



Minnesota Consumer Directed Community Supports (CDCS)

Acknowledgement of Waiver of Workers' Compensation

Name of Participant (please print) _____

Name of Employee (please print) _____

Name of Employer (please print) _____

Per the Minnesota Revised Statutes Chapter 176, if the employee is the spouse, child or parent of the employer in the Consumer Directed Community Supports (CDCS) program, the employer is not required to provide Workers' Compensation. By completing this form, the employer and employee agree that Workers' Compensation will not be provided for this employee.

Employee: Please mark your relation to the employer below.

- None**, no relation to employer – STOP! You do not qualify for this waiver.
- Spouse** of the employer
- Child** of the employer
- Parent** of the employer

By completing and signing this form, I acknowledge that the information on this form is correct. I understand my employer is not providing Workers' Compensation for me.

Employee Signature: _____ Date: _____

As the employer, I understand and acknowledge that the information on this form is correct. I am electing to waive providing Workers' Compensation to this employee.

Employer Signature: _____ Date: _____