Employee Packet
(Keep this folder for your records)

***Instructions* – You will need to complete the following steps in order to hire an employee. Enrollment forms to enroll and hire an Employee can be found in this portion of the packet.** *Employee and Employer, please review and ensure all forms listed below are complete and legible before they are returned to Acumen. Forms can be sent via email, fax, mail, or in-person. Note that some forms will require more than one signature. Please ensure all forms obtain the necessary signatures. An Acumen Representative can assist with any questions that may arise during the application/enrollment process.*

Electronic Enrollment - If you are completing the employee enrollment online through Acumen's Electronic Enrollment System (EES), the final forms will be automatically sent to Acumen after all individuals have signed. Some forms cannot be completed electronically so will require additional information and/or signatures. Acumen will contact the Employer to provide further instructions and/or request further documentation.

1. Interview applicants and decide who you think would be the best fit for your particular needs.
2. Work with your Case Manager/Service Coordinator and/or Support Advisor to determine the qualifications and the rate of pay for the applicant(s).
3. Have the person you decide to hire complete and send the following completed forms to Acumen: (Don't forget that enrollment can be completed electronically through the Acumen website at www.acumenfiscalagent.com).

   - ☐ TX Form 1724 New Employer Packet Cover
   - ☐ TX Form 1725 Criminal Conviction History and Registry Checks Form
   - ☐ TX Form 1728 Liability Acknowledgement Form
   - ☐ TX Form 1729 Applicant Verification for Employees Form
   - ☐ Form I-9

4. Once you have made the decision to hire an applicant, ensure the applicant completes the following forms (if you enrolled your employee through the Acumen Electronic Enrollment System, the forms listed below may have already been completed. Contact Acumen if you are unsure.) All certifications or additional documentation such as proof of CPR certification, driver's license, etc. will need to be sent to Acumen regardless of how you enrolled your employee. More information is provided below.

   - ☐ TX Form 1727 Occupational Exposure to Bloodborne Pathogens
   - ☐ TX Form 1730 Wage and Benefits Plan Form
   - ☐ TX Form 1731 Employee Work Schedule and Assigned Tasks
   - ☐ TX Form 1732 Management and Training of Service Provider (required within 30 days of hire)
   - ☐ TX Form 1732-EMR Employee Misconduct Registry Notification (required within 5 days of hire)
   - ☐ TX Form 1733 (if applicable) Exemption from Nursing Licensure Form
   - ☐ TX Form 1734 Service Provider and Employer Certification of Relationship Status
   - ☐ TX Form 1737 Employer and Employee Service Agreement Form
   - ☐ TX Form 1739 Service Provider Agreement
   - ☐ TX Form 1856e Attorney General Form
   - ☐ IRS Form W-4
   - ☐ Acumen Pay Selection Options for Employees Form
   - ☐ Acumen Employee Information Form

- ☐ Acumen Physical Demands Acknowledgement Form
- ☐ CPR Certification *(if applicable-must be legible if photocopied, current, and obtained through a hands-on course)*
- ☐ Texas Department of Public Safety Driver's License *(if providing transportation, and must be legible when photocopied, and current)*
- ☐ Proof of Auto Insurance *(if providing transportation)*
- ☐ Voided Check or Letter from Bank for Direct Deposit *(if direct deposit selected as payment method)*

5. Email, fax, or mail completed forms to Acumen. Acumen will notify you when your employee can begin working. Do not allow any work to be performed prior to this notification.

Examples of completed forms can be found on our website. Although you may photocopy blank forms for future employees, Acumen recommends that you download the forms from our website or contact our Customer Service Center to be sure you have the most up-to-date forms.

If you have questions, please e-mail customerservice@acumen2.net or call (866) 759-9524 to speak with a representative.

Employee State Tax Withholding
Texas state income tax will be withheld from all employees' pay based on state income tax withholding guidelines. Employees who live in another state may be required to file and pay state withholding tax in Texas and the state in which they live. Individuals in this situation should consult a tax advisor with any concerns they may have about their state tax liability.

Employee Changes and Termination
Complete the Employee Change Form if an employee changes his or her name or address. Complete the Termination Form when an employee no longer works for you. These changes should be reported to Acumen as soon as possible. Email, fax or mail completed forms to Acumen.

Employee Files
Acumen recommends that you always make a copy of any forms you submit and that you keep these copies in a safe place, as they contain sensitive and personal information. We recommend that you also maintain a current and accurate file on each employee hired. This file should contain all employee documentation, including but not limited to the following: W-4, I-9, and copies of completed timesheets.

Confidentiality and Protection of Records
Employees must not disclose or knowingly permit the disclosure of any information concerning the participant, the employer, or his/her family to any unauthorized person.

Medicaid Fraud
Medicaid fraud is committed when an EMPLOYER or EMPLOYEE is untruthful regarding services provided in order to obtain improper payment. The Medicaid Fraud Unit investigates and prosecutes people who commit fraud. Medicaid fraud is a felony, and conviction can lead to substantial penalties. Additionally, individuals convicted of Medicaid fraud can be excluded from any employment with a program or facility receiving Medicaid funding.

Examples of Medicaid Fraud include:

- Signing or submitting a timesheet for services that were not actually provided.
- Signing or submitting a timesheet for services provided by a different person.
- Signing or submitting a timesheet for services that were reimbursed by another source.
- Signing or submitting a duplicate timesheet for reimbursement from the same source.

As required by the State of Texas, suspected cases of fraud will be referred to the state for further investigation and possible prosecution.

To view Acumen's False Claims Policy – Fraud Protocol for the State of Texas, go to the Acumen website.

***For your records*:**

Employee Name _____ Date Hired _____
Phone # _____ Address _____
_____

□ W-4 □ I-9 □ Pay Selection Form/Direct Deposit or Pay Card
□ Employee Agreement □ Employment Application
□ Criminal History Check Completed_____
Comments _____
_____
Date Terminated _____

Employee Name _____ Date Hired _____
Phone # _____ Address _____
_____

□ W-4 □ I-9 □ Pay Selection Form/Direct Deposit or Pay Card
□ Employee Agreement □ Employment Application
□ Criminal History Check Completed_____
Comments _____
_____
Date Terminated _____

Employee Name _____ Date Hired _____
Phone # _____ Address _____
_____

□ W-4 □ I-9 □ Pay Selection Form/Direct Deposit or Pay Card
□ Employee Agreement □ Employment Application
□ Criminal History Check Completed_____
Comments _____
_____
Date Terminated _____

Employee Name _____ Date Hired _____
Phone # _____ Address _____
_____

□ W-4 □ I-9 □ Pay Selection Form/Direct Deposit or Pay Card
□ Employee Agreement □ Employment Application
□ Criminal History Check Completed_____
Comments _____
_____
Date Terminated _____

Acumen Fiscal Agent, LLC
5416 E. Baseline Rd., Suite 200
Mesa, AZ 85206
Phone: (866) 759-9524
Fax: (855) 264-3287
customerservice@acumen2.net

TEXAS Health and Human Services

Form 1724
August 2015-E

Consumer Directed Services

New Employee Packet Cover Sheet

Name of Individual Receiving Services	Employer Name
Employee Name	
Date of Hire	First Day of Work

Employer	Agency	FMSA	Document Description / Form Information
Before Hire: (1) Original or Copy for Employer's Personnel Files and (2) Original or Copy to FMSA			
☐	DADS	☐	**DADS Form 1725,** Criminal Conviction History and Registry Checks
☐	DADS	☐	**DADS Form 1729,** Applicant Verification for Employees; **DADS Form 1734,** Service Provider and Employer Certification of Relationship Status for CDS
☐	USCIS	☐	**USCIS Form I-9,** Employment Eligibility Verification
☐	DADS	☐	**DADS Form 1728,** Liability Acknowledgement
☐	DADS	☐	**Professional license verification** (nursing, professional therapies)
At Time of Hire: (1) Original or Copy for Employer's Personnel Files and (2) Original or Copy to FMSA			
☐	IRS	☐	**IRS Form W-4,** Employee's Withholding Allowance Certificate — Due before first payroll check is calculated; provide to the Financial Management Services Agency (FMSA) on date of hire.
☐	OAG	☐	**Texas Employer New Hiring Reporting Form** (www.employer.texasattorneygeneral.gov)
☐	DADS	☐	**DADS Form 1730,** Wage and Benefits Plan Employee Compensation, and any court-ordered garnishment(s); **DADS Form 1731,** Employee Work Schedule and Assigned Tasks; **DADS Form 1737,** Employer and Employee Service Agreement; **DADS Form 1739,** Service Provider Agreement
☐	DADS	☐	***CLASS, DBMD and MDCP only:*** **Cardiopulmonary resuscitation (CPR) certification** — Effective at time of service delivery initiation, and maintained. *Verify again before expiration date.*
☐	DADS	■	**Texas Department of Public Safety driver's license** (if transporting client) — *Verify again before expiration date.*
☐	DADS	■	**Proof of minimum auto insurance** (if transporting client)
☐	CDC OSHA	■	**DADS Form 1727,** Occupational Exposure to Bloodborne Pathogens (Acknowledgement: Hepatitis B Vaccination and Universal Precautions)
☐	TWCC	■	**Notice to Employees Concerning Workers' Compensation in Texas** (TWC Notice 5)
☐	DADS	☐	***If hiring a nurse:*** **DADS Form 1747,** Acknowledgment of Nursing Requirements
☐	CDS DADS	☐	***If applicable:*** **DADS Form 1733,** Employer and Employee Acknowledgement of Exemption from Nursing Licensure for Certain Services Delivered through Consumer Directed Services
☐	DADS	☐	**DADS Form 1732,** Management and Training of Service Provider — Initial training must be conducted within 30 days of hire.
Ongoing: (1) Original or Copy for Employer's Personnel Files and (2) Original or Copy to FMSA			
☐	DADS	☐	**DADS Form 1732,** Management and Training of Service Provider — Evaluation, employment status changes, documentation of training, documentation of conflict and job performance issues. (The employer must send the original or a copy to the FMSA within 30 calendar days of an initial orientation or annual evaluation and when an action affects the service provider's continued status with the employer, e.g., termination, change in payment.)
☐	DADS	■	**DADS Form 1732-EMR,** Management and Training of Service Provider Addendum — Must be signed by the employee within five days of hire.
☐	DADS	☐	**Time sheets/service logs** — **DADS Form 1745,** Service Delivery Log with Written Narrative/Written Summary, **or** facsimile approved by the FMSA
☐	Vendors	☐	**Receipts and invoices**

Code	Action
☑	Employer checks off each item for the **personnel file** and retains original or copy.
☑	Employer checks each required item when completed and sends original or copy to the FMSA as indicated. Employer retains original or copy.
■	Items the employer is **not** required to send to the FMSA, but which the employer **must** maintain on file in the employee's **personnel file**.

Code	Agency
CDC	Centers for Disease Control and Prevention
CDS	Consumer Directed Services
DADS	Texas Department of Aging and Disability Services
IRS	Internal Revenue Service
OAG	Office of the Attorney General, State of Texas
OSHA	Occupational Safety and Health Administration
TWCC	Texas Workers' Compensation Commission
USCIS	U.S. Citizenship and Immigration Services (formerly known as the **INS**, Immigration and Naturalization Services)

TEXAS Health and Human Services

Form 1725
March 2023

Consumer Directed Services

Criminal Conviction History and Registry Checks

The applicant is a person under consideration for hire as a service provider in the CDS option (employee or independent contractor [when required]). This form covers only criminal history conviction history and registry checks.

Note: An applicant may not be hired by the CDS employer, and must not start providing services for payment, until and unless the required criminal history and registry checks are conducted, in addition to other employee qualification checks. The CDS employer and Financial Management Services Agency (FMSA) review the results of all required qualification checks to determine that an applicant can be hired. This form is signed by the FMSA.

Section I - Applicant Authorization and Acknowledgment (Applicant must complete this section.)

I, (applicant's printed name) _____, give my permission to check for a criminal conviction history, to check the required registries annually, and to check the state and federal lists of people and entities excluded from participation in Medicaid (LEIE) monthly as part of my application as a service provider through the Consumer Directed Services (CDS) option. I also understand that a criminal conviction or a registry listing that prohibits a person from employment in a health care setting in the state of Texas may prohibit my employment.

I understand I may not begin delivering services until the FMSA and Employer confirm that I meet all qualifications to be hired.

Applicant Information Required by the Texas Department of Public Safety (DPS) (Applicant must complete this section.)

Individual's Name (Last, First, Middle)	Alias	Maiden Name
Date of Birth (mm/dd/yyyy)	Social Security No.	

Signature - Applicant _____ Date _____

Section II - Criminal Conviction History Check and Registry Verification Process (Employer must complete this section.)

Individual's Name	Employer Name

Criminal Conviction History Check (Check each box to certify agreement):

- ☐ I request that my FMSA obtain a **current** Criminal Conviction History Check of the applicant from DPS. I authorize the FMSA to be reimbursed for the cost of obtaining the DPS Criminal Conviction History Check and if I request the report, the cost of sending the report from my budgeted funds.
- ☐ I understand that if I request the report, the FMSA must send it to me through a secure method, DPS approved encrypted software or certified mail.
- ☐ I understand that all criminal records and reports obtained by my FMSA, and the information they contain, are confidential information.
- ☐ I understand all DPS criminal history information reports must be destroyed five days after I make the hiring decision. Paper records need to be shredded, pulped or burned. For electronic records, destroying the media or using specialized software to copy over the data are acceptable methods.
- ☐ I understand that sharing of criminal history information with any person or agency may be prosecuted as a Class A Misdemeanor.
- ☐ I understand I may not allow the applicant to begin delivering services until the FMSA and I confirm the applicant meets all qualifications to be hired.

Signature - Employer _____ Date _____

Registry Check

- ☐ I request that my FMSA obtain the applicant's status with the Employee Misconduct Registry and the Nurse Aide Registry initially and annually.
- ☐ I understand that the FMSA will screen the applicant initially and monthly using both the state and federal lists of excluded individuals and entities (LEIE).
- ☐ I also understand that the applicant cannot provide services and cannot be paid with program funds until the criminal history and registry checks are completed and my FMSA has notified me that the applicant meets the qualifications.

Signature - Employer _____ Date _____

I request that the FMSA provide the criminal history to me:

- ☐ Verbally
- ☐ Encrypted email
- ☐ Certified mail

_____
Date of Employer Request

Section III - Criminal Conviction History and Registry Check Results (FMSA must complete this section.)

DPS Criminal Conviction Criminal History Check

Date FMSA received Form 1725 with employer selection for criminal history results:	
Date of DPS Check	Time (specify a.m. or p.m.)
Obtained By	Convictions: ☐ **Yes** ☐ **No**

DPS approved dissemination method used to inform employer of results:

- ☐ Verbally
- ☐ Encrypted email
- ☐ Certified mail
- ☐ Did not specify method

Date FMSA staff notified employer: _____

FMSA staff:

If yes, does the conviction(s) prohibit service delivery in compliance with Health and Safety Code Chapter 250, Section 250.006(a), or Section 250.006(b)? ..... ☐ Yes ☐ No

Within five calendar days after the hiring decision, the FMSA must destroy the criminal history record information obtained from DPS whether or not hired or retained by the employer or designated representative.

