



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



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 | | | |
| <input type="checkbox"/> | DADS | <input type="checkbox"/> | DADS Form 1725, Criminal Conviction History and Registry Checks |
| <input type="checkbox"/> | DADS | <input type="checkbox"/> | DADS Form 1729, Applicant Verification for Employees; DADS Form 1734, Service Provider and Employer Certification of Relationship Status for CDS |
| <input type="checkbox"/> | USCIS | <input type="checkbox"/> | USCIS Form I-9, Employment Eligibility Verification |
| <input type="checkbox"/> | DADS | <input type="checkbox"/> | DADS Form 1728, Liability Acknowledgement |
| <input type="checkbox"/> | DADS | <input type="checkbox"/> | 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 | | | |
| <input type="checkbox"/> | IRS | <input type="checkbox"/> | 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. |
| <input type="checkbox"/> | OAG | <input type="checkbox"/> | Texas Employer New Hiring Reporting Form (www.employer.texasattorneygeneral.gov) |
| <input type="checkbox"/> | DADS | <input type="checkbox"/> | 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 |
| <input type="checkbox"/> | DADS | <input type="checkbox"/> | CLASS, DBMD and MDCP only: Cardiopulmonary resuscitation (CPR) certification — Effective at time of service delivery initiation, and maintained. <i>Verify again before expiration date.</i> |
| <input type="checkbox"/> | DADS | <input checked="" type="checkbox"/> | Texas Department of Public Safety driver's license (if transporting client) — <i>Verify again before expiration date.</i> |
| <input type="checkbox"/> | DADS | <input checked="" type="checkbox"/> | Proof of minimum auto insurance (if transporting client) |
| <input type="checkbox"/> | CDC OSHA | <input checked="" type="checkbox"/> | DADS Form 1727, Occupational Exposure to Bloodborne Pathogens (Acknowledgement: Hepatitis B Vaccination and Universal Precautions) |
| <input type="checkbox"/> | TWCC | <input checked="" type="checkbox"/> | Notice to Employees Concerning Workers' Compensation in Texas (TWC Notice 5) |
| <input type="checkbox"/> | DADS | <input type="checkbox"/> | <i>If hiring a nurse: DADS Form 1747, Acknowledgment of Nursing Requirements</i> |
| <input type="checkbox"/> | CDS DADS | <input type="checkbox"/> | <i>If applicable: DADS Form 1733, Employer and Employee Acknowledgement of Exemption from Nursing Licensure for Certain Services Delivered through Consumer Directed Services</i> |
| <input type="checkbox"/> | DADS | <input type="checkbox"/> | 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 | | | |
| <input type="checkbox"/> | DADS | <input type="checkbox"/> | 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.) |
| <input type="checkbox"/> | DADS | <input checked="" type="checkbox"/> | DADS Form 1732-EMR, Management and Training of Service Provider Addendum — Must be signed by the employee within five days of hire. |
| <input type="checkbox"/> | DADS | <input type="checkbox"/> | Time sheets/service logs — DADS Form 1745, Service Delivery Log with Written Narrative/Written Summary, or facsimile approved by the FMSA |
| <input type="checkbox"/> | Vendors | <input type="checkbox"/> | Receipts and invoices |

| Code | Action |
|-------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> | Employer checks off each item for the personnel file and retains original or copy. |
| <input checked="" type="checkbox"/> | Employer checks each required item when completed and sends original or copy to the FMSA as indicated. Employer retains original or copy. |
| <input checked="" type="checkbox"/> | 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) |



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: <input type="checkbox"/> Yes <input type="checkbox"/> 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 | <input type="checkbox"/> Employer <input type="checkbox"/> 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](http://www.txdps.state.tx.us/CrimeRecords/ReviewofPersonalCriminalHistory) 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 <u>X</u> _____ | initial |
| Purpose of CCH: <u>Employment</u> _____ | |
| Empl <u>X</u> Vol/Contractor _____ | initial |
| Date Printed: _____ | initial |
| Destroyed Date: _____ | initial |
| Retain in your files | |

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

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 |
|----------------------------------------------------------|------|--------------------------------------|------|

