

Employer Packet

(keep this folder for your records)

Congratulations on self-directing your own supports. We are excited to take part in this process with you. Acumen Fiscal Agent, LLC (Acumen) is one of the oldest and most experienced Fiscal Employer Agents in the nation. We have been helping people self-direct their own supports since 1995.

Please refer to your Employer Handbook for important information. This resource is provided to you by your support coordinator, and it will help you understand and be prepared for this exciting option.

Becoming an Employer

This folder contains the necessary forms and instructions that authorize Acumen to act on your behalf as your fiscal/employer agent. This applies only to this self-directed services program in Louisiana. For more information on the Self-Direction program please visit:

<http://ldh.la.gov/page/ocdd-waiver-related-documents-and-forms>

The below forms are needed to authorize Acumen to act as your fiscal/employer agent. The first four forms have to do with the withholding and filing of employer- and employee- related taxes. The last form is the "Service Agreement Form," and it is a program requirement. Your support coordinator will review this form with you; please direct any questions about the form to your support coordinator.

Please complete and return these forms to Acumen. Examples of completed forms can be found in the back of this packet. Please check and note the date you emailed, faxed or mailed to Acumen. *If you currently have or have had an Employer Identification Number (EIN), do not complete any further employer enrollment forms. Please call Acumen at the phone number listed below.

- Acumen Authorization Form _____
Date Sent
- Employer Appointment of Agent - IRS Form 2678 _____
Date Sent
- Application for Employer Identification Number – IRS form SS4 _____
Date Sent
- Service Agreement Form (OCDDWSS-R-09-003) _____
Date Sent

Email, Fax or Mail Information to Acumen

Acumen Fiscal Agent, LLC.
5416 E. Baseline Rd, Suite 200
Mesa, AZ 85206
Toll Free: 1 (855) 514-9938
Fax: 1 (866) 923-5334
enrollment-la@acumen2.net
www.acumenfiscalagent.com



Basic Employment Law

Employment law is complicated. It is considered a specialty area in the legal profession. The purpose of this overview is to briefly review some requirements in a general way. **This overview should in no way be considered a substitute for competent legal counsel.**

When You Hire an Employee:

1. It is important to not discriminate against an applicant because of their age, race, color, religion, sex, national origin or disability.
2. You must hire people who are authorized to work in the United States – citizens and legal aliens with proper documentation. You are required to complete a Form I-9 to verify their authorization to work. Employers must enter the date the employee began or will begin work for pay on the I-9. If the actual date of hire (first date of providing services for pay) for the employee changes from the date entered, it is the employer's responsibility to correct and resubmit the form to Acumen within three days of the actual date of hire. To review Frequently Asked Questions about Form I-9, please visit www.acumenfiscalagent.com. Choose your state, and then find your program.
3. Please allow up to two weeks before scheduling your employee's first day of work to be sure all federal and any required state or program clearances have been received.
4. Avoid the temptation to classify your workers as independent contractors, as they probably are not. If you have any questions, please call us at 1 (866) 514-9938.

After You Hire an Employee:

- The work environment must be “free from recognized hazards that are causing or are likely to cause death or serious physical harm.”
- Your employees should not be subjected to circumstances that would create a “hostile work environment.” Such an environment can be many things, but an employee should never be subjected to sexual harassment or belittlement, jokes, or prejudice because of their age, race, color, religion, sex, national origin or disability.
- You must pay your employees at least minimum wage.

If You Need to Terminate Employment:

It is important that you treat people professionally and fairly, and you cannot terminate or lay off an employee because of their age, race, color, religion, sex, national origin or disability. Please refer to Section 6 of your Employer Handbook. Remember, you must notify Acumen when you terminate an employee or when an employee stops working for you. You must also mail a completed “*Verification of Employment or Termination*” form to the Self Directed Program Manager.

More Information:

- The Federal Department of Labor issues a *Small Business Handbook*. This helpful document can be viewed and downloaded for free at www.dol.gov.
- Louisiana Workforce Commission: www.laworks.net
- Louisiana Department of Revenue: revenue.louisiana.gov
- The Louisiana Department of Health and Human Services Office for Citizens with Developmental Disabilities Self Directed Option “Employer Handbook”

Reminder

Having Acumen as your Fiscal Employer Agent does nothing to the employer-employee relationship. Acumen is not the employer.