Date report was destroyed: _____

Date employer notified FMSA of hiring decision: _____

Registry Checks (Conduct search at **emr.dads.state.tx.us/DadsEMRWeb/**)

Date of Registry Checks	Time (specify a.m. or p.m.)	Obtained By	☐ Employer ☐ FMSA Representative

Employee Misconduct Registry: ☐ No Record ☐ Record (must not be hired or retained)

Nurse Aide Registry: ☐ No Record ☐ Record (must not be hired or retained)

Medicaid Exclusion List: ☐ No Record ☐ Record (must not be hired)

Certification - I acknowledge that the applicant's DPS criminal conviction history and registry record were checked.

The applicant ☐ **is** ☐ **is not** eligible for hire, to be retained for service delivery based on the checks above.

_____
Signature - FMSA Representative

_____
Date FMSA notified the employer or Designated Representative

FMSA and Employer Must Each Keep Original or Copy of This Form

DPS Computerized Criminal History (CCH) Verification

(AGENCY COPY)

I, _____ , acknowledge that a Computerized Criminal

APPLICANT or EMPLOYEE NAME (Please print)

History (CCH) check may be performed by accessing the Texas Department of Public Safety Secure Website and may be based on name and DOB identifiers. (This is not a consent form, but serves as information for the applicant.) Authority for this agency to access an individual's criminal history data may be found in Texas Government Code 411; Subchapter F.

Name-based information is not an exact search and only fingerprint record searches represent true identification to criminal history record information (CHRI), therefore the organization conducting the criminal history check is not allowed to discuss with me any CHRI obtained using the name and DOB method. The agency may request that I also have a fingerprint search performed to clear any misidentification based on the result of the name and DOB search.

In order to complete the fingerprint process I must make an appointment with the Fingerprint Applicant Services of Texas (FAST) as instructed online at www.txdps.state.tx.us */Crime Records/Review of Personal Criminal History* or by calling the DPS Program Vendor at 1-888-467-2080, submit a full and complete set of fingerprints, request a copy be sent to the agency listed below, and pay a fee of $25.00 to the fingerprinting services company.

Once this process is completed the information on my fingerprint criminal history record may be discussed with me.

(This copy must remain on file by this agency. Required for future DPS Audits)

_____
Signature of Applicant or Employee (optional)

_____
Date

Acumen Fiscal Agent
_____
Agency Name (Please print)

_____
Agency Representative Name (Please print)

_____
Signature of Agency Representative

_____
Date

Please:
Check and Initial each Applicable Space

CCH Report Printed:

YES _____ NO X _____ initial

Purpose of CCH: Employment

Empl X Vol/Contractor ___ _____ initial

Date Printed:_____ _____ initial

Destroyed Date:_____ _____ initial

Retain in your files

Rev. 09/2015

Consumer Directed Services

Occupational Exposure to Bloodborne Pathogens

Universal Precautions

Blood has long been recognized as a potential source of pathogenic microorganisms that may present a risk to individuals who are exposed during the performance of their duties. Universal precautions is the method of control required by the Occupational Safety and Health Administration (OSHA) to protect employees from exposure to all human blood and body fluids. **Universal precautions** refers to a concept of bloodborne disease control, which requires that all human blood and certain human body fluids be treated as if known to be infectious for HIV (the virus that causes AIDS), the Hepatitis B virus and other bloodborne pathogens.

Protective barriers reduce the risk of exposure to blood, body fluids containing visible blood and other fluids to which universal precautions apply. Examples of protective barriers include gloves, gowns, masks and protective eyewear. Universal precautions are intended to supplement rather than replace recommendations for routine infection control, such as hand-washing and using gloves to prevent gross microbial contamination of hands. Universal precautions will be used during the provision of services as applicable and appropriate.

Employee Initials: _____ Date: _____

Hepatitis B

Hepatitis B is a serious infection involving the liver. Hepatitis B virus (HBV) can cause lifelong infection, cirrhosis (scarring) of the liver, liver cancer, liver failure and death. Hepatitis B is spread when blood or body fluids from an infected person enters the body of a person who is not infected. HBV is a major infectious occupational hazard for health care. Any health-care worker may be at risk for HBV exposure depending on the tasks that he or she performs. Workers should be vaccinated if their tasks involve contact with blood or blood-contaminated body fluids.

Employee Initials: _____ Date: _____

Hepatitis B Vaccination

OSHA standards effective June 4, 1992, require that employers make available the Hepatitis B vaccine and vaccination series to all employees who have occupational exposure. The Hepatitis B vaccine is available at no cost to the employee. The cost to provide vaccinations is an administrative expense to the employer and is reimbursable through the individuals's program budget.

The vaccine is administered in a prescribed series of three injections over a six-month period:

Dose 2 is administered 30 days after Dose 1.

Dose 3 is administered five months following Dose 2.

The employee is responsible for requesting from the healthcare provider administering the vaccination additional information specific to the efficiency, safety, benefits, method of administration and potential side effects of the Hepatitis B vaccination.

The employee may elect to **receive** or **decline** the Hepatitis B vaccination.

Employee Initials: _____ Date: _____

Informed Choice Related to Hepatitis B Vaccination

Employee Statement – Check one statement below.

☐ I **agree** to receive the Hepatitis B vaccination and will be reimbursed by my employer within 30 days of presenting a paid receipt for each dose. I understand that I will only be reimbursed for doses received while employed by the employer.

☐ I **agree** to receive the Hepatitis B vaccination and the employer and I have agreed to the following arrangement(s) related to covering the cost of the vaccination:

☐ I **decline** the Hepatitis B vaccination at this time because I have previously received the Hepatitis B vaccination.

☐ I **decline** the 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 Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine at this time. However, I decline the Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.**

Federal Register: 61 FR 5507, February 13, 1996
*OSHA 1910.1030 App A - *Mandatory Declination Statement*

Certification by Employee

I, _____, the **employee**, acknowledge and certify that I have received information on occupational exposure to bloodborne pathogens, universal precautions, Hepatitis B and Hepatitis B vaccination. I have been provided the opportunity to ask questions and to seek additional information. I have made my choice (as documented above) related to the Hepatitis B vaccination based on informed choice.

* I may decide in the future to request and accept the vaccination at no charge to me.

Employee:	**Employer:**
_____	_____
Printed Name	Printed Name
_____	_____
Signature	Signature
_____	_____
Date	Date

TEXAS Health and Human Services

Form 1728
October 2013-E

Consumer Directed Services

Liability Acknowledgement

Liability Acknowledgement Between the Employer and the Applicant for Employment

The individual receiving services or the individual's legally authorized representative (LAR) is the employer in the Consumer Directed Services (CDS) option.

The **employer** employs (hires, manages and terminates) employees. The **employer** is solely responsible and liable for any negligent acts or omissions by the employer; the employee; other employee(s) or service provider(s); the individual receiving services; or, if applicable, the employer's designated representative.

Employees or service providers are **not** employed or retained by the Texas Department of Aging and Disability Services (DADS); any other state or federal governmental agency; or by the Financial Management Services Agency (FMSA).

As an applicant for employment through the CDS option, I acknowledge that I have read and that I understand the above information regarding the employer and employee liability.

Signature – Employer (Must be signed by the employer)	Date	Signature – Applicant for Employment	Date

Liability Notice to Applicants for Employment

Section I:

The employer:

☐ **is** a subscriber of Texas Workers' Compensation through the Texas Department of Insurance, Division of Workers' Compensation.

☑ **is not** a subscriber of Texas Workers' Compensation through the Texas Department of Insurance, Division of Workers' Compensation. (Employer completes Section II below if this option applies.)

Section II:

Employer indicates the correct option in this section if the employer **is not** a subscriber to Texas Workers' Compensation.

☐ I have made the following arrangement(s) for employee work-related injuries/illnesses:

- ☐ self-insurance;
- ☐ homeowner's personal liability insurance;
- ☐ renter's personal liability insurance;
- ☐ medical coverage insurance;
- ☐ risk pool insurance;
- ☐ other: _____

☐ I have **no** insurance or other protection against employee work-related injuries/illnesses for my employee(s).

Acknowledgement by Employer and Applicant for Employment

I acknowledge that I have read and that I understand the above information in Section I and in Section II.

Signature – Employer (Must be signed by the employer)	Date	Signature – Applicant for Employment	Date

TEXAS Health and Human Services

Form 1729
March 2023

Consumer Directed Services

Applicant Verification for Employees

Individual's Name	Employer Name

Applicant Name	Applicant Social Security No.

The employer must verify the applicant meets each criterion. The employer must ensure the following forms or copies of documentation used to verify the criteria are valid and kept in the employee's personnel file. This form and supporting documentation **must** be sent to the Financial Management Services Agency (FMSA) for verification before the employer can hire the applicant.

Employment Qualifications

- ☐ The applicant is at least 18.
- ☐ The applicant is not disqualified based on a “Yes” response on Form 1734, Service Provider and Employer Certification of Relationship Status for CDS.
- ☐ The applicant is not barred from employment based on the results of the Texas Department of Public Safety (DPS) criminal conviction history check, the Texas Health and Safety Code Chapter 250 registry checks, or the Medicaid exclusion list (Form 1725, Criminal Conviction History and Registry Checks).
- ☐ The applicant has completed Form 1728, Liability Acknowledgement.
- ☐ The applicant has read Notice Concerning Workers' Compensation in Texas (TWC Notice 5).
- ☐ The applicant has current cardiopulmonary resuscitation (CPR) and first aid certification for Medically Dependent Children Program (MDCP) flexible family support and respite services.
- ☐ The applicant has current hands-on CPR, first aid and choking prevention certification, if providing services in the Deaf Blind with Multiple Disabilities (DBMD) Program.
- ☐ The applicant has the following educational qualifications, if providing services for DBMD, Home and Community-based Services (HCS), MDCP, Texas Home Living (TxHmL) or Community First Choice (CFC):
  - has a high school diploma or a certificate recognized by a state as the equivalent of a high school diploma; or
    - documentation of a proficiency evaluation of the employee's experience and competence to perform job tasks, including an ability to provide the services needed by the individual, as demonstrated through a written competency-based assessment; and
    - at least three personal references from people not related by blood that evidence the person's ability to provide a safe and healthy environment for the individual.
- ☐ The applicant has the following qualifications, if providing services for DBMD:
  - is fluent in the communication methods used by the individual (for example, American Sign Language, tactile symbols, communication boards, pictures and gestures) or has the ability to become fluent in the communication methods used by the individual within three months after beginning to work with the individual.

FMSA Certification

The applicant ☐ **does** ☐ **does not** meet qualifications for employment.

Only applicants who meet all qualifications may be employed.

Acknowledgement

The applicant and employer acknowledge that the applicant meets the qualifications for employment and that a copy of this form must be submitted to the FMSA. The FMSA must verify the applicant’s qualifications before the employer offers employment to the applicant.

Signature — Employer	Date	Signature — FMSA	Date

TEXAS Health and Human Services

Consumer Directed Services

Wage and Benefits Plan
Employee Compensation

Employee Name (Last, First, Middle Initial)		Social Security No.
Individual's Name		Employers Name
Date of Hire	First Date of Work	☐ Initial Wage and Benefit Plan ☐ Plan Change – Effective Date: _____
Program: ☐ CLASS ☐ DBMD ☐ HCS ☐ TxHmL ☐ PHC ☐ PCS ☐ STAR Kids/MDCP ☐ STAR+PLUS		

Compensation:

Service 1:	Wage: $	Service 2:	Wage: $	Service 3:	Wage: $

Benefits: ***Optional***

☐ **Hepatitis B Vaccination** (Attach completed Form 1727 if vaccination is requested by the employee.)

Employer: List other optional benefits here. (Attach additional sheet, if required.)

Withholdings:

☐ **W-4 Employee's Withholding Allowance Certificate** (Attach completed Form W-4.)

☐ **Required Garnishments**

Type:		Amount:
Frequency:	Payment To:	

☐ **Voluntary Withholdings** (not related to W-4)

Type:		Amount:
Frequency:	Payment To:	

☐ **Other** (specify): _____

Acknowledgement/Agreement:

Time Sheets/Service Delivery Logs must be completed accurately each work shift/day. Payment for services delivered is made from state and/or federal funds. Falsification of a time sheet is considered fraud and is punishable under the law. Accurate, signed time sheets are due every other Monday. Paych**ecks** are distributed by Check/Direct Deposit every other week according to posted payment schedule.

Employee and employer mutually agree to the compensation, benefits, withholdings and all information above and agree that any changes or revisions must be documented and provided to the employee, the employer and the Financial Management Services Agency.

Signature - Employer or Designated Representative	Date	Signature - Employee	Date

TEXAS Health and Human Services

Form 1731
January 2007-E

Consumer Directed Services

Employee Work Schedule and Assigned Tasks

Employee Name:	Individual Receiving Services

Purpose of Form:

☐ Initial

☐ Change

Activity Involved:

☐ Tasks

☐ Schedule

Effective Date: _____

Schedule I

Day	Time In	Time Out	Time In	Time Out	Time In	Time Out	Total Hours
Sunday							
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							
						Weekly Total Hours	

Schedule I - Tasks

Check all that apply- refer to plan of care:

- ☐ Assist w/medications
- ☐ Bathing
- ☐ Grooming
- ☐ Toileting
- ☐ Hygiene
- ☐ Dressing
- ☐ Meal Preparation
- ☐ Feeding, Eating
- ☐ Laundry
- ☐ Transfer/Ambulation
- ☐ Mobility
- ☐ Habilitation Training
- ☐ Approved Health Related Tasks
- ☐ Other:_____
- ☐ Other:_____

Schedule II

Day	Time In	Time Out	Time In	Time Out	Time In	Time Out	Total Hours
Sunday							
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							
						Weekly Total Hours	

Schedule II - Tasks

Acknowledgment of Work Schedule and Assigned Tasks - Sign and Date:

_____ Signature — Employer

_____ Date

_____ Signature — Employee

_____ Date

TEXAS Health and Human Services

Form 1732
October 2015-E

Consumer Directed Services

Management and Training of Service Provider

Service Provider Name (Employee)	First Day of Work	Annual Evaluation Due Date
Name of Individual Receiving Services	Program	Services Delivered
Name of Consumer Directed Services Employer		

I. Purpose

☐ Initial Orientation ☐ Ongoing Training

☐ Evaluation

☐ 30-Day ☐ 3-Month ☐ 6-Month ☐ Annual ☐ Other _____

☐ Supervision

☐ Verbal Warning: ☐ First ☐ Second ☐ Third ☐ Other _____

☐ Written Warning: ☐ First ☐ Second ☐ Third ☐ Other _____

☐ Conflict Resolution ☐ Other _____

II. Documentation of Topics Covered at Initial Orientation or Ongoing Training: *(Initial orientation must include training related to the individual's condition and the tasks the service provider will perform as well as any required training described in an applicable addendum to Form 1735, Employer and Financial Management Services Agency Service Agreement.)*

_____ Service Provider received orientation and training on individual's condition and all approved tasks to be performed.

_____ Service Provider demonstrated understanding, knowledge, and competence in performing all approved tasks.

III. Documentation of Abuse, Neglect and Exploitation Training: *(Initial orientation must include training on acts that constitute abuse, neglect or exploitation of an individual.)*

_____ Service Provider trained on identifying acts that constitute abuse, neglect, and exploitation, signs of ANE and methods to prevent ANE.

_____ Service Provider trained on how to report ANE and understands action will be taken if they are suspected/reported of committing ANE.

IV. Evaluation/Performance Review:

V. Corrective Action Plan (if applicable):

Date for follow-up on corrective action plan: _____

VI. Service Provider Comments:

SIGN HERE

_____ Signature of Service Provider _____ Date

This document has been reviewed with the service provider listed above.