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



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 | <input type="checkbox"/> Initial Wage and Benefit Plan <input type="checkbox"/> Plan Change – Effective Date: _____ | |
| Program: <input type="checkbox"/> CLASS <input type="checkbox"/> DBMD <input type="checkbox"/> HCS <input type="checkbox"/> TxHmL <input type="checkbox"/> PHC <input type="checkbox"/> PCS <input type="checkbox"/> STAR Kids/MDCP <input type="checkbox"/> 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. **Paychecks** 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



Consumer Directed Services
Employee Work Schedule and Assigned Tasks

| | |
|----------------|-------------------------------|
| Employee Name: | Individual Receiving Services |
|----------------|-------------------------------|

Purpose of Form:

Activity Involved:

Initial

Tasks

Change

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



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:

 _____
Signature of Service Provider Date

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

 _____  _____
Signature of Employer Date Signature of Witness Date

Date sent to FMSA: _____

Date received by FMSA: _____



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](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

**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.

| | | | | | |
|--------------------------|-------|--------------------------|-------|--------------------------|-------|
| <input type="checkbox"/> | _____ | <input type="checkbox"/> | _____ | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | _____ | <input type="checkbox"/> | _____ | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | _____ | <input type="checkbox"/> | _____ | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | _____ | <input type="checkbox"/> | _____ | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | _____ | <input type="checkbox"/> | _____ | <input type="checkbox"/> | _____ |

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? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 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.) | <input type="checkbox"/> | <input type="checkbox"/> | |
| 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.) | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4. | Are you the spouse* of the individual? (Consumer Managed Personal Attendant Services (CMPAS) service providers mark this item Not Applicable (N/A).)** | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. | Are you the spouse* of the employer? (CMPAS service providers mark this item NA.)** | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 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.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 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.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | Are you the power of attorney (attorney in fact or agent) for financial responsibilities on behalf of the individual? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 9. | Are you the DR or the CDS employer for the individual? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 10. | Are you the spouse* of the employer's DR? | <input type="checkbox"/> | <input type="checkbox"/> | |

* **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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | Are you the spouse* of the parent or primary caregiver? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 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.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | Are you the spouse* of the primary caregiver for the individual? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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



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:

Employee:

Printed Name

Printed Name

Signature

Signature

Date

Date



Consumer Directed Services
Service Provider Agreement

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 <input type="text"/> | | Employee's Email Address | | Employee's Telephone Number | |
| <p>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.</p> | Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.): | | | | | |
| | <input type="checkbox"/> 1. A citizen of the United States | | | | | |
| | <input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.) | | | | | |
| | <input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.) | | | | | |
| <input type="checkbox"/> 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) | <p>Additional Information</p> <input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents. | | | | |
| 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) | | | | | |
| <p>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.</p> | | | | | 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 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (2) An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI | OR | <ol style="list-style-type: none"> 1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <li style="text-align: center;">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 | AND | <ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security <p style="margin-left: 20px;">For examples, see Section 7 and Section 13 of the M-274 on uscis.gov/i-9-central.</p> <p style="margin-left: 20px;">The Form I-766, Employment Authorization Document, is a List A, Item Number 4, document, not a List C document.</p> |
| <p>Acceptable Receipts</p> <p>May be presented in lieu of a document listed above for a temporary period.</p> <p>For receipt validity dates, see the M-274.</p> | | | | |
| <ul style="list-style-type: none"> • 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 | <p>Receipt for a replacement of a lost, stolen, or damaged List B document.</p> | AND | <p>Receipt for a replacement of a lost, stolen, or damaged List C document.</p> |

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



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

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

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

| | | |
|----------------------------------------------------------|----------------------------------------------------------|-------------------------------------------------|
| Last Name (<i>Family Name</i>) from Section 1 . | First Name (<i>Given Name</i>) from Section 1 . | Middle initial (if any) from Section 1 . |
|----------------------------------------------------------|----------------------------------------------------------|-------------------------------------------------|

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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