Workers' Compensation

This program requires that the employer have Workers' Compensation. Upon enrollment, your employees are automatically covered by Workers' Compensation insurance with an "A" rated company. There are no additional forms you need to fill out.

Remember, you can do your part to prevent injury and keep the cost of this Workers' Compensation insurance down by providing a safe, hazard free workplace, and by training your employees on how best to support you.

You will find a Workers' Compensation poster in this packet. It is suggested that this poster be displayed in a prominent place to inform your employees of their rights and the resources available to them.

Please report all work-related injuries to Acumen within 24 hours. For more information or to report an injury, please call 1 (866) 472-2297. Please refer to Section 7 of your Employer Handbook.

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. Please refer to Section 2 of your Employer Handbook.

As required by the State of Louisiana, suspected cases of fraud will be referred to OCDD and Medicaid's Fraud Unit for further investigation and possible prosecution.

To view Acumen's False Claims Policy – Fraud Protocol for the State of Louisiana, go to <https://www.acumenfiscalagent.com/louisiana/> or www.acumenfiscalagent.com and click on our "Resources" tab.

Account Statements

We will provide you with reports after a check is sent from your account. We will provide you with reports after a check is sent from your budget account. These reports are referred to as Account Statements. It is important to read these reports and to call us with any questions that you may have. The reports summarize your employee's time, your beginning allocation, and a declining balance so you are aware of the remaining amount after each payment. Please refer to these reports for information on employee training expirations. Web Time Entry /DCI users can access their reports by logging in to their accounts. Visit <https://www.acumenfiscalagent.com/louisiana/> to get started with Web Time Entry / DCI. You will need a pre-assigned username and password, if you do not have this information, please contact our customer service team at 1(855) 514-9938.



Benefits

Your employees may be eligible for healthcare benefits such as Major Medical, Limited Medical, Dental, and other health benefits. Acumen has partnered with a company that provides these benefits to employees even if your employee does not work full time. Feel free to contact us for more information.

Communication

Acumen is committed to keeping the lines of communication open. Please do not hesitate to contact us at anytime in one of the following ways:

1. If you have a question, you can email enrollment-la@acumen2.net or call 1 (855) 514-9938 to speak with a representative. Remember, the call is toll-free and we'd love to hear from you. Our TTY toll-free number is 1 (888) 853-0010. Our customer service team is available Monday – Friday from 9:00 am – 5:00 pm Central Time.
2. If you have a suggestion, complaint, or concern, please contact Acumen's President directly by calling toll-free 1 (888) 530-7473 and leaving a message. Your call will be returned within two business days.





Authorization Form

Complete each item and fax (866) 923-5334 or mail 5416 E. Baseline Rd., Suite 200, Mesa, AZ 85206 to Acumen. Please call (855) 514-9938 if you have any questions.

I hereby authorize Acumen Fiscal Agent (Acumen) to:

1. File Form SS-4 on my behalf to obtain an Employer Identification Number (EIN), if I do not already have one, and allow the IRS to mail EIN information to Acumen once obtained. **Note: If you currently have or have had an EIN, please contact the above phone number before proceeding with the employer enrollment paperwork.**
2. Represent me as an employer for employer-related tax reporting purposes, by signing Form 2678.
3. Handle all correspondence regarding employer tax reporting issues.
4. Serve as my Full Service Agent for unemployment and withholding tax purposes. As such, Acumen shall provide all services for me, the employer, (tax, benefits, and appeals) and shall receive all documents related to my, the employer's, Louisiana unemployment and withholding tax account that would otherwise have been sent to me.
5. Receive confidential information and perform any and all acts the employer can perform relating to matters pertaining to Louisiana's unemployment compensation law and state tax withholding regulations effective signature date forward; subject to revocation.
6. Electronically send me (e.g. e-mail) information including, but not limited to: employer and/or employee enrollment information, account statement reports, good-to-go information, and new products or services.

Any limitations to this authorization must be specifically stated and attached. This authorization revokes all earlier authorizations and powers of attorney on file, and shall remain in effect until receipt of a written notice of revocation or a subsequent authorization or power of attorney by the Louisiana Workforce Commission and/or Louisiana Department of Revenue.

What am I really authorizing?