SIGN HERE

_____ Signature of Employer _____ Date

SIGN HERE

_____ Signature of Witness _____ Date

Date sent to FMSA: _____ **Date received by FMSA:** _____

TEXAS
Health and Human Services

Consumer Directed Services (CDS)

Management and Training of Service Provider Addendum

Employee Misconduct Registry Notification

Employee Name: _____ Date of Hire: _____

Position: Caregiver or RN or LVN Employer Name: _____

Long-term care employers, including Consumer Directed Service (CDS) employers, in Texas are required under 40, Texas Administrative Code (TAC), Part 1, Chapter 93, and Texas Health and Safety Code, Chapter 253 and to inform new unlicensed employees about the Employee Misconduct Registry (EMR).

The purpose of the EMR is to ensure that an unlicensed person who commits an act of abuse, neglect, or exploitation that meets the definition of reportable conduct against a consumer receiving services from a facility or against an individual receiving services in the CDS option is not employed in the Department of Aging and Disability Services (DADS)-regulated facilities and in certain programs including CDS. The EMR applies to employees who provide personal care services, treatment, or any other personal services and are not licensed by the state to perform the services.

A person listed in the EMR is not employable by a facility, agency, or individual employer. The EMR is governed by 40, Texas Administrative Code, Part 1, Chapter 93, and Texas Health and Safety Code, Chapter 253. Regarding a CDS employee, the Department of Family and Protective Services (DFPS) conducts EMR investigations and makes findings in accordance with DFPS rules at 40 TAC, Part 19, Chapter 711, Subchapter O.

Rules regarding the EMR can be found on the Secretary of State's website at:
http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=40&pt=19&ch=711&sch=O&rl=Y.

Questions may be directed to DADS Professional Credentialing Enforcement Unit at 512-438-5495.

The employer must provide the employee with a copy of this notice.

I, _____, have read and understand the above notification.

_____ _____
Signature Date

TEXAS
Health and Human Services

Employer and Employee Acknowledgement of Exemption from Nursing Licensure for Certain Services Delivered through Consumer Directed Services

The employer in the Consumer Directed Services (CDS) option is the individual receiving services or the individual's legally authorized representative (LAR). The employer may choose to have certain nursing services provided by an unlicensed person employed in the CDS option. The individual or the LAR must be capable of training the unlicensed employee in the performance of the task(s) and train and supervise the employee performing the task(s). The employee who delivers the service must not have been denied a license under Chapter 301, Occupations Code or have a license under Chapter 301, Occupations Code that is revoked or suspended.

When the employee is trained and supervised by the LAR, the employee delivers the service when the LAR is present or is immediately accessible to the employee. If the employee will perform the service when the LAR is not present, the LAR must observe the person performing the service at least once to assure the LAR that the employee performs the service correctly.

Government Code, Title 4, Subtitle I, Chapter 531, Subchapter B, §531.051, Consumer Direction for certain services for persons with disabilities, states the employee must not perform those service that are expressly prohibited from delegation by the **Texas Board of Nursing (Texas Administrative Code, *§225.13,Tasks Prohibited From Delegation), including:***

(1) physical, psychological, and social assessment, which requires professional nursing judgment, intervention, referral, or follow-up;

(2) formulation of the nursing care plan and evaluation of the client's response to the care rendered;

(3) specific tasks involved in the implementation of the care plan that require professional nursing judgment or intervention;

(4) the responsibility and accountability for client or client's responsible adult health teaching and health counseling which promotes client or client's responsible adult education and involves the client's responsible adult in accomplishing health goals; and

(5) the following tasks related to medication administration:

(A) calculation of any medication doses except for measuring a prescribed amount of liquid medication and breaking a tablet for administration, provided the RN has calculated the dose;

(B) administration of medications by an injectable route except for subcutaneous injectable insulin as permitted by §225.11(b) of this title (relating to Delegation of Administration of Medications From Pill Reminder Container and Administration of Insulin);

(C) administration of medications by way of a tube inserted in a cavity of the body except as permitted by §225.10(10) of this title (relating to Task That May Be Delegated);

(D) responsibility for receiving or requesting verbal or telephone orders from a physician, dentist, or podiatrist; and

(E) administration of the initial dose of a medication that has not been previously administered to the client.

Examples of services that may be exempt from nursing licensure and can be included in the Individual Service Plan for the CDS option if all the qualifying conditions are met include:

(1) bathing, including feminine hygiene;

(2) grooming, including nail care, except for individuals with medical conditions like diabetes;

(3) feeding, including feeding through a permanently placed feeding tube;

(4) routine skin care, including decubitus Stage 1;

(5) transferring, ambulation or positioning;

(6) exercising and range of motion; and digital stimulation;

(7) the administering of a bowel and bladder program, including suppositories, catheterization, enemas, manual evacuation and digital stimulation;

(8) administering oral medications that are normally self-administered, including administration through a gastrostomy tube; and

(9) non-invasive and non-sterile treatments with low risk of infection.

Employee:	**Employer:**
Printed Name	Printed Name
Signature	Signature
Date	Date

Certification - We, the employee and the employer, certify that the employer has trained and supervised the employee in the delivery of the services listed below. We understand that those services that cannot be provided by anybody except a licensed nurse, according to Texas Administrative Code, §225.13, **Tasks Prohibited** From **Delegation**, must not be provided by the employee. Checked tasks indicate the employee may perform those tasks when the LAR is not present to supervise.

☐ _____	☐ _____	☐ _____
☐ _____	☐ _____	☐ _____
☐ _____	☐ _____	☐ _____
☐ _____	☐ _____	☐ _____
☐ _____	☐ _____	☐ _____

TEXAS Health and Human Services

Form 1734
March 2023

Consumer Directed Services (CDS)

Service Provider and Employer Certification of Relationship Status for CDS

Section 1: Basic Information

Service Provider Applicant Name	Maiden Name — if applicable
Applicant Street Address	City, State and ZIP Code
Person Receiving Services	CDS Employer Name (if different than person receiving services)
Person Receiving Services Street Address	City, State and ZIP Code
Applicant's Relationship to Person Receiving Services	Designated Representative (DR) — if applicable
Applicant's Relationship to CDS Employer	Applicant's Relationship to DR

Service Provider Applicant: Place a check mark in the column that describes your status and relationship.

Section 2: All Programs

The applicant must answer the following questions.

	Service Provider Status and Relationship	Yes	No	NA
1.	Are you under 18?	☐	☐	
2.	Are you the individual's legally authorized representative (LAR)? (That is, the individual's natural parent, legal or adopted parent, stepparent or managing conservator if the individual is under 18 [a minor], or the court-appointed guardian of an individual of any age.)	☐	☐	
3.	Are you the spouse* of the individual's LAR? (That is, the spouse of the individual's natural parent, legal or adopted parent, stepparent or managing conservator if the individual is under 18 [a minor], or the spouse of the court-appointed guardian of an individual of any age.)	☐	☐	
4.	Are you the spouse* of the individual? (Consumer Managed Personal Attendant Services (CMPAS) service providers mark this item Not Applicable (N/A).)**	☐	☐	☐
5.	Are you the spouse* of the employer? (CMPAS service providers mark this item NA.)**	☐	☐	☐
6.	If the individual is a Texas Department of Family and Protective Services (DFPS) foster child or adult, are you their foster parent? (If the individual is not a DFPS foster child or adult, mark this item NA.)	☐	☐	☐
7.	If the individual is a DFPS foster child or adult, are you the spouse* of the foster parent? (If the individual is not a DFPS foster child or adult, mark this item NA.)	☐	☐	☐
8.	Are you the power of attorney (attorney in fact or agent) for financial responsibilities on behalf of the individual?	☐	☐	
9.	Are you the DR or the CDS employer for the individual?	☐	☐	
10.	Are you the spouse* of the employer's DR?	☐	☐	

* **Spouse** is defined as either a legal marriage or a marriage without formalities (common law marriage) in accordance with the Texas Family Code.

** The spousal relationship in questions 4 and 5 is not applicable for CMPAS. (The spouse may be employed.)

Section 3: Medically Dependent Children Program (MDCP)

If providing services in the MDCP program, please answer the following additional questions. (Mark these items NA if the individual is not enrolled in MDCP.)

	Service Provider Status and Relationship	Yes	No	NA
1.	Are you the parent or primary caregiver of the individual?	☐	☐	☐
2.	Are you the spouse* of the parent or primary caregiver?	☐	☐	☐

Section 4: Home and Community-based Services (HCS) and Texas Home Living (TxHmL)

If providing Community First Choice Personal Assistance Services or Habilitation (CFC PAS/HAB), respite, adaptive aids or behavioral support services in the HCS or TxHmL program, please answer the following additional questions, as applicable. (Mark these items NA if the individual is not receiving an applicable HCS or TxHmL service.)

	Applicant Status and Relationship	Yes	No	NA
1.	Are you a person living in the same household as the individual? (Applies to CFC PAS/HAB and respite services.)	☐	☐	☐
2.	Are you a person related to the individual within the fourth degree of consanguinity or within the second degree of affinity? (Applies to adaptive aids and behavioral support services.)	☐	☐	☐

Section 5: Community Living Assistance and Support Services (CLASS) — Respite Service Providers Only

If providing respite services in the CLASS program **and the primary caregiver is the CFC PAS/HAB applicant**, answer the following additional question. (Mark this item NA if the individual is not receiving CLASS respite services. Also mark this item NA if the individual is receiving CLASS respite services, but the primary caregiver is not the CFC PAS/HAB service provider.)

	Applicant Status and Relationship	Yes	No	NA
1.	Do you live in the same household as the individual?	☐	☐	☐

Section 6: Primary Home Care (PHC), Community Attendant Services (CAS) and Family Care (FC)

If providing PHC, CAS or FC, please answer the following additional questions. (Mark these items NA if the individual is not enrolled in PHC, CAS or FC.)

	Applicant Status and Relationship	Yes	No	NA
1.	Are you the primary caregiver for the individual?	☐	☐	☐
2.	Are you the spouse* of the primary caregiver for the individual?	☐	☐	☐

Employer and Service Provider Applicant Verification

If any item above is marked Yes, the applicant is not eligible to be a paid service provider (employee, contractor or vendor) in the CDS option for this individual.

If every item above is marked No or NA, the applicant meets relationship eligibility for employment in the CDS option for this individual, unless contraindicated by requirements of the individual's program. (NA only applies where indicated.) The employer and the applicant certify that the responses are accurate.

Employer confirmation and acknowledgement: As the CDS employer, I confirm that the information provided on this form is true and correct to the best of my knowledge. I understand that an applicant cannot be paid for providing services if they are not eligible for employment.

Printed Employer Name	Signature — Employer	Date

Applicant confirmation and acknowledgement: As the applicant, I confirm that the information provided on this form is true and correct to the best of my knowledge. I understand that I cannot be paid for providing services if I am not eligible for employment.

Printed Service Provider Applicant Name	Signature — Service Provider Applicant	Date

TEXAS Health and Human Services

Form 1734
June 2015-E

STAR Kids/PCS PROGRAM

Consumer Directed Services (CDS)

Service Provider and Employer Certification of Relationship Status for CDS

Service Provider Name	Maiden Name — if applicable
Individual Receiving Services	Employer Name
Service Provider's Relationship to Individual	Designated Representative (DR) — if applicable
Service Provider's Relationship to Employer	Service Provider's Relationship to DR

Service Provider: Place a check mark in the column that describes your status and relationship.

Section 1: All Programs

All service providers must answer the following questions.

	Service Provider Status and Relationship	Yes	No	N/A
1.	Are you under age 18?	☐	☐	
2.	Are you the individual's legally authorized representative (LAR)? (That is, the individual's natural parent, legal/adopted parent, stepparent or managing conservator if the individual is under age 18 [a minor], or the court-appointed guardian of an individual of any age.)	☐	☐	
3.	Are you the spouse* of the individual's LAR? (That is, the spouse of the individual's natural parent, legal/adopted parent, stepparent or managing conservator if the individual is under age 18 [a minor], or the spouse of the court-appointed guardian of an individual of any age.)	☐	☐	
4.	Are you the spouse* of the individual? (Consumer Managed Personal Attendant Services (CMPAS) service providers mark this item Not Applicable (N/A).)**	☐	☐	☐
5.	Are you the spouse* of the employer? (CMPAS service providers mark this item N/A.)**	☐	☐	☐
6.	If the individual is a Texas Department of Family and Protective Services (DFPS) foster child or adult, are you the individual's foster parent? (If the individual is not a DFPS foster child/adult, mark this item N/A.)	☐	☐	☐
7.	If the individual is a DFPS foster child or adult, are you the spouse* of the individual's foster parent? (If the individual is not a DFPS foster child/adult, mark this item N/A.)	☐	☐	☐
8.	Are you the power of attorney (attorney in fact or agent) for financial responsibilities on behalf of the individual?	☐	☐	
9.	Are you the DR or the CDS employer for the individual?	☐	☐	
10.	Are you the spouse* of the employer's DR?	☐	☐	

* **Spouse** is defined as either a legal marriage or a marriage without formalities (common law marriage) in accordance with the Texas Family Code.

** The spousal relationship in questions 4 and 5 is not applicable for CMPAS. (The spouse may be employed.)

Section 2: Medically Dependent Children Program (MDCP)

If providing services in the MDCP program, please answer the following additional questions. (Mark these items N/A if the individual is not enrolled in MDCP.)

	Service Provider Status and Relationship	Yes	No	N/A
1.	Are you the parent or primary caregiver of the individual?	☐	☐	✓
2.	Are you the spouse* of the parent or primary caregiver?	☐	☐	✓

Section 3: Home and Community-based Services (HCS) and Texas Home Living (TxHmL)

If providing respite, adaptive aids or behavioral support services in the HCS or TxHmL program, please answer the following additional questions, as applicable. (Mark these items N/A if the individual is not receiving an applicable HCS or TxHmL service.)

	Service Provider Status and Relationship	Yes	No	N/A
1.	Are you a person living in the same household as the individual? (Applies to respite services.)	☐	☐	☑
2.	Are you the spouse* of a person living in the same household as the individual? (Applies to respite services.)	☐	☐	☑
3.	Are you a person related to the individual within the fourth degree of consanguinity or within the second degree of affinity? (Applies to adaptive aids and behavioral support services.)	☐	☐	☑

Section 4: Community Living Assistance and Support Services (CLASS) — Respite Service Providers Only

If providing respite services in the CLASS program **and the primary caregiver is the Community First Choice (CFC) Personal Assistance Services/Habilitation (PAS/HAB) service provider**, please answer the following additional question. (Mark this item N/A if the individual is not receiving CLASS respite services. Also mark this item N/A if the individual is receiving CLASS respite services, but the primary caregiver is not the CFC PAS/HAB service provider.)

	Service Provider Status and Relationship	Yes	No	N/A
1.	Do you live in the same household as the individual?	☐	☐	☑

Section 5: Primary Home Care (PHC), Community Attendant Services (CAS) and Family Care (FC)

If providing PHC, CAS or FC, please answer the following additional questions. (Mark these items N/A if the individual is not enrolled in PHC, CAS or FC.)

	Service Provider Status and Relationship	Yes	No	N/A
1.	Are you the primary caregiver for the individual?	☐	☐	☑
2.	Are you the spouse* of the primary caregiver for the individual?	☐	☐	☑

Employer and Service Provider Certification

Employer: Place a check mark to determine eligibility for employment in CDS. ☐

If any item above is marked Yes, the service provider is not eligible to be a paid service provider (employee, contractor or vendor) in the CDS option for this individual. If every item above is marked No or N/A, the service provider meets relationship eligibility for employment in CDS for this individual unless contraindicated by requirements of the individual's program. (N/A only applies where indicated.) The employer and the service provider certify that the responses are accurate.