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

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

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

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

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

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

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



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 (<i>Family Name</i>) from Section 1 . | First Name (<i>Given Name</i>) 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 (<i>if applicable</i>) | New Name (<i>if applicable</i>) | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|------------------------------------------------|------------------------------------------------------------------------------------------------------------------|
| Date (<i>mm/dd/yyyy</i>) | 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) (<i>mm/dd/yyyy</i>) | |
| 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 (<i>mm/dd/yyyy</i>) | |
| Additional Information (Initial and date each notation.) | | | <input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents. |

| Date of Rehire (<i>if applicable</i>) | New Name (<i>if applicable</i>) | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|------------------------------------------------|------------------------------------------------------------------------------------------------------------------|
| Date (<i>mm/dd/yyyy</i>) | 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) (<i>mm/dd/yyyy</i>) | |
| 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 (<i>mm/dd/yyyy</i>) | |
| Additional Information (Initial and date each notation.) | | | <input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents. |

| Date of Rehire (<i>if applicable</i>) | New Name (<i>if applicable</i>) | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|------------------------------------------------|------------------------------------------------------------------------------------------------------------------|
| Date (<i>mm/dd/yyyy</i>) | 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) (<i>mm/dd/yyyy</i>) | |
| 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 (<i>mm/dd/yyyy</i>) | |
| Additional Information (Initial and date each notation.) | | | <input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents. |

Employee's Withholding Certificate

Department of the Treasury
Internal Revenue Service

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.

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) <input type="checkbox"/> Single or Married filing separately | | |
| <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse | | |
| <input type="checkbox"/> 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**
- (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

If applicable -->

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

Step 3: Claim Dependent and Other Credits

If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by \$2,000 \$ _____

Multiply the number of other dependents by \$500 \$ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here

3 \$

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.

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

Date

Employers Only

Employer's name and address

First date of
employment

Employer identification
number (EIN)

Employer
Name Here

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

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

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

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

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

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

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

Specific Instructions

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

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

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

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



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

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

Step 4 (optional).

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

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

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

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



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

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

- 1 Two jobs. If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, skip to line 3
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
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
c Add the amounts from lines 2a and 2b and enter the result on line 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.
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)

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

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

Table with 13 columns: Higher Paying Job Annual Taxable Wage & Salary, Lower Paying Job Annual Taxable Wage & Salary (\$0-9,999 to \$110,000-120,000), and 12 rows of wage brackets from \$0-9,999 to \$525,000 and over.

Single or Married Filing Separately

Table with 13 columns: Higher Paying Job Annual Taxable Wage & Salary, Lower Paying Job Annual Taxable Wage & Salary (\$0-9,999 to \$110,000-120,000), and 17 rows of wage brackets from \$0-9,999 to \$450,000 and over.

Head of Household

Table with 13 columns: Higher Paying Job Annual Taxable Wage & Salary, Lower Paying Job Annual Taxable Wage & Salary (\$0-9,999 to \$110,000-120,000), and 15 rows of wage brackets from \$0-9,999 to \$450,000 and over.



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



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: <input type="checkbox"/> Checking (attach a voided check) <input type="checkbox"/> Savings (attach routing & account information printout) | Secondary Account 2 (Mandatory for Flat dollar option) Account Type: <input type="checkbox"/> Checking (attach a voided check) <input type="checkbox"/> Savings (attach routing & account information printout) |
| <input type="checkbox"/> Flat Dollar Amount <input type="checkbox"/> Percentage | <input type="checkbox"/> 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 fee 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



Employee Information Form Relationship Disclosure

Employee Name: _____ SSN: _____
 Physical Address: _____ City/State/Zip: _____
 Mailing Address (if different): _____ City/State/Zip: _____
 County of Physical Address: _____
 Phone Number: _____ Email (optional): _____
 Name of Individual: _____
 Name of Employer (if applicable): _____

Instructions: There are some tax exemptions for certain domestic employer and employee relationships. Please select any of the below boxes if a relationship exists between you as the employee and the employer:

- None**, no relation to employer
- *Spouse** of the employer (*a spouse of the employer cannot be a paid employee in CDS option*)
- *Child** of the employer and under the age of 21
- *Parent** of the employer - if this option is marked, read below and check all that apply:
 - You are employed by your son or daughter**
 - Your son or daughter has a child or stepchild living in the home**
 - Your son or daughter is a widower, divorced, or is living with a spouse who, because of a mental or physical condition, cannot care for the child or stepchild for at least 4 continuous weeks in a calendar quarter**
 - Your son or daughter's child or stepchild is under the age of 18 and requires the personal care of an adult for at least 4 continuous weeks in a calendar quarter due to a mental or physical condition**

| |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| *Internal Use Only |
| <ul style="list-style-type: none"> • If Parent (employee) selected all 4 parent conditions, parent/employee is FUTA and SUTA Exempt • If Parent (employee) did NOT select all 4 parent conditions, parent/employee is FICA, FUTA, SUTA Exempt |
| <ul style="list-style-type: none"> • If Spouse or Child are selected, employee is FICA, FUTA, SUTA Exempt |