- Your appointment grants Acumen Fiscal Agent a limited power of attorney to act as your agent for acts required under Section 3504 and Chapters 21, 22, 24, and/or 25 of Subchapter C of the Internal Revenue Code, and for taxes required under 3301.
- You are appointing Acumen Fiscal Agent to act as your agent for the Louisiana Workforce Commission and Louisiana Department of Revenue in the fulfilling of domestic employer responsibilities relative to the employing of persons through initiatives funded by the State of Louisiana, Department of Health and Hospitals.

Employer

The person who hires, fires, trains and manages staff.

Name:	
Social Security Number:	
Street Address:	
City/State/Zip:	
Mailing Address (if different):	
City/State/Zip (if different):	
Parish of Residence:	
Phone Number:	
E-mail Address :	

Participant

The individual receiving services.

Name:	
Date of Birth:	
Physical Address (if different):	
City/State/Zip (if different):	

Support Coordinator

Name:	
E-mail Address:	
Phone Number:	

Your signature means that you have read and understand the above information.

Signature:	
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Date:	
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Form **2678** **Employer/Payer Appointment of Agent**

(Rev. December 2023) Department of the Treasury — Internal Revenue Service

OMB No. 1545-0748

Use this form if you want to request approval to have an agent file returns and make deposits or payments of employment or other withholding taxes or if you want to revoke an existing appointment.

- If you're an employer or payer who wants to request approval, complete Parts 1 and 2 and sign Part 2. Then give it to the agent. Have the agent complete Part 3 and sign it.

Note: This appointment isn't effective until we approve your request. See the instructions for more information.

- If you're an employer, payer, or agent who wants to revoke an existing appointment, complete all three parts. In this case, only one signature is required.

For IRS use:

Part 1: Why you're filing this form.

(Check one)

- You want to **appoint** an agent for tax reporting, depositing, and paying.
- You want to **revoke** an existing appointment.

Part 2: Employer or Payer Information: Complete this part if you want to appoint an agent or revoke an appointment.

1 Employer identification number (EIN)

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2 Employer's or payer's name
(not your trade name)

3 Trade name (if any)

4 Address

Number	Street	Suite or room number
City	State	ZIP code
Foreign country name	Foreign province/county	Foreign postal code

5 Forms for which you want to appoint an agent or revoke the agent's appointment to file. (Check all that apply.)

	For ALL employees/ payees/payments	For SOME employees/ payees/payments
Form 940, Employer's Annual Federal Unemployment (FUTA) Tax Return* (all 940 series)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Form 941, Employer's QUARTERLY Federal Tax Return (all 941 series)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Form 943, Employer's Annual Federal Tax Return for Agricultural Employees (all 943 series)	<input type="checkbox"/>	<input type="checkbox"/>
Form 944, Employer's ANNUAL Federal Tax Return (all 944 series)	<input type="checkbox"/>	<input type="checkbox"/>
Form 945, Annual Return of Withheld Federal Income Tax	<input type="checkbox"/>	<input type="checkbox"/>
Form CT-1, Employer's Annual Railroad Retirement Tax Return	<input type="checkbox"/>	<input type="checkbox"/>
Form CT-2, Employee Representative's Quarterly Railroad Tax Return	<input type="checkbox"/>	<input type="checkbox"/>

* Generally, you can't appoint an agent to report, deposit, and pay tax reported on Form 940, unless you're a home care service recipient.

- Check here if you're a home care service recipient, and you want to appoint the agent to report, deposit, and pay FUTA tax for you. See the instructions.

I am authorizing the IRS to disclose otherwise confidential tax information to the agent relating to the authority granted under this appointment, including disclosures required to process Form 2678. The agent may contract with a third party, such as a reporting agent or certified public accountant, to prepare or file the returns covered by this appointment, or to make any required deposits and payments. Such contract may authorize the IRS to disclose confidential tax information of the employer/payer and agent to such third party. If a third party fails to file the returns or make the deposits and payments, the agent and employer/payer remain liable.

Sign your name here

Date / /

Print your name here

Print your title here HCSR EMPLOYER

Best daytime phone

Now give this form to the agent to complete.

Application for Employer Identification Number

(For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, Indian tribal entities, certain individuals, and others.)

See separate instructions for each line. Keep a copy for your records.
Go to www.irs.gov/FormSS4 for instructions and the latest information.