Employer check one: The service provider ☐ *is* or ☐ *is not* eligible for employment in CDS for this individual.

Printed Employer Name	Signature — Employer	Date
Printed Service Provider Name	Signature — Service Provider	Date

TEXAS Health and Human Services

Form 1737
September 2013-E

Consumer Directed Services

Employer and Employee Service Agreement

The name of individual receiving services, hereafter referred to as the "**Individual**," is:

_____ .

The Individual's program, _____ , hereafter referred to as the "**program**," is funded and administered by the Texas Health and Human Services Commission (HHSC).

The name of the employer, hereafter referred to as "**Employer**" is: _____ .

The Employer is the ☐ Individual, ☐ parent of a minor or ☐ court-appointed guardian of the Individual.

This agreement is between the Employer and _____ hereafter referred to as "**Employee**."

The Employer Agrees:

1. **To give notice to the Employee as soon as possible of any change(s) in the work schedule, the tasks to be performed or the number of hours the Employee will work.**
2. To adhere to all federal, state, and local employment-related laws and regulations.
3. To assume responsibility for:
   a. liability for any negligent acts or omissions by the Employer, his/her Employee(s) and service provider(s), the Designated Representative (if applicable), the Individual or others in the work place; and
   b. managing the risk and liability of any incidence(s) of Employee work-related injury/injuries or illnesses.
4. To provide orientation and training to the Employee of tasks and activities to be performed.
5. To provide the Employee with written notice of compensation for services delivered.

The Employee Agrees:

1. I, _____ the Employee, am willing and able to perform the tasks as outlined by, and at the direction of, the Employer, the Individual or the Designated Representative, if applicable.
2. To provide information and documents to the Employer, as required, to maintain current, up-to-date personnel records. The information and documents include at least changes in address and/or telephone numbers, criminal convictions and evidence of employment status and qualifications.
3. To not use the personal property of the Employer or the Individual without prior approval. The Employee will reimburse the Employer for any expense incurred related to his/her personal use of the personal property.
4. To respect the rights and dignity of the Individual and to follow safety procedures for the benefit of the Individual and the Employee.
5. To notify the Employer as soon as possible when the Employee will be late for work or is not able to work, as well as not report to work when illness or another condition may jeopardize the health and safety of the Individual.

Both the Employer and the Employee Agree:

1. That this document serves as an agreement, not an employment contract.
2. That the Employer employs the Employee. The Employee is not an independent contractor. The Employer controls the training and management, evaluation and firing/termination of the Employee.
3. That the Employee is not barred by relationship to the Individual, Employer or Designated Representative, if applicable, from being an Employee.
4. That a Financial Management Services Agency (FMSA) is responsible for the administration of program funds on behalf of the Employer, including payroll functions.
5. That funds for services to pay the Employee is from public sources, and financial accountability and liability applies to the use of the funds. Both the Employer and the Employee have an individual and joint responsibility to be accountable for the public funds spent through the Consumer Directed Services (CDS) option and understand that submitting false or fraudulent time sheets, submitting a time sheet of an unqualified service provider, submitting a time sheet for tasks other than those approved on the service plan or implementation plan will be reported to the appropriate authorities for investigation and possible prosecution as Medicaid fraud.

6. To provide an accurate accounting of services delivered by the Employee, and to submit accurate time sheets and documentation for reimbursement to the FMSA.
7. To bill only for actual time worked, allowable benefits and CDS-related expenses (billing for services and items not allowed or budgeted results in non-payment by the FMSA).
8. The Employer must not charge any fee to the Employee. The Employee must not make any payment to the Employer related to the Employee's employment. Any corrections to payroll are made by the FMSA.
9. That neither the FMSA or HHSC is responsible or liable for any negligent acts, work-related injuries or omissions by the Employer, Individual, Employee, other Employees and service providers and/or the Designated Representative, if applicable.
10. That personal medical and personal information and data about the Individual and the Employee is confidential. This information is not to be discussed, directly or indirectly, with others outside of the work environment at any time, currently or in the future.

Duration and Modification of Service Agreement

1. This service agreement will be in effect as of the date this agreement is signed by the Employer and Employee. This service agreement must not precede the date the Individual is eligible to participate in the program or in CDS
2. This service agreement can be modified by agreement of both parties, unless prohibited by HHSC rules or policy, or by applicable state, federal and/or local regulations.
3. This service agreement will terminate when:
   a. the Individual's participation in CDS ends voluntarily or involuntarily;
   b. the individual is no longer eligible for the HHSC program or for CDS participation;
   c. the Employee is convicted of a crime or listed on a registry that forbids employment by law;
   d. a relationship change occurs and continued employment is prohibited; or
   e. the Employee fails to maintain and provide documentation of eligibility or qualifications for continued employment.
4. This service agreement may be terminated, without cause, by either party with 14-calendar days written notice. A different time frame may be used if both parties agree in writing.

The following required documents are incorporated by reference:

Document	Date of Signature
HHSC Form 1725, Criminal Conviction History and Registry Checks	
HHSC Form 1729, Applicant Verification for Employees	
HHSC Form 1733, Employer and Employee Acknowledgement of Exemption from Nursing Licensure for Certain Services Delivered through Consumer Directed Services, if applicable	
HHSC Form 1734, Applicant and Employer Certification of Relationship for Employment	

Acknowledgement of service agreement, including documents incorporated by reference:

Employer:

Printed Name

Signature

Date

Employee:

Printed Name

Signature

Date

TEXAS Health and Human Services

Consumer Directed Services

Service Provider Agreement

Form 1739
October 2013-E

This agreement is between the **Texas Health and Human Services Commission** (HHSC), the state Medicaid agency; the **Texas Department of Aging and Disability Services** (DADS), the state operating agency; a **Financial Management Services Agency** (FMSA); and a **service provider** providing services to one or more individuals through the Consumer Directed Services (CDS) Option.

The **service provider,** _____ ☐ an individual or

☐ an entity, located at (Address) _____,

_____; Telephone _____ Fax _____

The service provider agrees to:

- provide services, items or goods that are authorized prior to purchase to individuals in home and community support programs in accordance with program rules and policy;
- keep records of purchased services, items and goods in accordance with program rules and policy;
- accept checks from the FMSA as full and complete payment for authorized services, items or goods purchased for individuals served through home and community-based programs;
- neither impose on or accept from individuals any additional charges for the services, items or goods paid for by the check; and
- provide records and other information upon request to the individual, the FMSA, HHSC, DADS or their representative.

The FMSA, HHSC and DADS agree:

- that the FMSA will pay the service provider for services, items or goods provided to the individual in accordance with this agreement and program rules and policy; and
- to allow the service provider to charge the individual for approved upgrades or purchases not authorized or paid for in accordance with this agreement, program rules and policy.

The service provider, FMSA, HHSC and DADS mutually agree that:

- the FMSA Acumen Fiscal Agent, LLC., doing business in Allen, Texas, provides financial management services (FMS) to the individual receiving services for purchases from the service provider;
- the FMSA is responsible for acquiring the completed agreement and retaining the original on behalf of HHSC and DADS;
- payment from the FMSA will not be issued prior to the receipt of this agreement by the FMSA;
- payment from the FMSA is funded by HHSC and DADS with government funds; and
- the FMSA is not a Texas or federal government agency.

This agreement is effective _____, and terminates when the service provider is no longer providing services to individuals through the FMSA.

Service Provider or Representative* (Print)	Service Provider or Representative* (Signature)	Date
FMSA Representative* (Print)	FMSA Representative* (Signature)	Date

** If the service provider is an entity, a representative from the entity with authorization to negotiate this agreement on behalf of the entity must sign.*

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)

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)					
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):

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

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 *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

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 *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	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 *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	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 *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	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 *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

Supplement B,
Reverification and Rehire (formerly Section 3)

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

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

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the Handbook for Employers: Guidance for Completing Form I-9 (M-274)

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	Last Name (Family Name)	First Name (Given Name)	Middle Initial
Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.			
Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)	
I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.			
Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	
Additional Information (Initial and date each notation.)		☐ Check here if you used an alternative procedure authorized by DHS to examine documents.	

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	Last Name (Family Name)	First Name (Given Name)	Middle Initial
Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.			
Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)	
I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.			
Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	
Additional Information (Initial and date each notation.)		☐ Check here if you used an alternative procedure authorized by DHS to examine documents.	

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	Last Name (Family Name)	First Name (Given Name)	Middle Initial
Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.			
Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)	
I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.			
Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	
Additional Information (Initial and date each notation.)		☐ Check here if you used an alternative procedure authorized by DHS to examine documents.	

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

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

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

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

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.

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

Employers Only

Employer Name Here

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

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 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.

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

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

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 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

Physical Demands Acknowledgement Form

Individual Name: _____

Employee Name: _____

As my employee, you will be providing services in accordance with my Plan of Care. It is required that you acknowledge your ability to meet the physical demands of this position.

The physical demands include but are not limited to:

- The ability to frequently stand, walk, bend, stoop and twist throughout the workday.
- The ability to lift and/or transfer up to _____ pounds.

Other duties may include but are not limited to:

_____
_____
_____
_____
_____
_____

Employee, by signing this form you acknowledge that you are fully able to meet the minimum requirements as stated above.

_____ _____
Employee Signature *Date*

_____ _____
Employer or Legal Guardian Signature *Date*

Acumen Fiscal Agent, LLC.
5416 E. Baseline Rd., Suite 200
Mesa, AZ 85206
Phone: (866) 759-9524
Fax: (855) 264-3287
Enrollment@acumen2.net

Acumen Fiscal Agent
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Pay Selection Options

Below are the options employees have for receiving their paychecks through Acumen. Please read the information about each option and select the one that is right for you. Paystubs will be sent through DCI Message Center. Your login information will be provided on your Good to Go. **You will need to provide additional information based on your selection; please read the instructions below and return all the necessary forms.**

Direct Deposit

With this option, your paycheck will be automatically deposited into your bank account on payday. There is no charge from Acumen to receive your pay via direct deposit. You won't have to wait for the mail or make a trip to the bank. On payday, paystubs will be sent via DCI messaging. You can have your paycheck deposited into one or two accounts, and you may change your account information at any time. **Please note:** You have the option to deposit a flat dollar amount **or** a percentage amount of your check to the primary account. If you choose to have a flat dollar amount deposited into your primary account, you will need to provide a secondary account in which the remainder of the funds will be deposited to. If you choose to have a percentage amount of your check deposited into two accounts, you must indicate the percentage to be deposited to each. The percentage total must be 100%. If no amounts are indicated, 100% will be deposited into the primary account. To enroll, fill out the information on the Authorization for Direct Deposit section of the form and return it, along with the additional requested items, to Acumen. You will receive paper checks by mail until your bank information is verified – usually within two pay periods.

Pay Card

Pay cards – also called pre-paid debit cards – work just like a regular debit card but are used only for payroll deposits. Acumen does not charge for this option, although the card provider may charge fees for certain transactions. Pay cards are up to 80% less expensive to use than check cashing services. Paystubs will be sent by email on payday. To enroll, complete the Authorization for Pay Card section of the form and return it to Acumen. Money Network will send you an information kit. You will need to activate the card with Money Network and then contact Acumen with your account information. You will receive paper checks by mail until this process is complete. For a complete fee schedule, see: https://docs.moneynetwork.com/moneynetwork/prepaid-fees.html

Please return the completed form to Acumen. You may send by email, fax, or mail listed below:

Email: enrollment-tx@acumen2.net
Fax: (855) 264 - 3287
Mail: 1130 E. Arapaho Rd., Suite 525, Richardson, TX 75081

Note: if you do not select one of the options, Acumen will send your paycheck via regular mail, according to the established pay schedule you have received. We make every effort to get your check to you by payday; however, it is impossible to guarantee the date that paper checks will arrive. Acumen is not responsible for any delays or misdirected mail after checks have been submitted to the U.S. Postal Service. If your paper check does not arrive within 5 business days of payday, you can call Acumen to issue a stop payment and have a new check issued. A processing fee of $35.00 will be deducted from the new check for each stop payment request. This fee may be waived by signing up for direct deposit or pay card.

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

Check ☐ Direct Deposit ☐ Pay Card ☐

DIRECT DEPOSIT INFORMATION

Please attach a voided check or **bank letter** for checking or savings account(s). For savings accounts, please send a printout from your bank that provides the routing number and account information. Submit any changes to your account(s) immediately!

Primary Account 1 Account Type: ☐ **Checking** (attach a voided check) ☐ **Savings** (attach routing & account information printout)	**Secondary Account 2 (Mandatory for Flat dollar option)** Account Type: ☐ **Checking** (attach a voided check) ☐ **Savings** (attach routing & account information printout)
☐ **Flat Dollar Amount** ☐ **Percentage**	☐ **Remainder account.** (Used if percentage is less than 100% or net pay exceeds the flat dollar amount listed for Primary Account 1)
Financial Institution Name	Financial Institution Name
Financial Institution Address	Financial Institution Address
Routing Number	Routing Number
Account Number	Account Number
Flat dollar **amount or %** of check to be deposited:	All remaining funds exceeding Primary Account 1 allocations will deposit into this account.

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

AUTHORIZATION FOR DIRECT DEPOSIT or PAY CARD or PAPER CHECK

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. If I selected Paper Check, I understand that Acumen will make every effort to ensure my check will arrive by payday; however, it is impossible to guarantee the date that my paper check will arrive. Acumen is not responsible for any delays or misdirected mail after checks have been submitted to the U.S. Postal Service. If my paper check does not arrive within 5 business days of payday, I can call Acumen to issue a stop payment and have a new check issued. I understand that if I request a stop payment, a processing for of $35.00 will be deducted from my new check. If I require that this fee be waived, I must sign up for either direct deposit or a Pay Card. I understand that the Money Network pay card will have fees for transactions, and that I will be responsible for these fees if I choose this option. I understand that I may elect to have direct deposit to an existing pay card that is already in my name, as long as I provide supporting documentation to verify the routing & account number and name on the account. I understand that Acumen is not liable for any pay card fraudulent activity related to third party transactions. I understand that upon my request, Acumen may attempt a payment reversal. However, if the reversal is not successful, I understand that Acumen is not responsible and I will need to work with my institution to rectify said payment.

_____	_____	_____
Print Name	Social Security Number	Date of Birth
_____	_____	_____
Email Address	Signature	Date

Return completed form by email enrollment@acumen2.net, fax (866) 862-6862 or mail to 5416 E. Baseline Rd., Ste. 200, Mesa, AZ 85206

Acumen Fiscal Agent
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Employee/Employer Relationship Disclosure for Tax Exemptions

Based on Age, Student Status, and Family Relationship

Employee Name _____ Employee SSN _____

Employer Name _____

Participant Name _____

Employees providing domestic services, such as respite or nursing, may be exempt from paying certain federal and state taxes based on the employee's age, student status, or family relationship to the employer. In some cases, the employer may also be exempt based on the employee's status. If you and your employer qualify for these exemptions, **you must take them**. Acumen Fiscal Agent will determine the tax exemptions that apply to you and to your employer based upon your answers below. Please answer all the following questions based on your age, student status, and relationship to the employer.