The fine print - under IRS guidelines, Publication 15 (Circular E) Section 3, employees are not subject to Social Security, Medicare and federal unemployment tax (FUTA) if these relationships exist. The exemptions are as follows:

- A. Child employed by parents – Payments for work other than in a trade or business, such as domestic work in the parent's private home, are not subject to Social Security, Medicare, and FUTA tax until the child reaches age 21. (*IRS Pub.15, Section 3, Paragraph 1*)
- B. One spouse employed by another – Payments for services of one spouse employed by another in other than a trade or business, such as domestic service in a private home, are not subject to Social Security, Medicare, and FUTA tax. (*IRS Pub.15, Section 3, Paragraph 2*)
- C. Parent employed by child – Payments for the services of a parent employed by his or her child in other than a trade or business, such as domestic services, are not subject to Social Security, Medicare and FUTA tax as long as the above conditions apply. (*IRS Pub.15, Section 3, Paragraph 4*)

The State of Texas follows the federal guidelines in applying liability for state unemployment tax (SUTA). If the Caregiver falls into the category of Spouse or Child as outlined above, Social Security and Medicare tax will not be withheld from their checks. If the Caregiver falls into the category of Parent and meets all 4 parent conditions, Social Security and Medicare tax **will** be withheld from their checks. If the employee is exempt from FUTA, SUTA, Social Security and Medicare, the employer will not be charged for their share of Social Security and Medicare or FUTA and SUTA withholdings.

Employee Signature: _____ Date: _____



Figure:1 TAC §55.303(c)(1)(B)

Texas Employer New Hire Reporting Form

| | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---|---|---|---|---|---|
| <p>Submit within 20 calendar days of new employee's first day of work to:</p> <p>ENHR Operations Center, P.O. Box 149224 Austin, TX 78714-9224</p> <p>Phone: 1-800-850-6442 Fax: 1-800-732-5015</p> <p>Online: www.employer.texasattorneygeneral.gov</p> | <p>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:</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="padding: 2px 10px;">A</td> <td style="padding: 2px 10px;">B</td> <td style="padding: 2px 10px;">C</td> <td style="padding: 2px 10px;">1</td> <td style="padding: 2px 10px;">2</td> <td style="padding: 2px 10px;">3</td> </tr> </table> | A | B | C | 1 | 2 | 3 |
| 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). 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.

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) EMPLOYEE | | First Name (Given Name) JANE | | Middle Initial (if any) E | Other Last Names Used (if any) | |
| Address (Street Number and Name) 123 HAPPY VALLEY RD | | | Apt. Number (if any) | City or Town ANYTOWN | | State AZ |
| Date of Birth (mm/dd/yyyy) 01/01/1990 | | U.S. Social Security Number 5 5 5 5 5 5 5 5 | | Employee's Email Address EMAIL@EXAMPLE.COM | | Employee's Telephone Number (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.):

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 in the United States (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

| | | | | |
|----------------|----|----------------------------|----|-------------------------------------------------|
| USCIS A-Number | OR | Form I-94 Admission Number | OR | Foreign Passport Number and Country of Issuance |
|----------------|----|----------------------------|----|-------------------------------------------------|

Signature of Employee
EMPLOYEE SIGNATURE

Today's Date (mm/dd/yyyy)
08/03/2023

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: An Employer 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.

| Document Title 1 | List B | AND | List C |
|--------------------------|-------------------------|-----|-----------------------------|
| | 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)

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

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

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

Employee's Withholding Certificate

Department of the Treasury
Internal Revenue Service

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.