OMB No. 1545-0003

EIN

Employer's Name Here

Type or print clearly.
Employer's County & State Here

Employer's Name Here

Employer's Name Here

Employer's Street Address Here

Employer's City, St, Zip Here

Employer's SSN Here

Telephone number required

Employer's Name Here

Employer Sign Here

Employer's Date Here

1 Legal name of entity (or individual) for whom the EIN is being requested		
2 Trade name of business (if different from name on line 1)	3 Executor, administrator, trustee, "care of" name	
4a Mailing address (room, apt., suite no. and street, or P.O. box) 5416 E BASELINE RD STE 200	5a Street address (if different) (Don't enter a P.O. box.)	
4b City, state, and ZIP code (if foreign, see instructions) MESA AZ 85206-4704	5b City, state, and ZIP code (if foreign, see instructions)	
6 County and state where principal business is located		
7a Name of responsible party		7b SSN, ITIN, or EIN
8a Is this application for a limited liability company (LLC) (or a foreign equivalent)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		8b If 8a is "Yes," enter the number of LLC members
8c If 8a is "Yes," was the LLC organized in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No		
9a Type of entity (check only one box). Caution: If 8a is "Yes," see the instructions for the correct box to check.		
<input type="checkbox"/> Sole proprietor (SSN) _____ <input type="checkbox"/> Estate (SSN of decedent) _____ <input type="checkbox"/> Partnership _____ <input type="checkbox"/> Plan administrator (TIN) _____ <input type="checkbox"/> Corporation (enter form number to be filed) _____ <input type="checkbox"/> Trust (TIN of grantor) _____ <input type="checkbox"/> Personal service corporation _____ <input type="checkbox"/> Military/National Guard <input type="checkbox"/> State/local government _____ <input type="checkbox"/> Church or church-controlled organization _____ <input type="checkbox"/> Farmers' cooperative <input type="checkbox"/> Federal government _____ <input type="checkbox"/> Other nonprofit organization (specify) _____ <input type="checkbox"/> REMIC <input type="checkbox"/> Indian tribal governments/enterprises _____ <input checked="" type="checkbox"/> Other (specify) HCSR EMPLOYER Group Exemption Number (GEN) if any _____		
9b If a corporation, name the state or foreign country (if applicable) where incorporated	State	Foreign country
10 Reason for applying (check only one box)		
<input type="checkbox"/> Started new business (specify type) _____ <input type="checkbox"/> Banking purpose (specify purpose) _____ <input type="checkbox"/> Hired employees (Check the box and see line 13.) <input type="checkbox"/> Changed type of organization (specify new type) _____ <input type="checkbox"/> Compliance with IRS withholding regulations <input type="checkbox"/> Purchased going business _____ <input checked="" type="checkbox"/> Other (specify) HCSR EMPLOYER <input type="checkbox"/> Created a trust (specify type) _____ <input type="checkbox"/> Created a pension plan (specify type) _____		
11 Date business started or acquired (month, day, year). See instructions.		12 Closing month of accounting year DECEMBER
13 Highest number of employees expected in the next 12 months (enter -0- if none). If no employees expected, skip line 14.		
Agricultural	Household	Other
14 If you expect your employment tax liability to be \$1,000 or less in a full calendar year and want to file Form 944 annually instead of Forms 941 quarterly, check here. (Your employment tax liability will generally be \$1,000 or less if you expect to pay \$5,000 or less, \$6,536 or less if you're in a U.S. territory, in total wages.) If you don't check this box, you must file Form 941 for every quarter <input type="checkbox"/>		
15 First date wages or annuities were paid (month, day, year). Note: If applicant is a withholding agent, enter date income will first be paid to nonresident alien (month, day, year)		
16 Check one box that best describes the principal activity of your business.		
<input type="checkbox"/> Construction <input type="checkbox"/> Rental & leasing <input type="checkbox"/> Transportation & warehousing <input type="checkbox"/> Health care & social assistance <input type="checkbox"/> Wholesale—agent/broker <input type="checkbox"/> Real estate <input type="checkbox"/> Manufacturing <input type="checkbox"/> Finance & insurance <input type="checkbox"/> Accommodation & food service <input type="checkbox"/> Wholesale—other <input type="checkbox"/> Retail <input checked="" type="checkbox"/> Other (specify) HCSR EMPLOYER		
17 Indicate principal line of merchandise sold, specific construction work done, products produced, or services provided. HCSR EMPLOYER		
18 Has the applicant entity shown on line 1 ever applied for and received an EIN? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes," write previous EIN here		