Relationship Questionnaire
1. Are you a non-resident alien temporarily in the United States on an F-1, J-1, M-1, or Q-1 visa admitted to the US for providing domestic services? ☐ **YES**, that description fits my visa status. ☐ **NO**, that description does not fit my visa status.
2. Are you the child of the employer (includes adopted children)? ☐ **YES**, my employer is my parent (mother or father). ☐ **NO**, my employer is not my parent.
3. Are you the spouse of the employer? ☐ **YES**, my employer is my spouse (husband, wife domestic partner, or other in footnote #3). ☐ **NO**, my employer is not my spouse.
4. Are you the parent of the employer (includes adopted children)? ☐ **YES**, my employer is my child (son or daughter). ☐ **NO**, my employer is not my child.
5. If you answered, "YES," to Question 4, check any of the following that apply. ☐ **YES**, I also provide care for my grandchild or step-grandchild in my child's home. ☐ **YES**, my grandchild or step-grandchild is under 18, or has a physical or mental condition that requires personal care of an adult for at least four weeks in a row during the calendar quarter in which services are performed. ☐ **YES**, my child (son or daughter) is widowed, divorced, not remarried, or living with a spouse who has a mental or physical condition so the spouse cannot care for my grandchild for at least four weeks in a row during the calendar quarter in which services are performed. ☐ **NO**, none of the above apply.
6. Are you under the age of 18 or do you turn 18 before December 31? ☐ **YES**, I am under 18 or am turning 18 **before December 31** ☐ **NO**, I am over 18. *If you answered, "**YES**," to Question 6, answer the following question. If you answered, "**NO**," skip the question below.* **Is this job of performing household services (respite) your principal occupation?** **NOTE: Do not answer, "YES," if you are a student.** ☐ **YES,** this is my main job. ☐ **NO,** this is not my main job.

IMPORTANT: You must notify Acumen Fiscal Agent if your status changes.

Employee Signature _____ Date _____

Employee/Employer Relationship Disclosure for Tax Exemptions

Employee Copy – Keep for your records

Employees providing domestic services such as personal assistance may be exempt from paying certain federal and state taxes based on the employee's age, student status or family relationship to the employer. In some cases, the employer may also be exempt from paying certain taxes based on the employee's status.

IMPORTANT: Please see IRS Publication: #926 – Household Employer's Tax Guide, and IRS website article: "Foreign Student Liability for Social Security and Medicare Taxes" for additional information.

IMPORTANT:

- **These exemptions are not optional.** If the employee and employer qualify for these tax exemptions, they must be taken.
- If the employee's earnings are exempt from these taxes, the employee may not qualify for the related benefits, such as retirement benefits and unemployment compensation.
- The questions regarding family relationship refer to the relationship between the employee and the employer of record (common law employer). In some cases, the program participant is the employer of record. In other cases, the employer of record may be someone other than the program participant. Check program rules.
- Program rules may prohibit some types of employees. For example, most Medicaid-funded programs do not permit a spouse to be paid as an employee for providing services to a spouse. Check program rules.
- Acumen Fiscal Agent LLC will determine the tax exemptions that apply to the employee and employer based on the information provided by the employee. Acumen Fiscal Agent LLC cannot provide tax advice.

Question #1: Tax Exemptions for Non-Resident Students

For a non-resident student in the United States on an F-1, J-1, M-1, or Q-1 visa admitted to the US for the purpose of providing domestic services, the employer and employee are exempt from paying FICA (Social Security and Medicare taxes) and the employer is exempt from paying FUTA (Federal Unemployment Tax) on wages paid to this employee. The employer may also be exempt from paying State Unemployment Insurance, depending on the rules in the state. See footnote #1.

Question #2: Tax Exemptions for Children under 21 years old Employed by Parent

For a child (**does not include step-child.**) under 21 employed by his or her parent, the employer and employee are exempt from paying FICA (Social Security and Medicare taxes) and the employer is exempt from paying FUTA (Federal Unemployment Tax) on wages paid to this employee until the child (employee) turns 21 years of age. The employer may also be exempt from paying State Unemployment Insurance, depending on the rules in the state. See footnote #2.

Question #3: Tax Exemptions for Spouses Employed Spouses

For a spouse (husband, wife, or domestic partner in some states) employed by his or her spouse, the employer and employee are exempt from paying FICA (Social Security and Medicare taxes) and the employer is exempt from paying FUTA (Federal Unemployment Tax) on wages paid to this employee. The employer may also be exempt from paying State Unemployment Insurance, depending on the rules in the state. See footnote #3.

Question #4 & #5: Tax Exemptions for Parents Employed by Children

For a parent (**does not include stepparent,)** employed by his or her child and answering "No" to any of the additional questions under Question #5 regarding caring for a grandchild or step grandchild, the employer and employee are exempt from paying FICA (Social Security and Medicare taxes) and the employer is exempt from paying FUTA (Federal Unemployment Tax) on wages paid to this employee. The employer may also be exempt from paying State Unemployment Insurance, depending on the rules in the state.

For a parent (**does not include stepparent.)** employed by his or her child and answering "Yes" to all the additional questions under Question #5 regarding caring for a grandchild or step grandchild, the employer is exempt from paying Federal Unemployment Tax (FUTA) on wages paid to this employee. The employer may also be exempt from paying State Unemployment Insurance, depending on the rules in the state. See footnote #4

For Question #5, the term calendar quarter means January-March, April-June, July-September, October-December

Question #6: Tax Exemptions for Employee under Age 18 at any point during the calendar year

For employees under the age of 18 or turning 18 in the calendar year: If the employee is a student, domestic services are deemed not to be the employee's principal occupation and the employer and employee are exempt from paying FICA (Social Security and Medicare taxes).

Employment Relationship Status	Federal Insurance Contributions Act - Social Security and Medicare Taxes (FICA)	Federal Unemployment Tax Act (FUTA)	State Unemployment Insurance (SUTA)
Foreign Student on VISA in US for Purpose of Providing Domestic Service	FICA exempt	FUTA exempt	See footnote #1
Child (does not include stepchild) while employers by Parent	FICA exempt only until 21st birthday	FUTA exempt only until 21st birthday	See footnote #2
Spouse Employed by Spouse	FICA exempt	FUTA exempt	SUTA exempt. See footnote #3
Parent (does not include stepparent) Employed by Child	FICA Exempt only if not also caring for dependent child (including stepchild) of the employer (employee's grandchild)	FUTA exempt	SUTA exempt except in NY and WA, See footnote #4
Employee Under 18 or Turning Age 18 in the Calendar Year	FICA exempt through year of 18th birthday only if enrolled as a full-time student	Not Applicable	Not Applicable

FOOTNOTES:

(1) A foreign student in the United States on an F-1 or J-1 visa is exempt from SUTA in PA and WA. MT and WI exempt F-1, J-1, M-1, and Q-1 visas from SUTA tax.

(2) A child under age 18 employed by his or her parent is exempt from SUTA in the following states: CA, IL, MA, ME, MN, NJ, NV, OH, OR, PA, SC, TN, WA, WV. A child under age 21 employed by his or her parent is exempt from SUTA in the following states: AL, AZ, GA, HI, ID, IN, KS, LA, MO, NC, NY, OK, TX, UT, VA, WY and the District of Columbia. GA defines a child as "natural, legally adopted, step, and foster except that foster must be living in the same home as the employer." MO and WY define a child as "natural, legally adopted, foster, and step." MT exempts anyone classified as a dependent

(3) AL exempts common law marriages created prior to 1/1/2017.
CA, NV, and WA exempt a domestic partner employed by his or her domestic partner.
GA exempts common law marriages created prior to 1/1/1997.
HI exempts reciprocal beneficiary relationships and civil unions.
ID exempts common law marriages created prior to 1/1/1996.
IN exempts common law marriages created before 1/1/1958.
KS, MT, and TX exempt all common law marriages.
NJ exempts civil unions.
OH exempts common law marriages created prior to 10/10/1991.
SC exempts common law marriages created prior to 07/24/2019.
All states recognize common law marriages created in a different state.

(4) A parent employed by his or her child is exempt from SUTA in the District of Columbia and all states except NY and WA. MO defines parents as natural, foster, or step."

Figure:1 TAC §55.303(c)(1)(B)

Texas Employer New Hire Reporting Form

Submit within20 calendar days of new employee's first day of work to: **ENHR Operations Center, P.O. Box 149224 Austin, TX 78714-9224 Phone: 1-800-850-6442 Fax: 1-800-732-5015 Online: www.employer.texasattorneygeneral.gov**	To ensure the highest level of accuracy, please print neatly in capital letters and avoid contact with the edges of the boxes. The following will serve as an example: A B C 1 2 3

Employer Information

1. Federal Employer ID Number (FEIN): (*Please use the same FEIN that appears on quarterly wage reports)* _____ Acumen will provide the FEIN
2. State Employer ID Number (Optional): _____
3. Employer Name:_____
4. Employer Address: *(Please indicate the address where the Income Withholding Orders should be sent)* _____
5. Employer City (if US): _____
6. State (if US): _____ 7. ZIP Code (if US): _____ - _____
8. Province/Region (if foreign): _____
9. Country (if foreign): _____ 10. Postal Code (if foreign): _____
11. Employer Telephone (Optional): _____ 12. Employer FAX (Optional): _____
13. New Hire Contact Person (Optional): _____

Employee Information

14. Social Security Number (SSN): _____ 15. Date of Hire (MM/DD/YYYY): ___/___/____
16. Employee First Name: _____ Acumen will complete the date of hire
17. Employee Middle Name: _____
18. Employee Last Name: _____
19. Employee Home Address: _____
20. Employer City (if US): _____
21. State (if US): _____ 22. ZIP Code (if US): _____ - _____
23. Province/Region (if foreign): _____
24. Country (if foreign): _____ 25. Postal Code (if foreign): _____
26. State Where Employee Was Hired (Optional): _____
27. Employee DOB (MM/DD/YYYY) (Optional): ___/___/____
28. Employee's Salary (Dollars and Cents) (Optional): $_____
29. Salary Frequency (Check One ONLY) (Optional):

☐ Hourly ☐ Weekly ☐ Biweekly ☐ Semi-Monthly ☐ Monthly ☐ Annually

INSTRUCTIONS FOR COMPLETING THE TEXAS EMPLOYER NEW HIRE REPORTING FORM

The purpose of the Texas New Hire Reporting Form is to allow employers to fulfill new hire reporting requirements. You may enter your employer information and photocopy a supply and then enter employee information on the copies.

REPORTING OF NEW HIRES IS REQUIRED:

All required items (numbers 1, 3, 4, 5, 6, 7, 14, 15, 16, 17, 18, 19, 20, 21, 22) on this form must be completed.

Box 1: Federal Employer ID Number (FEIN). Provide the 9-digit employer identification number that the federal government assigns to the employer. This is the same number used for federal tax reporting. Please use the same FEIN that appears on quarterly wage reports.

Box 2: State Employer ID Number (Optional). Identification number assigned to the employer by the Texas Workforce Commission.

Box 3: Employer Name. The employer name as listed on the employee's W4 form. Please do not provide more than one employer name (for example, "ABC, Inc DBA. John Doe Paint and Body Shop" is not correct).

Box 4: Employer Address. Please indicate the address where the Income Withholding Orders should be sent. Do not provide more than one address (for example, P.O. Box 123, 1313 Mockingbird Lane is not correct).

Box 8: Employer Province/Region (if foreign). Provide this information if the employer address is not in the United States.

Box 9: Employer Country (if foreign). Provide the two letter country abbreviation if the employer address is not in the United States.

Box 10: Postal Code (if foreign). Provide the postal code if the employer address is not in the United States.

Box 13: New Hire Contact Person (Optional). Providing the name of a contact staff person will facilitate communication between the employer and the Texas Employer New Hire Reporting Program.

Box 15: Date of Hire. List the date in month, day and year order. Use four digits for the year (for example, 2001). <u>This should be the first day that services are performed for wages by an individual. If you are reporting a rehire (where a new W-4 is prepared) use the return date, not the original date of hire.</u>

Box 23: Employee Province/Region (if foreign). Provide this information if the employee does not reside in the United States.

Box 24: Employee Country (if foreign). Provide the two letter country abbreviation if the employee address is not in the United States.

Box 25: Postal Code (if foreign). Provide the postal code if the employee address is not in the United States.

Box 26: State Where Employee was Hired. Use the abbreviation recognized by the U.S. Postal Service for the state in which the employee was hired.

Box 27: Employee DOB (Date of Birth) (Optional). List the date in month, day and year order. Use four digits for the year (for example,1985).

Box 28: Employee Salary (Optional). Enter employee's exact wages in dollars and cents. This should correspond to the salary pay frequency indicated in Box 29.

Box 29: Salary (Check One ONLY) (Optional). Check the appropriate box relating to the employee's salary pay frequency. Check " Bi- weekly" if the salary is based on 26 pay periods. Check "Semi-monthly" if the salary is based on 24 pay periods. Check "Annually" if salary payment is a one-time distribution.

SUBMISSION OF NEW HIRE REPORTS. The Texas Employer New Hire Reporting Program offers a variety of methods that employers can use to submit new hire reports. For further information on which method may be best for you, call 1-800-850-6442. Employers are encouraged to keep photocopies or electronic records of all reports submitted. When the form is completed, send it to the Texas Employer New Hire Reporting Program using one of the following means:

- **FAX:** 1-800-732-5015
- **U.S. Mail:** **ENHR Operations Center**
  P.O. Box 149224
  Austin, TX 78714-9224
- **Telephone Submissions:** 1-800-850-6442
- **Internet Submissions:** **www.employer.texasattorneygeneral.gov**

Employers must provide all of the required information within 20 calendar days of the employee's first day of work to be in compliance. State law provides a penalty of $25 for each employee an employer knowingly fails to report, and a penalty of $500 for conspiring with an employee to 1) fail to file a report or 2) submit a false or incomplete report.

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	Today's Date (mm/dd/yyyy)
EMPLOYEE SIGNATURE	08/05/2023

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 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.