2024

Step 1: Enter Personal Information

Physical
Address
Required
(No P.O. Box)

| | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| (a) First name and middle initial Jane E. | Last name Employee | (b) Social security number 123-45-6789 |
| Address 111 Main St Apt 2 | | 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 Anytown, State 12345 | | |
| (c) <input checked="" type="checkbox"/> Single or Married filing separately | | |
| <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse | | |
| <input type="checkbox"/> 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**
- (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

If applicable -->

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 (\$100,000 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's name and address

Employer Name
222 Main St
Anytown, State 12345

First date of
employment

Employer identification
number (EIN)

Employer
Name Here



Consumer Directed Services
New Employee Packet Cover Sheet

| | |
|--------------------------------------------------------|----------------------------------|
| Name of Individual Receiving Services Cassie Client | Employer Name Elaine Employer |
| Employee Name Emily Employee | |
| Date of Hire 06/23/2017 | First Day of Work 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 | | | |
| <input checked="" type="checkbox"/> | HHSC | <input checked="" type="checkbox"/> | HHSC Form 1725, Criminal Conviction History and Registry Checks |
| <input checked="" type="checkbox"/> | HHSC | <input checked="" type="checkbox"/> | HHSC Form 1729, Applicant Verification for Employees; HHSC Form 1734, Service Provider and Employer Certification of Relationship Status for CDS |
| <input checked="" type="checkbox"/> | USCIS | <input checked="" type="checkbox"/> | USCIS Form I-9, Employment Eligibility Verification |
| <input checked="" type="checkbox"/> | HHSC | <input checked="" type="checkbox"/> | HHSC Form 1728, Liability Acknowledgement |
| <input checked="" type="checkbox"/> | HHSC | <input checked="" type="checkbox"/> | 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 | | | |
| <input checked="" type="checkbox"/> | IRS | <input checked="" type="checkbox"/> | 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. |
| <input checked="" type="checkbox"/> | OAG | <input checked="" type="checkbox"/> | Texas Employer New Hiring Reporting Form (www.employer.texasattorneygeneral.gov) |
| <input checked="" type="checkbox"/> | HHSC | <input checked="" type="checkbox"/> | 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 |
| <input checked="" type="checkbox"/> | HHSC | <input checked="" type="checkbox"/> | CLASS, DBMD and MDCP only: Cardiopulmonary resuscitation (CPR) certification — Effective at time of service delivery initiation, and maintained. <i>Verify again before expiration date.</i> |
| <input checked="" type="checkbox"/> | HHSC | <input type="checkbox"/> | Texas Department of Public Safety driver's license (if transporting client) — <i>Verify again before expiration date.</i> |
| <input checked="" type="checkbox"/> | HHSC | <input type="checkbox"/> | Proof of minimum auto insurance (if transporting client) |
| <input checked="" type="checkbox"/> | CDC OSHA | <input type="checkbox"/> | HHSC Form 1727, Occupational Exposure to Bloodborne Pathogens (Acknowledgement: Hepatitis B Vaccination and Universal Precautions) |
| <input checked="" type="checkbox"/> | TWCC | <input type="checkbox"/> | Notice to Employees Concerning Workers' Compensation in Texas (TWC Notice 5) |
| <input checked="" type="checkbox"/> | HHSC | <input checked="" type="checkbox"/> | <i>If hiring a nurse:</i> HHSC Form 1747, Acknowledgment of Nursing Requirements |
| <input checked="" type="checkbox"/> | CDS HHSC | <input checked="" type="checkbox"/> | <i>If applicable:</i> HHSC Form 1733, Employer and Employee Acknowledgement of Exemption from Nursing Licensure for Certain Services Delivered through Consumer Directed Services |
| <input checked="" type="checkbox"/> | HHSC | <input checked="" type="checkbox"/> | 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 | | | |
| <input checked="" type="checkbox"/> | HHSC | <input checked="" type="checkbox"/> | 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.) |
| <input checked="" type="checkbox"/> | HHSC | <input type="checkbox"/> | HHSC Form 1732-EMR, Management and Training of Service Provider Addendum — Must be signed by the employee within five days of hire. |
| <input checked="" type="checkbox"/> | HHSC | <input checked="" type="checkbox"/> | Time sheets/service logs — HHSC Form 1745, Service Delivery Log with Written Narrative/Written Summary, or facsimile approved by the FMSA |
| <input type="checkbox"/> | Vendors | <input type="checkbox"/> | Receipts and invoices |

| Code | Action |
|-------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> | Employer checks off each item for the personnel file and retains original or copy. |
| <input checked="" type="checkbox"/> | Employer checks each required item when completed and sends original or copy to the FMSA as indicated. Employer retains original or copy. |
| <input type="checkbox"/> | 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) |



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) Employee, Emile E | Alias N/A | Maiden Name N/A |
| Date of Birth (mm/dd/yyyy) 01/01/1980 | Social Security No. 555-55-5555 | |

04/04/2023

Signature - Applicant

Date

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

| | |
|------------------------------------|------------------------------------|
| Individual's Name Cassie Client | Employer Name Employee, Emile E |
|------------------------------------|------------------------------------|

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.

