.

Indicate whether or not you are connected with an agency.

SAMPLE

Page 2

Printed name of CSW

Signature of CSW Date

Note: Each CSW must sign personally.

Employee Dates Here

Employee Signs Here

Participant–Community Support Worker Employment Agreement – Part 1

Page 1

Employee Instructions: This agreement is a State form that the employee completes with the Participant/Legal Guardian. This document is used to specify what types of services you, the employee will be providing. In addition to the type of services you will be providing, this form also captures the rate of pay for each service, how often and how long you will provide the service.

Employer and Employee, read this form in its entirety.

The Participant's name goes here.

This agreement is hereby made between Joe Smith (Participant's Name), a Participant of the Self Directed Community Supports (SDCS) Option, a Medicaid Option administered by the Department of Health and Welfare (Department), and Jane Smith (CSW's Name), a Community Support Worker (CSW).

The Employee's name goes here as the CSW.

Participant or Legal Guardian complete this section below.

Page 3

13. Terms and conditions of work. **Effective Date:** _____.

COLUMN A	B	C		D		E
Service needed	Type of Support ☑ only one box per row	Number of hours per year OR Number of miles/year		Wage per hour OR Wage per mile		Annual Cost
	☐ Personal PSS ☐ Job JSS ☐ Transportation TSS (hourly) ☐ Learning LSS ☐ Emotional ESS ☐ Skilled Nursing SNS ☐ Relationship RSS ☐ Transportation Mileage Reimbursement (MR)		x		=	$ Sub-Total
	☐ Personal PSS ☐ Job JSS ☐ Transportation TSS (hourly) ☐ Learning LSS ☐ Code for second rate of pay/hour ☐ Emotional ESS ☐ Skilled Nursing SNS ☐ Relationship RSS ☐ Transportation Mileage Reimbursement (MR) _____ Fill in code		x		=	$ Sub-Total

Participant–Community Support Worker Employment Agreement – Part 2

Page 4

Participant or Legal Guardian, complete this section.

14. The CSW must meet the following specific qualifications in order to provide the following services including attaching copy of certification/licensure, if applicable, as outlined in IDAPA 16.03.13 Subsections 120.05 and 110.03:

_____

_____

_____

_____

Age Criteria for CSWs:

- CSWs 17 years of age and older may provide supervision, direct services or chore type services
- CSWs under 17 years of age may provide chore type services

☐ I am under 17 and the support provided aligns with the Department's guidance.

If the employee is under the age of 17, indicate so here.

Participant or Legal Guardian, indicate whether you will be waiving or requesting the employee's criminal history background check. If requesting a background report, ensure the employee signs next to that option. If waiving, ensure you sign next to the waive option.

☐ The CSW gives permission to the fiscal employer agent to notify the Participant (Employer) of the results of the Criminal History Background Check. _____
CSW Signature

☐ I am waiving the Criminal History Check requirement. I have completed the attached Waiver of Liability form. I understand that even if CHC is waived the CSW cannot receive Medicaid dollars if he is on a federal or state Medicaid exclusion list. _____
Participant or Legal Guardian Signature

Participant–Community Support Worker Employment Agreement – Part 3

Page 4

The Participant signs & dates here (if he or she is able to). If they cannot, leave blank.

The Legal Guardian signs & dates here (if applicable).

The CSW (employee) signs & dates here.

Criminal History Check – Waiver of Liability- Assumption of Risk

Participant/Legal Guardian and/or Support Broker Instructions: If you wish to waive the criminal history background check for your CSW, you will need to complete this form. Please be prepared to provide a reason for choosing to waive your CSW's background check, as well provide a description on how the participant will remain safe and healthy.

Participant Name: _____ **MID #** _____ **Date:** _____

Waiver: I do not want (name of community support worker) _____ to be subject to Criminal History Check requirements.

Relationship to the Participant: _____

Description of Service: _____

Participant/Legal Guardian, complete this entire section.

Reason:

_____

_____

_____

I Will Make Sure I am Healthy and Safe by: _____

_____

Provide a reason for waiving the background check.

Include a quick summary as to how the Participant will remain safe & healthy.

The Participant signs & dates here (if he or she is able to). If they cannot, leave blank.

The Legal Guardian signs & dates here (if applicable).

_____ _____

Signature of Individual Date Signature of Legal Guardian (if applicable) Date

Legal Guardian name or Participant name goes here if they are representing themselves

I have provided education and counseling to _____ **regarding the risks of waiving a criminal history check for this individual.**

Comments: Include additional comments here.

_____

Support Broker signs and dates here.

_____

Signature of Support Broker Date

Criminal History Check – Waiver of Liability- Assumption of Risk – Failed Criminal History Check

Participant/Legal Guardian and/or Support Broker Instructions: If you wish to waive the criminal history background check for your CSW after he or she has failed their background check, you will need to complete this form. Please be prepared to provide a reason for choosing to waive your CSW's background check, as well provide a description on how the participant will remain safe and healthy.

Participant Name: _____ **MID #** _____ **Date:** _____

Waiver: I choose to hire (name of community support worker) _____ as my community support worker. I understand that they have failed the criminal history check per requirements at IDAPA 15.05.06, "Rules Governing Mandatory Criminal History Checks".

Relationship to the Participant: _____

Description of Service: _____

Reason: _____

_____

_____

I Will Make Sure I am Healthy and Safe by: _____

Participant/Legal Guardian, complete this entire section.

Provide a reason for waiving the background check.

Include a quick summary as to how the Participant will remain safe & healthy.

The Participant signs & dates here (if he or she is able to). If they cannot, leave blank.

The Legal Guardian signs & dates here (if applicable).

_____ _____

Signature of Individual Date Signature of Legal Guardian (if applicable) Date

Legal Guardian name or Participant name goes here if they are representing themselves

I have provided education and counseling to _____ **regarding the risks of waiving a criminal history check for this individual.**

Comments: Include additional comments here.

_____

Support Broker signs and dates here.

_____

Signature of Support Broker Date