SAMPLE

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

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

Required field even if "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		

SAMPLE

TEXAS Health and Human Services

Form 1724
August 2015-E

Consumer Directed Services

New Employee Packet Cover Sheet

Name of Individual Receiving Services	Employer Name
Cassie Client	Elaine Employer
Employee Name	
Emily Employee	
Date of Hire	First Day of Work
06/23/2017	07/01/2017

Employer	Agency	FMSA	Document Description / Form Information
Before Hire: (1) Original or Copy for Employer's Personnel Files and (2) Original or Copy to FMSA			
☑	HHSC	☑	**HHSC Form 1725,** Criminal Conviction History and Registry Checks
☑	HHSC	☑	**HHSC Form 1729,** Applicant Verification for Employees; **HHSC Form 1734,** Service Provider and Employer Certification of Relationship Status for CDS
☑	USCIS	☑	**USCIS Form I-9,** Employment Eligibility Verification
☑	HHSC	☑	**HHSC Form 1728,** Liability Acknowledgement
☑	HHSC	☑	**Professional license verification** (nursing, professional therapies)
At Time of Hire: (1) Original or Copy for Employer's Personnel Files and (2) Original or Copy to FMSA			
☑	IRS	☑	**IRS Form W-4,** Employee's Withholding Allowance Certificate — Due before first payroll check is calculated; provide to the Financial Management Services Agency (FMSA) on date of hire.
☑	OAG	☑	**Texas Employer New Hiring Reporting Form** (www.employer.texasattorneygeneral.gov)
☑	HHSC	☑	**HHSC Form 1730,** Wage and Benefits Plan Employee Compensation, and any court-ordered garnishment(s); **HHSC Form 1731,** Employee Work Schedule and Assigned Tasks; **HHSC Form 1737,** Employer and Employee Service Agreement; **HHSC Form 1739,** Service Provider Agreement
☑	HHSC	☑	***CLASS, DBMD and MDCP only:* Cardiopulmonary resuscitation (CPR) certification** — Effective at time of service delivery initiation, and maintained. *Verify again before expiration date.*
☑	HHSC	■	**Texas Department of Public Safety driver's license** (if transporting client) — *Verify again before expiration date.*
☑	HHSC	■	**Proof of minimum auto insurance** (if transporting client)
☑	CDC OSHA	■	**HHSC Form 1727,** Occupational Exposure to Bloodborne Pathogens (Acknowledgement: Hepatitis B Vaccination and Universal Precautions)
☑	TWCC	■	**Notice to Employees Concerning Workers' Compensation in Texas** (TWC Notice 5)
☑	HHSC	☑	***If hiring a nurse:* HHSC Form 1747,** Acknowledgment of Nursing Requirements
☑	CDS HHSC	☑	***If applicable:* HHSC Form 1733,** Employer and Employee Acknowledgement of Exemption from Nursing Licensure for Certain Services Delivered through Consumer Directed Services
☑	HHSC	☑	**HHSC Form 1732,** Management and Training of Service Provider — Initial training must be conducted within 30 days of hire.
Ongoing: (1) Original or Copy for Employer's Personnel Files and (2) Original or Copy to FMSA			
☑	HHSC	☑	**HHSC Form 1732,** Management and Training of Service Provider — Evaluation, employment status changes, documentation of training, documentation of conflict and job performance issues. (The employer must send the original or a copy to the FMSA within 30 calendar days of an initial orientation or annual evaluation and when an action affects the service provider's continued status with the employer, e.g., termination, change in payment.)
☑	HHSC	■	**HHSC Form 1732-EMR,** Management and Training of Service Provider Addendum — Must be signed by the employee within five days of hire.
☑	HHSC	☑	**Time sheets/service logs** — **HHSC Form 1745,** Service Delivery Log with Written Narrative/Written Summary, **or** facsimile approved by the FMSA
☐	Vendors	☐	**Receipts and invoices**

Code	Action
☑	Employer checks off each item for the **personnel file** and retains original or copy.
☑	Employer checks each required item when completed and sends original or copy to the FMSA as indicated. Employer retains original or copy.
■	Items the employer is **not** required to send to the FMSA, but which the employer **must** maintain on file in the employee's **personnel file**.

Code	Agency
CDC	Centers for Disease Control and Prevention
CDS	Consumer Directed Services
HHSC	Texas Health and Human Services Commission
IRS	Internal Revenue Service
OAG	Office of the Attorney General, State of Texas
OSHA	Occupational Safety and Health Administration
TWCC	Texas Workers' Compensation Commission
USCIS	U.S. Citizenship and Immigration Services (formerly known as the **INS**, Immigration and Naturalization Services)

SAMPLE

TEXAS Health and Human Services

Form 1725
March 2023

Consumer Directed Services

Criminal Conviction History and Registry Checks

The applicant is a person under consideration for hire as a service provider in the CDS option (employee or independent contractor [when required]). This form covers only criminal history conviction history and registry checks.

Note: An applicant may not be hired by the CDS employer, and must not start providing services for payment, until and unless the required criminal history and registry checks are conducted, in addition to other employee qualification checks. The CDS employer and Financial Management Services Agency (FMSA) review the results of all required qualification checks to determine that an applicant can be hired. This form is signed by the FMSA.

Section I - Applicant Authorization and Acknowledgment (Applicant must complete this section.)

I, (applicant's printed name) Emily Employee, give my permission to check for a criminal conviction history, to check the required registries annually, and to check the state and federal lists of people and entities excluded from participation in Medicaid (LEIE) monthly as part of my application as a service provider through the Consumer Directed Services (CDS) option. I also understand that a criminal conviction or a registry listing that prohibits a person from employment in a health care setting in the state of Texas may prohibit my employment.

I understand I may not begin delivering services until the FMSA and Employer confirm that I meet all qualifications to be hired.

Applicant Information Required by the Texas Department of Public Safety (DPS) (Applicant must complete this section.)

Individual's Name (Last, First, Middle)	Alias	Maiden Name
Employee, Emile E	N/A	N/A

Date of Birth (mm/dd/yyyy)	Social Security No.
01/01/1980	555-55-5555

Signature - Applicant: _____ Date: 04/04/2023

SAMPLE

Section II - Criminal Conviction History Check and Registry Verification Process (Employer must complete this section.)

Individual's Name	Employer Name
Cassie Client	Elaine Employer

Criminal Conviction History Check (Check each box to certify agreement):

- [x] I request that my FMSA obtain a **current** Criminal Conviction History Check of the applicant from DPS. I authorize the FMSA to be reimbursed for the cost of obtaining the DPS Criminal Conviction History Check and if I request the report, the cost of sending the report from my budgeted funds.
- [x] I understand that if I request the report, the FMSA must send it to me through a secure method, DPS approved encrypted software or certified mail.
- [x] I understand that all criminal records and reports obtained by my FMSA, and the information they contain, are confidential information.
- [x] I understand all DPS criminal history information reports must be destroyed five days after I make the hiring decision. Paper records need to be shredded, pulped or burned. For electronic records, destroying the media or using specialized software to copy over the data are acceptable methods.
- [x] I understand that sharing of criminal history information with any person or agency may be prosecuted as a Class A Misdemeanor.
- [x] I understand I may not allow the applicant to begin delivering services until the FMSA and I confirm the applicant meets all qualifications to be hired.

Signature - Employer: _____ Date: 04/04/2023

Registry Check

- [x] I request that my FMSA obtain the applicant's status with the Employee Misconduct Registry and the Nurse Aide Registry initially and annually.
- [x] I understand that the FMSA will screen the applicant initially and monthly using both the state and federal lists of excluded individuals and entities (LEIE).
- [x] I also understand that the applicant cannot provide services and cannot be paid with program funds until the criminal history and registry checks are completed and my FMSA has notified me that the applicant meets the qualifications.

Signature - Employer: _____ Date: 04/04/2023

I request that the FMSA provide the criminal history to me:

- [x] Verbally
- [ ] Encrypted email
- [ ] Certified mail

04/03/2023
Date of Employer Request

Section III - Criminal Conviction History and Registry Check Results (FMSA must complete this section.)

DPS Criminal Conviction Criminal History Check

Date FMSA received Form 1725 with employer selection for criminal history results:
04/04/2023

Date of DPS Check	Time (specify a.m. or p.m.)
04/04/2023	10:00 a.m.
Obtained By Alice Acumen	Convictions: [ ] **Yes** [x] **No**

DPS approved dissemination method used to inform employer of results:

- [x] Verbally
- [ ] Encrypted email
- [ ] Certified mail
- [ ] Did not specify method

Date FMSA staff notified employer: 04/04/2023

FMSA staff:

If yes, does the conviction(s) prohibit service delivery in compliance with Health and Safety Code Chapter 250, Section 250.006(a), or Section 250.006(b)? [ ] Yes [x] No

Within five calendar days after the hiring decision, the FMSA must destroy the criminal history record information obtained from DPS whether or not hired or retained by the employer or designated representative.

Date report was destroyed: 04/05/2023

Date employer notified FMSA of hiring decision: 04/04/2023

SAMPLE

Registry Checks (Conduct search at emr.dads.state.tx.us/DadsEMRWeb/)

Date of Registry Checks	Time (specify a.m. or p.m.)	Obtained By	
04/04/2023	10:30 a.m.	Alice Acumen	[ ] Employer [x] FMSA Representative

Employee Misconduct Registry:	[x] No Record	[ ] Record (must not be hired or retained)
Nurse Aide Registry:	[x] No Record	[ ] Record (must not be hired or retained)
Medicaid Exclusion List:	[x] No Record	[ ] Record (must not be hired)

Certification - I acknowledge that the applicant's DPS criminal conviction history and registry record were checked.

The applicant [x] **is** [ ] **is not** eligible for hire, to be retained for service delivery based on the checks above.

Signature - FMSA Representative

Date FMSA notified the employer or Designated Representative

FMSA and Employer Must Each Keep Original or Copy of This Form

Consumer Directed Services

Occupational Exposure to Bloodborne Pathogens

Universal Precautions

Blood has long been recognized as a potential source of pathogenic microorganisms that may present a risk to individuals who are exposed during the performance of their duties. Universal precautions is the method of control required by the Occupational Safety and Health Administration (OSHA) to protect employees from exposure to all human blood and body fluids. **Universal precautions** refers to a concept of bloodborne disease control, which requires that all human blood and certain human body fluids be treated as if known to be infectious for HIV (the virus that causes AIDS), the Hepatitis B virus and other bloodborne pathogens.

Protective barriers reduce the risk of exposure to blood, body fluids containing visible blood and other fluids to which universal precautions apply. Examples of protective barriers include gloves, gowns, masks and protective eyewear. Universal precautions are intended to supplement rather than replace recommendations for routine infection control, such as hand-washing and using gloves to prevent gross microbial contamination of hands. Universal precautions will be used during the provision of services as applicable and appropriate.

Employee Initials: EE Date: 06/23/2017

Hepatitis B

Hepatitis B is a serious infection involving the liver. Hepatitis B virus (HBV) can cause lifelong infection, cirrhosis (scarring) of the liver, liver cancer, liver failure and death. Hepatitis B is spread when blood or body fluids from an infected person enters the body of a person who is not infected. HBV is a major infectious occupational hazard for health care. Any health-care worker may be at risk for HBV exposure depending on the tasks that he or she performs. Workers should be vaccinated if their tasks involve contact with blood or blood-contaminated body fluids.

SAMPLE

Employee Initials: EE Date: 06/23/2017

Hepatitis B Vaccination

OSHA standards effective June 4, 1992, require that employers make available the Hepatitis B vaccine and vaccination series to all employees who have occupational exposure. The Hepatitis B vaccine is available at no cost to the employee. The cost to provide vaccinations is an administrative expense to the employer and is reimbursable through the individuals's program budget.

The vaccine is administered in a prescribed series of three injections over a six-month period:

Dose 2 is administered 30 days after Dose 1.

Dose 3 is administered five months following Dose 2.

The employee is responsible for requesting from the healthcare provider administering the vaccination additional information specific to the efficiency, safety, benefits, method of administration and potential side effects of the Hepatitis B vaccination.

The employee may elect to **receive** or **decline** the Hepatitis B vaccination.

Employee Initials: EE Date: 06/23/2017

Informed Choice Related to Hepatitis B Vaccination

Employee Statement – Check one statement below.

☐ I **agree** to receive the Hepatitis B vaccination and will be reimbursed by my employer within 30 days of presenting a paid receipt for each dose. I understand that I will only be reimbursed for doses received while employed by the employer.

☐ I **agree** to receive the Hepatitis B vaccination and the employer and I have agreed to the following arrangement(s) related to covering the cost of the vaccination:

☐ I **decline** the Hepatitis B vaccination at this time because I have previously received the Hepatitis B vaccination.

☑ I **decline** the 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 Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine at this time. However, I decline the Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.**

Federal Register: 61 FR 5507, February 13, 1996
*OSHA 1910.1030 App A - *Mandatory Declination Statement*

SAMPLE

Certification by Employee

I, Emily Employee, the **employee**, acknowledge and certify that I have received information on occupational exposure to bloodborne pathogens, universal precautions, Hepatitis B and Hepatitis B vaccination. I have been provided the opportunity to ask questions and to seek additional information. I have made my choice (as documented above) related to the Hepatitis B vaccination based on informed choice.

* I may decide in the future to request and accept the vaccination at no charge to me.

Employee:	**Employer:**
Emily Employee	Elaine Employer
Printed Name	Printed Name
Signature	Signature
06/23/2017	06/23/2017
Date	Date

TEXAS Health and Human Services

Form 1728
October 2013-E

Consumer Directed Services

Liability Acknowledgement

Liability Acknowledgement Between the Employer and the Applicant for Employment

The individual receiving services or the individual's legally authorized representative (LAR) is the employer in the Consumer Directed Services (CDS) option.

The **employer** employs (hires, manages and terminates) employees. The **employer** is solely responsible and liable for any negligent acts or omissions by the employer; the employee; other employee(s) or service provider(s); the individual receiving services; or, if applicable, the employer's designated representative.

Employees or service providers are **not** employed or retained by the Texas Health and Human Services Commission (HHSC); any other state or federal governmental agency; or by the Financial Management Services Agency (FMSA).

As an applicant for employment through the CDS option, I acknowledge that I have read and that I understand the above information regarding the employer and employee liability.

	06/23/2017		06/23/2017
Signature – Employer (Must be signed by the employer)	Date	Signature – Applicant for Employment	Date

Liability Notice to Applicants for Employment

Section I:

The employer:

☐ **is** a subscriber of Texas Workers' Compensation through the Texas Department of Insurance, Division of Workers' Compensation.

☑ **is not** a subscriber of Texas Workers' Compensation through the Texas Department of Insurance, Division of Workers' Compensation. (Employer completes Section II below if this option applies.)

SAMPLE

Section II:

Employer indicates the correct option in this section if the employer **is not** a subscriber to Texas Workers' Compensation.

☑ I have made the following arrangement(s) for employee work-related injuries/illnesses:

- ☐ self-insurance;
- ☐ homeowner's personal liability insurance;
- ☐ renter's personal liability insurance;
- ☐ medical coverage insurance;
- ☐ risk pool insurance;
- ☑ other: Crum & Forsler

☐ I have **no** insurance or other protection against employee work-related injuries/illnesses for my employee(s).

Acknowledgement by Employer and Applicant for Employment

I acknowledge that I have read and that I understand the above information in Section I and in Section II.

Signature – Employer (Must be signed by the employer)	Date	Signature – Applicant for Employment	Date

TEXAS Health and Human Services

Form 1729
March 2023

Consumer Directed Services

Applicant Verification for Employees

Individual's Name	Employer Name
Cassie Client	Elaine Employer
Applicant Name	**Applicant Social Security No.**
Emily Employee	555-55-5555

The employer must verify the applicant meets each criterion. The employer must ensure the following forms or copies of documentation used to verify the criteria are valid and kept in the employee's personnel file. This form and supporting documentation **must** be sent to the Financial Management Services Agency (FMSA) for verification before the employer can hire the applicant.

Employment Qualifications

- [x] The applicant is at least 18.
- [x] The applicant is not disqualified based on a “Yes” response on Form 1734, Service Provider and Employer Certification of Relationship Status for CDS.
- [x] The applicant is not barred from employment based on the results of the Texas Department of Public Safety (DPS) criminal conviction history check, the Texas Health and Safety Code Chapter 250 registry checks, or the Medicaid exclusion list (Form 1725, Criminal Conviction History and Registry Checks).
- [x] The applicant has completed Form 1728, Liability Acknowledgement.
- [x] The applicant has read Notice Concerning Worker's Compensation in Texas (TWC Notice 5).
- [x] The applicant has current cardiopulmonary resuscitation (CPR) and first aid certification for Medically Dependent Children Program (MDCP) flexible family support and respite services.
- [ ] The applicant has current hands-on CPR, first aid and choking prevention certification, if providing services in the Deaf Blind with Multiple Disabilities (DBMD) Program.
- [ ] The applicant has the following educational qualifications, if providing services for DBMD, Home and Community-based Services (HCS), MDCP, Texas Home Living (TxHmL) or Community First Choice (CFC):
  - has a high school diploma or a certificate recognized by a state as the equivalent of a high school diploma; or
    - documentation of a proficiency evaluation of the employee's experience and competence to perform job tasks, including an ability to provide the services needed by the individual, as demonstrated through a written competency-based assessment; and
    - at least three personal references from people not related by blood that evidence the person's ability to provide a safe and healthy environment for the individual.
- [ ] The applicant has the following qualifications, if providing services for DBMD:
  - is fluent in the communication methods used by the individual (for example, American Sign Language, tactile symbols, communication boards, pictures and gestures) or has the ability to become fluent in the communication methods used by the individual within three months after beginning to work with the individual.