04/04/2023

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.

04/04/2023

Signature - Employer

Date

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

- 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

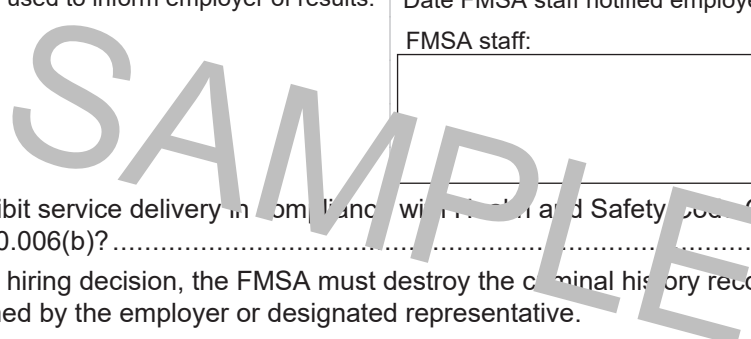
| | |
|---------------------------------|----------------------------------------------------------------------------------|
| Date of DPS Check 04/04/2023 | Time (specify a.m. or p.m.) 10:00 a.m. |
| Obtained By Alice Acumen | Convictions: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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: 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 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

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

| | | | |
|---------------------------------------|-------------------------------------------|-----------------------------|----------------------------------------------------------------------------------------------|
| Date of Registry Checks 04/04/2023 | Time (specify a.m. or p.m.) 10:30 a.m. | Obtained By Alice Acumen | <input type="checkbox"/> Employer <input checked="" type="checkbox"/> 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

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.

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*

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

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.)

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 |

Consumer Directed Services
Applicant Verification for Employees

Individual's Name

Cassie Client

Employer Name

Elaine Employer

Applicant Name

Emily Employee

Applicant Social Security No.

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

- 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 checks, 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 1713, Liability Acknowledgement.
- The applicant has read Notice Concerning Worker's 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.

04/04/2023

04/04/2023

Signature — Employer

Date

Signature — FMSA

Date

Consumer Directed Services
Wage and Benefits Plan
Employee Compensation

| | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| Employee Name (Last, First, Middle Initial) EMMA EMPLOYEE | | Social Security No. 321-45-6789 |
| Individual's Name CASSIE CLIENT | | Employers Name ELAINE EMPLOYER |
| Date of Hire 01/01/01 | First Date of Work 01/01/01 | <input type="checkbox"/> Initial Wage and Benefit Plan <input checked="" type="checkbox"/> Plan Change – Effective Date: 01/01/01 |
| Program: <input checked="" type="checkbox"/> CLASS <input type="checkbox"/> DBMD <input type="checkbox"/> HCS <input type="checkbox"/> TxHmL <input type="checkbox"/> PHC <input type="checkbox"/> PCS <input type="checkbox"/> STAR Kids/MDCP <input type="checkbox"/> STAR+PLUS | | |

Compensation:

| | | | | | |
|-----------------------------|-------------------------|------------------------------|-------------------------|-------------------------------------|-------------------------|
| Service 1: PASHAB | Wage: \$ 8.00 | Service 2: RESPITE | Wage: \$ 8.00 | Service 3: TRANSPORTATION | Wage: \$ 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. Paychecks 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 |  01/01/01 Date |  Signature - Employee |  01/01/01 Date |
|------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|



Consumer Directed Services
Employee Work Schedule and Assigned Tasks

| | |
|----------------------------------------|-------------------------------------------------------|
| Employee Name: EMMA EMPLOYEE | Individual Receiving Services CASSIE CLIENT |
|----------------------------------------|-------------------------------------------------------|

Purpose of Form:

- Initial
 Change

Activity Involved:

- 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:

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

Claine Employer

Signature — Employer

SIGN HERE

01/01/01

Date

Emma Employee

Signature — Employee

SIGN HERE

01/01/01

Date



Consumer Directed Services
Management and Training of Service Provider

| | | |
|-----------------------------------------------------------------------|--------------------------------------|-------------------------------------------------|
| Service Provider Name (Employee) EMMA EMPLOYEE | First Day of Work 01/01/01 | Annual Evaluation Due Date 01/01/02 |
| Name of Individual Receiving Services CASSIE CLIENT | Program CLASS | Services Delivered 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.