Third Party Designee	Complete this section only if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form.	
	Designee's name ALMA STEWART, SUNNY HUDSON	Designee's telephone number (include area code) (623) 792-6100
	Address and ZIP code 5416 E BASELINE RD STE 200, MESA AZ 85206-4704	Designee's fax number (include area code) (480) 371-2241
Under penalties of perjury, I declare that I have examined this application, and to the best of my knowledge and belief, it is true, correct, and complete.		Applicant's telephone number (include area code)
Name and title (type or print clearly) HCSR EMPLOYER		Applicant's fax number (include area code)
Signature	Date	Employer's Date Here

See below to determine whether you need an EIN. However, for further information on applying for an EIN, including how to submit an EIN application, see the separate instructions at www.irs.gov/FormSS4.

Do I Need an EIN?

File Form SS-4 if the applicant entity doesn't already have an EIN but is required to show an EIN on any return, statement, or other document.¹ See also the separate instructions for each line on Form SS-4.

IF the applicant...	AND...	THEN...
started a new business	doesn't currently have (nor expect to have) employees	complete lines 1, 2, 4a-8a, 8b-c (if applicable), 9a, 9b (if applicable), 10-14, and 16-18.
hired (or will hire) employees, including household employees	doesn't already have an EIN	complete lines 1, 2, 4a-6, 7a-b, 8a, 8b-c (if applicable), 9a, 9b (if applicable), and 10-18.
opened a bank account	needs an EIN for banking purposes only	complete lines 1-5b, 7a-b, 8a, 8b-c (if applicable), 9a, 9b (if applicable), 10, and 18.
changed type of organization	either the legal character of the organization or its ownership changed (for example, you incorporate a sole proprietorship or form a partnership) ²	complete lines 1-18 (as applicable).
purchased a going business ³	doesn't already have an EIN	complete lines 1-18 (as applicable).
created a trust	the trust is other than a grantor trust or an IRA trust ⁴	complete lines 1-18 (as applicable).
created a pension plan as a plan administrator ⁵	needs an EIN for reporting purposes	complete lines 1, 3, 4a-5b, 7a-b, 9a, 10, and 18.
is a foreign person needing an EIN to comply with IRS withholding regulations	needs an EIN to complete a Form W-8 (other than Form W-8ECI), avoid withholding on portfolio assets, or claim tax treaty benefits ⁶	complete lines 1-5b, 7a-b (SSN or ITIN as applicable), 8a, 8b-c (if applicable), 9a, 9b (if applicable), 10, and 18.
is administering an estate	needs an EIN to report estate income on Form 1041	complete lines 1-7b, 9a, 10-12, 13-17 (if applicable), and 18.
is a withholding agent for taxes on nonwage income paid to an alien (that is, individual, corporation, or partnership, etc.)	is an agent, broker, fiduciary, manager, tenant, or spouse who is required to file Form 1042, Annual Withholding Tax Return for U.S. Source Income of Foreign Persons	complete lines 1, 2, 3 (if applicable), 4a-5b, 7a-b, 8a, 8b-c (if applicable), 9a, 9b (if applicable), 10, and 18.
is a state or local agency	serves as a tax reporting agent for public assistance recipients under Rev. Proc. 80-4, 1980-1 C.B. 581 ⁷	complete lines 1, 2, 4a-5b, 7a-b, 9a, 10, and 18.
is a single-member LLC (or similar single-member entity)	needs an EIN to file Form 8832, Entity Classification Election, for filing employment tax returns and excise tax returns, or for state reporting purposes ⁸ , or is a foreign-owned U.S. disregarded entity and needs an EIN to file Form 5472, Information Return of a 25% Foreign-Owned U.S. Corporation or a Foreign Corporation Engaged in a U.S. Trade or Business	complete lines 1-18 (as applicable).
is an S corporation	needs an EIN to file Form 2553, Election by a Small Business Corporation ⁹	complete lines 1-18 (as applicable).