FMSA Certification

The applicant [x] **does** [ ] **does not** meet qualifications for employment.

Only applicants who meet all qualifications may be employed.

Acknowledgement

The applicant and employer acknowledge that the applicant meets the qualifications for employment and that a copy of this form must be submitted to the FMSA. The FMSA must verify the applicant’s qualifications before the employer offers employment to the applicant.

Signature — Employer	Date	Signature — FMSA	Date
	04/04/2023		04/04/2023

SAMPLE

TEXAS Health and Human Services

Form 1730
October 2013-E

Consumer Directed Services

Wage and Benefits Plan
Employee Compensation

Employee Name (Last, First, Middle Initial)	Social Security No.
EMMA EMPLOYEE	321-45-6789
Individual's Name	**Employers Name**
CASSIE CLIENT	ELAINE EMPLOYER

Date of Hire	First Date of Work	☐ Initial Wage and Benefit Plan ☑ Plan Change – Effective Date: 01/01/01
01/01/01	01/01/01	

Program:
☑ CLASS ☐ DBMD ☐ HCS ☐ TxHmL ☐ PHC ☐ PCS ☐ STAR Kids/MDCP ☐ STAR+PLUS

Compensation:

Service 1:	Wage:	Service 2:	Wage:	Service 3:	Wage:
PASHAB	$ 8.00	RESPITE	$ 8.00	TRANSPORTATION	$ 8.00

Benefits: ***Optional***

☐ **Hepatitis B Vaccination** (Attach completed Form 1727 if vaccination is requested by the employee.)

Employer: List other optional benefits here. (Attach additional sheet, if required.)

EMPLOYEE PERFORMANCE BONUS $150

SAMPLE

Withholdings:

☐ **W-4 Employee's Withholding Allowance Certificate** (Attach completed Form W-4.)

☐ **Required Garnishments**

Type:	Amount:
Frequency:	Payment To:

☐ **Voluntary Withholdings** (not related to W-4)

Type:	Amount:
Frequency:	Payment To:

☐ **Other** (specify): _____

Acknowledgement/Agreement:

Time Sheets/Service Delivery Logs must be completed accurately each work shift/day. Payment for services delivered is made from state and/or federal funds. Falsification of a time sheet is considered fraud and is punishable under the law. Accurate, signed time sheets are due every other Monday. Paych**ecks** are distributed by Check/Direct Deposit every other week according to posted payment schedule.

Employee and employer mutually agree to the compensation, benefits, withholdings and all information above and agree that any changes or revisions must be documented and provided to the employee, the employer and the Financial Management Services Agency.

Signature - Employer or Designated Representative	Date	Signature - Employee	Date
Elaine Employer (SIGN HERE)	01/01/01	Emma Employee (SIGN HERE)	01/01/01

TEXAS Health and Human Services

Form 1731
January 2007-E

Consumer Directed Services

Employee Work Schedule and Assigned Tasks

Employee Name:	Individual Receiving Services
EMMA EMPLOYEE	CASSIE CLIENT

Purpose of Form:
- [x] Initial
- [ ] Change

Activity Involved:
- [x] Tasks
- [ ] Schedule

Effective Date: 01/01/01

Schedule I VARIES

Day	Time In	Time Out	Time In	Time Out	Time In	Time Out	Total Hours
Sunday							
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							
						Weekly Total Hours	

Schedule I - Tasks

Check all that apply- refer to plan of care:

- [x] Assist w/medications
- [x] Bathing
- [x] Grooming
- [x] Toileting
- [x] Hygiene
- [x] Dressing
- [ ] Meal Preparation
- [x] Feeding, Eating
- [ ] Laundry
- [x] Transfer/Ambulation
- [x] Mobility
- [ ] Habilitation Training
- [ ] Approved Health Related Tasks
- [x] Other: Community Integration
- [ ] Other:

SAMPLE

Schedule II

Day	Time In	Time Out	Time In	Time Out	Time In	Time Out	Total Hours
Sunday							
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							
						Weekly Total Hours	

Schedule II - Tasks

Acknowledgment of Work Schedule and Assigned Tasks - Sign and Date:

Claire Employer — SIGN HERE — 01/01/01

Signature — Employer — Date

Emma Employee — SIGN HERE — 01/01/01

Signature — Employee — Date

TEXAS Health and Human Services

Form 1732
October 2015-E

Consumer Directed Services

Management and Training of Service Provider

Service Provider Name (Employee)	First Day of Work	Annual Evaluation Due Date
EMMA EMPLOYEE	01/01/01	01/01/02
Name of Individual Receiving Services	**Program**	**Services Delivered**
CASSIE CLIENT	CLASS	CFC PASHAB/RESPITE
Name of Consumer Directed Services Employer		
ELAINE EMPLOYER		

I. Purpose

☑ Initial Orientation ☐ Ongoing Training

☐ Evaluation

☐ 30-Day ☐ 3-Month ☐ 6-Month ☐ Annual ☐ Other _____

☐ Supervision

☐ Verbal Warning: ☐ First ☐ Second ☐ Third ☐ Other _____

☐ Written Warning: ☐ First ☐ Second ☐ Third ☐ Other _____

☐ Conflict Resolution ☐ Other _____

II. Documentation of Topics Covered at Initial Orientation or Ongoing Training: *(Initial orientation must include training related to the individual's condition and the tasks the service provider will perform as well as any required training described in an applicable addendum to Form 1735, Employer and Financial Management Services Agency Service Agreement.)*

EE Service Provider received orientation and training on individual's condition and all approved tasks to be performed.

EE Service Provider demonstrated understanding, knowledge, and competence in performing all approved tasks.

SAMPLE

III. Documentation of Abuse, Neglect and Exploitation Training: *(Initial orientation must include training on acts that constitute abuse, neglect or exploitation of an individual.)*

EE Service Provider trained on identifying acts that constitute abuse, neglect, and exploitation, signs of ANE and methods to prevent ANE.

EE Service Provider trained on how to report ANE and understands action will be taken if they are suspected/reported of committing ANE.

IV. Evaluation/Performance Review:

V. Corrective Action Plan (if applicable):

Date for follow-up on corrective action plan: _____

VI. Service Provider Comments:

EMMA EMPLOYEE SIGN — SIGN HERE

Signature of Service Provider — Date

This document has been reviewed with the service provider listed above.

ELAINE EMPLOYER'S SIGNATURE — SIGN HERE

Signature of Employer — Date — Signature of Witness — Date

Date sent to FMSA: _____ **Date received by FMSA:** _____

TEXAS Health and Human Services

Form 1732-EMR
October 2014-E

Consumer Directed Services (CDS)

Management and Training of Service Provider Addendum

Employee Misconduct Registry Notification

Employee Name: EMILY EMPLOYEE Date of Hire: 7/1/2017

Position: DIRECT CARE STAFF Employer Name: ELAINE EMPLOYER

Long-term care employers, including Consumer Directed Service (CDS) employers, in Texas are required under 40, Texas Administrative Code (TAC), Part 1, Chapter 93, and Texas Health and Safety Code, Chapter 253 and to inform new unlicensed employees about the Employee Misconduct Registry (EMR).

The purpose of the EMR is to ensure that an unlicensed person who commits an act of abuse, neglect, or exploitation that meets the definition of reportable conduct against a consumer receiving services from a facility or against an individual receiving services in the CDS option is not employed in the Texas Health and Human Services Commission (HHSC) regulated facilities and in certain programs including CDS. The EMR applies to employees who provide personal care services, treatment, or any other personal services and are not licensed by the state to perform the services.

A person listed in the EMR is not employable by a facility, agency, or individual employer. The EMR is governed by 40, Texas Administrative Code, Part 1, Chapter 93, and Texas Health and Safety Code, Chapter 253. Regarding a CDS employee, the Department of Family and Protective Services (DFPS) conducts EMR investigations and makes findings in accordance with DFPS rules at 40 TAC, Part 19, Chapter 711, Subchapter O.

Rules regarding the EMR can be found on the Secretary of State's website at:
http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=40&pt=19&ch=711&sch=O&rl=Y.

SAMPLE

Questions may be directed to HHSC Professional Credentialing Enforcement Unit at 512-438-5495.

The employer must provide the employee with a copy of this notice.

I, EMILY EMPLOYEE, have read and understand the above notification.

Signature

07/01/2017
Date

TEXAS Health and Human Services

Employer and Employee Acknowledgement of Exemption from Nursing Licensure for Certain Services Delivered through Consumer Directed Services

Form 1733
October 2013-E

The employer in the Consumer Directed Services (CDS) option is the individual receiving services or the individual's legally authorized representative (LAR). The employer may choose to have certain nursing services provided by an unlicensed person employed in the CDS option. The individual or the LAR must be capable of training the unlicensed employee in the performance of the task(s) and train and supervise the employee performing the task(s). The employee who delivers the service must not have been denied a license under Chapter 301, Occupations Code or have a license under Chapter 301, Occupations Code that is revoked or suspended.

When the employee is trained and supervised by the LAR, the employee delivers the service when the LAR is present or is immediately accessible to the employee. If the employee will perform the service when the LAR is not present, the LAR must observe the person performing the service at least once to assure the LAR that the employee performs the service correctly.

Government Code, Title 4, Subtitle I, Chapter 531, Subchapter B, §531.051, Consumer Direction for certain services for persons with disabilities, states the employee must not perform those service that are expressly prohibited from delegation by the **Texas Board of Nursing (Texas Administrative Code, *§225.12,Tasks Prohibited From Delegation), including:***

(1) physical, psychological, and social assessment, which requires professional nursing judgment, intervention, referral, or follow-up;

(2) formulation of the nursing care plan and evaluation of the client's response to the care rendered;

(3) specific tasks involved in the implementation of the care plan that require professional nursing judgment or intervention;

(4) the responsibility and accountability for client or client's responsible adult health teaching and health counseling which promotes client or client's responsible adult education and involves the client's responsible adult in accomplishing health goals; and

(5) the following tasks related to medication administration:

(A) calculation of any medication doses except for measuring a prescribed amount of liquid medication and breaking a tablet for administration, provided the RN has calculated the dose;

(B) administration of medications by an injectable route except for subcutaneous injectable insulin as permitted by §225.11(b) of this title (relating to Delegation of Administration of Medications From Pill Reminder Container and Administration of Insulin);

(C) administration of medications by way of a tube inserted in a cavity of the body except as permitted by §225.10(10) of this title (relating to Task That May Be Delegated);

(D) responsibility for receiving or requesting verbal or telephone orders from a physician, dentist, or podiatrist; and

(E) administration of the initial dose of a medication that has not been previously administered to the client.

Examples of services that may be exempt from nursing licensure and can be included in the Individual Service Plan for the CDS option if all the qualifying conditions are met include:

(1) bathing, including feminine hygiene;

(2) grooming, including nail care, except for consumers with medical conditions like diabetes;

(3) feeding, including feeding through a permanently placed feeding tube;

(4) routine skin care, including decubitus Stage 1;

(5) transferring, ambulation or positioning;

(6) exercising and range of motion; and digital stimulation;

(7) the administering of a bowel and bladder program, including suppositories, catheterization, enemas, manual evacuation and digital stimulation;

SAMPLE

(8) administering oral medications that are normally self-administered, including administration through a gastrostomy tube; and

(9) non-invasive and non-sterile treatments with low risk of infection.

Employee:

EMILY EMPLOYEE
Printed Name

Signature

07/01/2017
Date

Employer:

ELAINE EMPLOYER
Printed Name

Signature

07/01/2017
Date

Certification - We, the employee and the employer, certify that the employer has trained and supervised the employee in the delivery of the services listed below. We understand that those services that cannot be provided by anybody except a licensed nurse, according to Texas Administrative Code, §225.12, **Tasks Prohibited** From **Delegation**, must not be provided by the employee. Checked tasks indicate the employee may perform those tasks when the LAR is not present to supervise.

- [x] BATHING
- [x] FEEDING
- [x] GROOMING
- [x] ADMINISTER ORAL MEDS
- [x] PRN MEDS
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]

SAMPLE

Employee:

Signature

07/01/2017
Date

Employer:

Signature

07/01/2017
Date

TEXAS Health and Human Services

Form 1734
March 2023

Consumer Directed Services (CDS)

Service Provider and Employer Certification of Relationship Status for CDS

Section 1: Basic Information

Service Provider Applicant Name EMILY EMPLOYEE	Maiden Name — if applicable N/A
Applicant Street Address 111 MAIN ST APT 2	City, State and ZIP Code ANYTOWN, STATE 12345
Person Receiving Services CASSIE CLIENT	CDS Employer Name (if different than person receiving services) ELAINE EMPLOYER
Person Receiving Services Street Address 222 MAINE AVE	City, State and ZIP Code ANYTOWN, STATE 12345
Applicant's Relationship to Person Receiving Services NONE	Designated Representative (DR) — if applicable DONNA DESIGNATE
Applicant's Relationship to CDS Employer NONE	Applicant's Relationship to DR NONE

Service Provider Applicant: Place a check mark in the column that describes your status and relationship.

SAMPLE

Section 2: All Programs

The applicant must answer the following questions.

	Service Provider Status and Relationship	Yes	No	NA
1.	Are you under 18?	☐	☑	
2.	Are you the individual's legally authorized representative (LAR)? (That is, the individual's natural parent, legal or adopted parent, stepparent or managing conservator if the individual is under 18 [a minor], or the court-appointed guardian of an individual of any age.)	☐	☑	
3.	Are you the spouse* of the individual's LAR? (That is, the spouse of the individual's natural parent, legal or adopted parent, stepparent or managing conservator if the individual is under 18 [a minor], or the spouse of the court-appointed guardian of an individual of any age.)	☐	☑	
4.	Are you the spouse* of the individual? (Consumer Managed Personal Attendant Services (CMPAS) service providers mark this item Not Applicable (N/A).)**	☐	☑	☐
5.	Are you the spouse* of the employer? (CMPAS service providers mark this item NA.)**	☐	☑	☐
6.	If the individual is a Texas Department of Family and Protective Services (DFPS) foster child or adult, are you their foster parent? (If the individual is not a DFPS foster child or adult, mark this item NA.)	☐	☐	☑
7.	If the individual is a DFPS foster child or adult, are you the spouse* of the foster parent? (If the individual is not a DFPS foster child or adult, mark this item NA.)	☐	☐	☑
8.	Are you the power of attorney (attorney in fact or agent) for financial responsibilities on behalf of the individual?	☐	☑	
9.	Are you the DR or the CDS employer for the individual?	☐	☑	
10.	Are you the spouse* of the employer's DR?	☐	☑	

* **Spouse** is defined as either a legal marriage or a marriage without formalities (common law marriage) in accordance with the Texas Family Code.

** The spousal relationship in questions 4 and 5 is not applicable for CMPAS. (The spouse may be employed.)

Section 3: Medically Dependent Children Program (MDCP)

If providing services in the MDCP program, please answer the following additional questions. (Mark these items NA if the individual is not enrolled in MDCP.)