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

Signature of Service Provider



Date

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

ELAINE EMPLOYER'S SIGNATURE

Signature of Employer



Date

Signature of Witness

Date

Date sent to FMSA: _____

Date received by FMSA: _____



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&t=40&pt=19&ch=711&sch=O&rl=Y](http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&t=40&pt=19&ch=711&sch=O&rl=Y).

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



**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:

EMILY EMPLOYEE

ELAINE EMPLOYER

Printed Name

Printed Name

Emily Employee Signature

Elaine Employer Signature

Signature

Signature

12/21/18

12/21/18

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.

- | | | |
|----------------------------------------------------------|--------------------------|--------------------------|
| <input checked="" type="checkbox"/> BATHING | <input type="checkbox"/> | <input type="checkbox"/> |
| <input checked="" type="checkbox"/> FEEDING | <input type="checkbox"/> | <input type="checkbox"/> |
| <input checked="" type="checkbox"/> GROOMING | <input type="checkbox"/> | <input type="checkbox"/> |
| <input checked="" type="checkbox"/> ADMINISTER ORAL MEDS | <input type="checkbox"/> | <input type="checkbox"/> |
| <input checked="" type="checkbox"/> PRN MEDS | <input type="checkbox"/> | <input type="checkbox"/> |

SAMPLE

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.

Section 2: All Programs

The applicant must answer the following questions.

| Service Provider Status and Relationship | | Yes | No | NA |
|------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------|-------------------------------------|
| 1. | Are you under 18? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | |
| 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.) | <input type="checkbox"/> | <input checked="" type="checkbox"/> | |
| 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.) | <input type="checkbox"/> | <input checked="" type="checkbox"/> | |
| 4. | Are you the spouse* of the individual? (Consumer Managed Personal Attendant Services (CMPAS) service providers mark this item Not Applicable (N/A).)** | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 5. | Are you the spouse* of the employer? (CMPAS service providers mark this item NA.)** | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 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.) | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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.) | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8. | Are you the power of attorney (attorney in fact or agent) for financial responsibilities on behalf of the individual? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | |
| 9. | Are you the DR or the CDS employer for the individual? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | |
| 10. | Are you the spouse* of the employer's DR? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | |

* **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? | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. | Are you the spouse* of the parent or primary caregiver? | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

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.) | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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.) | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

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? | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

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? | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. | Are you the spouse* of the primary caregiver for the individual? | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

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



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 [X] 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:

- 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.
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:

Employee:

ELAINE EMPLOYER

 Printed Name

 Signature

07/01/2017

 Date

EMILY EMPLOYEE

 Printed Name

 Signature

07/01/2017

 Date



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 [X] 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.

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 Service Provider or Representative* (Print) Service Provider or Representative* (Signature) 07/01/2017 Date
ALICE ACUMEN FMSA Representative* (Print) FMSA Representative* (Signature) 07/01/2017 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 within 20 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

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

Employee Information

- Social Security Number (SSN): _____ 15. Date of Hire (MM/DD/YYYY): 01 / 01 / 2018
- Employee First Name: John Acumen will complete the date of hire
- Employee Middle Name: K.
- Employee Last Name: Doe
- Employee Home Address: 456 Somewhere St.
- Employer City (if US): Anytown
- State (if US): TX 22. ZIP Code (if US): 7777 - 1234
- Province/Region (if foreign): _____
- Country (if foreign): _____ 25. Postal Code (if foreign): _____
- State Where Employee Was Hired (Optional): _____
- Employee DOB (MM/DD/YYYY) (Optional): ___/___/___
- Employee's Salary (Dollars and Cents) (Optional): \$ _____
- 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!

Form with fields for Primary Account 1, Secondary Account 2, Flat dollar amount, Financial Institution Name, Address, Routing Number, and Account Number.

Is your name on the account(s) listed above? [X] 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

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.

JANE E. EMPLOYEE

123-45-6789

04/04/1950

Print Name

Social Security Number

Date of Birth

email@example.com

Jane E. Employee (Signature)

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