¹ For example, a sole proprietorship or self-employed farmer who establishes a qualified retirement plan, or is required to file excise, employment, alcohol, tobacco, or firearms returns, must have an EIN. A partnership, corporation, REMIC (real estate mortgage investment conduit), nonprofit organization (church, club, etc.), or farmers' cooperative must use an EIN for any tax-related purpose even if the entity doesn't have employees.

² However, don't apply for a new EIN if the existing entity only (a) changed its business name, (b) elected on Form 8832 to change the way it is taxed (or is covered by the default rules), or (c) terminated its partnership status because at least 50% of the total interests in partnership capital and profits were sold or exchanged within a 12-month period. The EIN of the terminated partnership should continue to be used. See Regulations section 301.6109-1(d)(2)(iii).

³ Don't use the EIN of the prior business unless you became the "owner" of a corporation by acquiring its stock.

⁴ However, grantor trusts that don't file using Optional Method 1 and IRA trusts that are required to file Form 990-T, Exempt Organization Business Income Tax Return, must have an EIN. For more information on grantor trusts, see the Instructions for Form 1041.

⁵ A plan administrator is the person or group of persons specified as the administrator by the instrument under which the plan is operated.

⁶ Entities applying to be a Qualified Intermediary (QI) need a QI-EIN even if they already have an EIN. See Rev. Proc. 2000-12.

⁷ See also *Household employer agent* in the instructions. **Note:** State or local agencies may need an EIN for other reasons, for example, hired employees.

⁸ See *Disregarded entities* in the instructions for details on completing Form SS-4 for an LLC.

⁹ An existing corporation that is electing or revoking S corporation status should use its previously assigned EIN.



Self-Direction Option for the Community Choices Waiver Employer Service Agreement

I. Employer Responsibilities – I agree/understand the following:

1. I will receive assistance from my support coordinator and the Louisiana Department of Health (LDH)/Office of Aging and Adult Services (OAAS), or its designee, in order to ensure continued participation in the Self-Direction option.
2. I choose to be the legal employer of the employee(s) who will provide services to me (or the participant that I have been authorized to represent). The employer is not the Fiscal Employer Agent (FEA) or the State of Louisiana. I must recruit, hire, train, and supervise my employees and perform and fulfill the duties of an employer, in accordance with applicable state and federal regulations and the policies and procedures of Self-Direction.
3. My support coordinator will provide me with enrollment materials and guidance to complete each form. It is my responsibility to ensure all forms that my employee(s) and/or I complete are correct and submitted timely.
4. The FEA will send me automated (general announcement) communications and information electronically (i.e. email) including, but not limited to payroll reports. I understand that I can request to receive all information through U.S. Mail service and not through email.
5. The FEA will fulfill my payroll duties and must clear all applicants/potential employee(s) for hire before I can hire them or allow them to perform any work for me (or the participant).
6. I must comply and pay all of my employee(s) in accordance with the Department of Labor Regulations including the Fair Labor Standards Act and the Final Rule effective **December 1, 2016** (Federal Link: https://www.dol.gov/whd/homecare/homecare_guide.pdf) and according to
7. All applicants/potential new employees must have a criminal history background check conducted by the FEA and the applicant may not be hired if they have a conviction that bars employment.
8. I am responsible for conducting ongoing checks of current employees on the Louisiana State Adverse Actions List Search and the Office of Inspector General (OIG) List of Excluded Individuals databases as outlined in the OAAS CCW Self-Direction Employer Handbook. The results of these reports must be printed and kept confidential.
9. I will not allow employee(s) to begin work until I receive a “good to go” date and the employee(s) is active in the system.
10. I am responsible for meeting my staffing needs and have the primary responsibility

for making arrangements for back-up services in the event that an employee is unable to work on a scheduled day.