	Service Provider Status and Relationship	Yes	No	NA
1.	Are you the parent or primary caregiver of the individual?	☐	☐	☑
2.	Are you the spouse* of the parent or primary caregiver?	☐	☐	☑

Section 4: Home and Community-based Services (HCS) and Texas Home Living (TxHmL)

If providing Community First Choice Personal Assistance Services or Habilitation (CFC PAS/HAB), respite, adaptive aids or behavioral support services in the HCS or TxHmL program, please answer the following additional questions, as applicable. (Mark these items NA if the individual is not receiving an applicable HCS or TxHmL service.)

	Applicant Status and Relationship	Yes	No	NA
1.	Are you a person living in the same household as the individual? (Applies to CFC PAS/HAB and respite services.)	☐	☐	☑
2.	Are you a person related to the individual within the fourth degree of consanguinity or within the second degree of affinity? (Applies to adaptive aids and behavioral support services.)	☐	☐	☑

SAMPLE

Section 5: Community Living Assistance and Support Services (CLASS) — Respite Service Providers Only

If providing respite services in the CLASS program **and the primary caregiver is the CFC PAS/HAB applicant**, answer the following additional question. (Mark this item NA if the individual is not receiving CLASS respite services. Also mark this item NA if the individual is receiving CLASS respite services, but the primary caregiver is not the CFC PAS/HAB service provider.)

	Applicant Status and Relationship	Yes	No	NA
1.	Do you live in the same household as the individual?	☐	☐	☑

Section 6: Primary Home Care (PHC), Community Attendant Services (CAS) and Family Care (FC)

If providing PHC, CAS or FC, please answer the following additional questions. (Mark these items NA if the individual is not enrolled in PHC, CAS or FC.)

	Applicant Status and Relationship	Yes	No	NA
1.	Are you the primary caregiver for the individual?	☐	☐	☑
2.	Are you the spouse* of the primary caregiver for the individual?	☐	☐	☑

Employer and Service Provider Applicant Verification

If any item above is marked Yes, the applicant is not eligible to be a paid service provider (employee, contractor or vendor) in the CDS option for this individual.

If every item above is marked No or NA, the applicant meets relationship eligibility for employment in the CDS option for this individual, unless contraindicated by requirements of the individual's program. (NA only applies where indicated.) The employer and the applicant certify that the responses are accurate.

Employer confirmation and acknowledgement: As the CDS employer, I confirm that the information provided on this form is true and correct to the best of my knowledge. I understand that an applicant cannot be paid for providing services if they are not eligible for employment.

ELAINE EMPLOYER		04/04/2023
Printed Employer Name	Signature — Employer	Date

Applicant confirmation and acknowledgement: As the applicant, I confirm that the information provided on this form is true and correct to the best of my knowledge. I understand that I cannot be paid for providing services if I am not eligible for employment.

EMILY EMPLOYEE		04/04/2023
Printed Service Provider Applicant Name	Signature — Service Provider Applicant	Date

SAMPLE

TEXAS Health and Human Services

Form 1737
September 2013-E

Consumer Directed Services

Employer and Employee Service Agreement

The name of individual receiving services, hereafter referred to as the "**Individual**," is:

CASSIE CLIENT .

The Individual's program, CLASS , hereafter referred to as the "**program**," is funded and administered by the Texas Health and Human Services Commission (HHSC).

The name of the employer, hereafter referred to as "**Employer**" is: ELAINE EMPLOYER .

The Employer is the ☐ Individual, ☐ parent of a minor or ☒ court-appointed guardian of the Individual.

This agreement is between the Employer and EMILY EMPLOYEE hereafter referred to as "**Employee**."

The Employer Agrees:

1. **To give notice to the Employee as soon as possible of any change(s) in the work schedule, the tasks to be performed or the number of hours the Employee will work.**
2. To adhere to all federal, state, and local employment-related laws and regulations.
3. To assume responsibility for:
   a. liability for any negligent acts or omissions by the Employer, his/her Employee(s) and service provider(s), the Designated Representative (if applicable), the Individual or others in the work place; and
   b. managing the risk and liability of any incidence(s) of Employee work-related injury/injuries or illnesses.
4. To provide orientation and training to the Employee of tasks and activities to be performed.
5. To provide the Employee with written notice of compensation for services delivered.

The Employee Agrees:

SAMPLE

1. I, EMILY EMPLOYEE the Employee, am willing and able to perform the tasks as outlined by, and at the direction of, the Employer, the Individual or the Designated Representative, if applicable.
2. To provide information and documents to the Employer, as required, to maintain current, up-to-date personnel records. The information and documents include at least changes in address and/or telephone numbers, criminal convictions and evidence of employment status and qualifications.
3. To not use the personal property of the Employer or the Individual without prior approval. The Employee will reimburse the Employer for any expense incurred related to his/her personal use of the personal property.
4. To respect the rights and dignity of the Individual and to follow safety procedures for the benefit of the Individual and the Employee.
5. To notify the Employer as soon as possible when the Employee will be late for work or is not able to work, as well as not report to work when illness or another condition may jeopardize the health and safety of the Individual.

Both the Employer and the Employee Agree:

1. That this document serves as an agreement, not an employment contract.
2. That the Employer employs the Employee. The Employee is not an independent contractor. The Employer controls the training and management, evaluation and firing/termination of the Employee.
3. That the Employee is not barred by relationship to the Individual, Employer or Designated Representative, if applicable, from being an Employee.
4. That a Financial Management Services Agency (FMSA) is responsible for the administration of program funds on behalf of the Employer, including payroll functions.
5. That funds for services to pay the Employee is from public sources, and financial accountability and liability applies to the use of the funds. Both the Employer and the Employee have an individual and joint responsibility to be accountable for the public funds spent through the Consumer Directed Services (CDS) option and understand that submitting false or fraudulent time sheets, submitting a time sheet of an unqualified service provider, submitting a time sheet for tasks other than those approved on the service plan or implementation plan will be reported to the appropriate authorities for investigation and possible prosecution as Medicaid fraud.

6. To provide an accurate accounting of services delivered by the Employee, and to submit accurate time sheets and documentation for reimbursement to the FMSA.
7. To bill only for actual time worked, allowable benefits and CDS-related expenses (billing for services and items not allowed or budgeted results in non-payment by the FMSA).
8. The Employer must not charge any fee to the Employee. The Employee must not make any payment to the Employer related to the Employee's employment. Any corrections to payroll are made by the FMSA.
9. That neither the FMSA or HHSC is responsible or liable for any negligent acts, work-related injuries or omissions by the Employer, Individual, Employee, other Employees and service providers and/or the Designated Representative, if applicable.
10. That personal medical and personal information and data about the Individual and the Employee is confidential. This information is not to be discussed, directly or indirectly, with others outside of the work environment at any time, currently or in the future.

Duration and Modification of Service Agreement

1. This service agreement will be in effect as of the date this agreement is signed by the Employer and Employee. This service agreement must not precede the date the Individual is eligible to participate in the program or in CDS
2. This service agreement can be modified by agreement of both parties, unless prohibited by HHSC rules or policy, or by applicable state, federal and/or local regulations.
3. This service agreement will terminate when:
   a. the Individual's participation in CDS ends voluntarily or involuntarily;
   b. the individual is no longer eligible for the HHSC program or for CDS participation;
   c. the Employee is convicted of a crime or listed on a registry that forbids employment by law;
   d. a relationship change occurs and continued employment is prohibited; or
   e. the Employee fails to maintain and provide documentation of eligibility or qualifications for continued employment.

SAMPLE

4. This service agreement may be terminated, without cause, by either party with 14-calendar days written notice. A different time frame may be used if both parties agree in writing.

The following required documents are incorporated by reference:

Document	Date of Signature
HHSC Form 1725, Criminal Conviction History and Registry Checks	06/23/2017
HHSC Form 1729, Applicant Verification for Employees	06/23/2017
HHSC Form 1733, Employer and Employee Acknowledgement of Exemption from Nursing Licensure for Certain Services Delivered through Consumer Directed Services, if applicable	07/01/2017
HHSC Form 1734, Applicant and Employer Certification of Relationship for Employment	07/01/2017

Acknowledgement of service agreement, including documents incorporated by reference:

Employer:

ELAINE EMPLOYER
Printed Name

Signature

07/01/2017
Date

Employee:

EMILY EMPLOYEE
Printed Name

Signature

07/01/2017
Date

TEXAS Health and Human Services

Form 1739
October 2013-E

Consumer Directed Services

Service Provider Agreement

This agreement is between the **Texas Health and Human Services Commission** (HHSC), the state Medicaid agency; a **Financial Management Services Agency** (FMSA); and a **service provider** providing services to one or more individuals through the Consumer Directed Services (CDS) Option.

The **service provider,** HELPING HANDS SPEECH SERVICES ☐ an individual or

☒ an entity, located at (Address) 1234 MAIN STREET,

DALLAS, TX 75201; Telephone 555-123-4567 Fax 999-123-4567

The service provider agrees to:

- provide services, items or goods that are authorized prior to purchase to individuals in home and community support programs in accordance with program rules and policy;
- keep records of purchased services, items and goods in accordance with program rules and policy;
- accept checks from the FMSA as full and complete payment for authorized services, items or goods purchased for individuals served through home and community-based programs;
- neither impose on or accept from individuals any additional charges for the services, items or goods paid for by the check; and
- provide records and other information upon request to the individual, the FMSA, HHSC, or their representative.

The FMSA and HHSC agree:

- that the FMSA will pay the service provider for services, items or goods provided to the individual in accordance with this agreement and program rules and policy; and
- to allow the service provider to charge the individual for approved upgrades or purchases not authorized or paid for in accordance with this agreement, program rules and policy.

SAMPLE

The service provider, FMSA and HHSC mutually agree that:

- the FMSA ACUMEN FISCAL AGENT, doing business in ALLEN, TX, provides financial management services (FMS) to the individual receiving services for purchases from the service provider;
- the FMSA is responsible for acquiring the completed agreement and retaining the original on behalf of HHSC;
- payment from the FMSA will not be issued prior to the receipt of this agreement by the FMSA;
- payment from the FMSA is funded by HHSC with government funds; and
- the FMSA is not a Texas or federal government agency.

This agreement is effective 08/01/2017, and terminates when the service provider is no longer providing services to individuals through the FMSA.

BOB BOSS, OWNER		07/01/2017
Service Provider or Representative* (Print)	Service Provider or Representative* (Signature)	Date
ALICE ACUMEN		07/01/2017
FMSA Representative* (Print)	FMSA Representative* (Signature)	Date

** If the service provider is an entity, a representative from the entity with authorization to negotiate this agreement on behalf of the entity must sign.*

Figure:1 TAC §55.303(c)(1)(B)

Texas Employer New Hire Reporting Form

Submit within20 calendar days of new employee's first day of work to: **ENHR Operations Center, P.O. Box 149224 Austin, TX 78714-9224 Phone: 1-800-850-6442 Fax: 1-800-732-5015 Online: www.employer.texasattorneygeneral.gov**	To ensure the highest level of accuracy, please print neatly in capital letters and avoid contact with the edges of the boxes. The following will serve as an example: A B C 1 2 3

Employer Information

1. Federal Employer ID Number (FEIN): (*Please use the same FEIN that appears on quarterly wage reports)* _____ Acumen will provide the FEIN
2. State Employer ID Number (Optional): _____
3. Employer Name: Jane Doe
4. Employer Address: *(Please indicate the address where the Income Withholding Orders should be sent)* 123 Anywhere Ave.
5. Employer City (if US): Any Town
6. State (if US): TX 7. ZIP Code (if US): 77777 - 1234
8. Province/Region (if foreign): _____
9. Country (if foreign): _____ 10. Postal Code (if foreign): _____
11. Employer Telephone (Optional): 555-555-1234 12. Employer FAX (Optional): _____
13. New Hire Contact Person (Optional): _____

SAMPLE

Employee Information

14. Social Security Number (SSN): _____ 15. Date of Hire (MM/DD/YYYY): 01 /01 / 2018
16. Employee First Name: John Acumen will complete the date of hire
17. Employee Middle Name: K.
18. Employee Last Name: Doe
19. Employee Home Address: 456 Somewhere St.
20. Employer City (if US): Anytown
21. State (if US): TX 22. ZIP Code (if US): 7777 - 1234
23. Province/Region (if foreign): _____
24. Country (if foreign): _____ 25. Postal Code (if foreign): _____
26. State Where Employee Was Hired (Optional): _____
27. Employee DOB (MM/DD/YYYY) (Optional): ___/___/____
28. Employee's Salary (Dollars and Cents) (Optional): $_____
29. Salary Frequency (Check One ONLY) (Optional):

☐ Hourly ☐ Weekly ☐ Biweekly ☐ Semi-Monthly ☐ Monthly ☐ Annually

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

Check ☐ Direct Deposit ☑ Pay Card ☐

FOR DIRECT DEPOSIT

MUST include a voided check or bank letter for direct deposit. To avoid processing delays, please do not staple your voided check or bank letter to this form. For savings accounts, please send a printout from your bank that gives the routing number and account information. Send any changes to your account(s) right away!

Primary Account 1 Account Type: ☑ **Checking** (Include a voided check or bank letter) ☐ **Savings** (Include routing & account information printout)	**Secondary Account 2** (Mandatory for Flat dollar option) Account Type: ☐ **Checking** (Include a voided check or bank letter) ☑ **Savings** (Include routing & account information printout)
☐ **Flat Dollar Amount** ☑ **Percentage**	☑ **Remainder account.** (Used if percentage is less than 100% or net pay exceeds the flat dollar amount listed for Primary Account 1)
Flat dollar amount or % of check to be deposited: 75%	Financial Institution Name BANK TWO
Financial Institution Name BANK ONE	Financial Institution Address 789 OAK LANE CITY, STATE 12345
Financial Institution Address 456 OAK LANE, CITY, STATE 12345	Routing Number 4445556666
Routing Number 1112223333	Account Number 9876543210
Account Number 0123456789	All remaining funds exceeding Primary Account 1 allocations will be deposit into this account.

Is your name on the account(s) listed above? ☑ **Yes** ☐ **No**

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

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

Employee Signature

SAMPLE

AUTHORIZATION FOR DIRECT DEPOSIT, PAY CARD or PAPER CHECK

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 I selected Paper Check, I understand that Acumen will make every effort to ensure my check will arrive by payday; however, it is impossible to guarantee the date that my paper check will arrive. Acumen is not responsible for any delays or misdirected mail after checks have been submitted to the U.S. Postal Service. If my paper check does not arrive within 5 business days of payday, I can call Acumen to issue a stop payment and have a new check issued. I understand that if I request a stop payment, a processing for of $35.00 will be deducted from my new check. If I require that this fee be waived, I must sign up for direct deposit. I understand that the Money Network paycard will have fees for transactions, and that I will be responsible for these fees if I choose this option. I understand that I may elect to have direct deposit to an existing paycard that is already in my name, as long as I provide supporting documentation to verify the routing & account number and name on the account. I understand that Acumen is not is not liable for any paycard fraudulent activity related to third party transactions. I understand that upon my request, Acumen may attempt a payment reversal. However if the reversal is not successful, I understand that Acumen is not responsible and I will need to work with my institution to rectify said payment

JANE E. EMPLOYEE	123-45-6789	04/04/1950
Print Name	Social Security Number	Date of Birth
email@example.com	Jane E. Employee	04/04/2022
Email Address for Paystub Delivery	Signature	Date

Employee Street Address/City/State/Zip: EMPLOYEE STREET ADDRESS CITY, STATE ZIP CODE

Return completed form by email enrollment@acumen2.net, fax (855) 264 - 3287 or mail to

5416 E. Baseline Rd., Suite 200, Mesa, AZ 85206