11. I have primary responsibility for having a functional or working Emergency Plan in place, in the event of a disaster.
12. I must determine my employees' duties consistent with the service specifications. I am responsible for giving each employee a job description and/or employment agreement, which contains the duties of the job.
13. I am responsible for making sure each employee complies with all training requirements as established by LDH/OAAS or its designee. I also understand that my employees must comply with all applicable training requirements in order for the employee to be paid for working.
14. I am responsible for planning my employees' schedules and understand that services must be provided in accordance with my approved Plan of Care (POC) and within the limits of the program specifications.
15. The FEA will only make payments on my behalf in accordance with the authorized amounts and hours approved in my POC consistent with program specifications.
16. I am responsible for making sure that my employee(s) clock in when they start providing services to me and clock out when they stop providing services to me using the Electronic Visit Verification (EVV) system.
17. I must approve that my employees' submitted hours were actually worked, using a mobile application or a computer.
18. All paper payment requests must have my approval signature and date unless it is submitted through the FEA's online time entry system.
19. Payment of my claims may be from Federal and State funds, and I may be prosecuted under applicable Federal or State laws, for any false claims, false statements or documents, or concealment of a material fact. Any misuse of funds may result in being fined or penalized including but not limited to the repayment of claims. Any collection costs or legal fees will be my responsibility to pay.
20. I must review my payroll reports which includes information on my remaining available balance for the quarter. I accept responsibility for payment of any overtime and hours worked above what is approved and authorized in my POC.
21. I must pay my employees overtime, which is 1½ times the regularly hourly pay wage, for any hours that they work over 40 hours in a work week.
22. Service logs, including progress notes, must be completed in accordance with the LDH/OAAS' instructions for completing this documentation.
23. I am responsible for maintaining all required documentation and providing for the retention of records in accordance with the Self-Direction policies and procedures.
24. I am responsible for evaluating my employees' performance.

25. I must notify the FEA immediately if an employee is injured on the job.
26. I must notify the FEA and the support coordinator of the date and reason when I fire/terminate an employee.
27. I must report critical incidents in accordance with the policies and procedures specified in the OAAS CCW Self-Direction Employer Handbook.
28. I must follow all policies and procedures as specified in the OAAS CCW Self-Direction Employer Handbook and any notifications issued by LDH. I understand and agree that if I do not follow the Self-Direction policies and procedures that I may be involuntarily terminated from this option. Furthermore, I am also responsible for repayment of any over payments or improper billing for which payment has been received.
29. I must **IMMEDIATELY** report any changes to my support coordinator that may affect my eligibility, safety and/or need for services.
30. I must **IMMEDIATELY** notify the FEA and my support coordinator when I am admitted to and discharged from a hospital or nursing facility. I understand that I cannot pay my employees on days that I am admitted as a patient and receiving care at a hospital or nursing facility.
31. I must notify the FEA **IMMEDIATELY** of any changes (e.g. loss of Medicaid, hospitalization, placement in a facility, etc.) that affect my eligibility for Self-Direction. I may be responsible for payment of any work performed during a loss of eligibility.

II. Support Coordinator Responsibilities - I agree that my support coordinator has:

1. Assisted me with learning about choices and options for services.
2. Informed me of all Self-Direction rules, policies and procedures and all CCW program rules, policies and procedures.
3. Assisted me with determining the supports I need to participate in Self-Direction (e.g. minimum number of employee(s) needed, access to fax machine or internet, etc.).
4. Assisted me with developing my POC, Back-Up Staffing Plan and Emergency Plan.
5. Provided me with a copy of the OAAS CCW Self-Direction Employer Handbook and all of the documents in the Appendices, including print outs of the linked documents.
6. Advised me on the material contained in the OAAS CCW Self-Direction Employer Handbook, which includes information on the following:
 - The process for hiring employees;
 - How to orient and instruct my employees in duties;
 - How to evaluate my employees' performance; and
 - How to instruct my employee(s) in completing service logs that include progress notes and critical incident reports.

7. Assisted me with preparing and completing required forms for my participation in Self-Direction.
8. Assisted me with developing a job description, task list, and work schedule for my employees consistent with the approved POC.
9. Assisted and will continue to assist me with budget planning and determining my employees' wages within the program guidelines.
10. Informed me of the beginning annual balance of hours that I have available for use in Self-Direction.

III. Signature of Understanding and Agreement

My signature below confirms my understanding and agreement to abide by the terms, conditions, and responsibilities as stated above. I have also received, reviewed, and understand the requirements indicated in the OAAS CCW Self-Direction Employer Handbook.

Name of Participant (Print): _____

Name of Employer (if other than participant) (Print): _____

Phone: (____) _____ **Email Address:** _____

Employer's Signature

Date



Power of Attorney and Declaration of Representative

Mail to:
Louisiana Department of Revenue
Revenue Processing Center
Special Tax Programs Unit
P.O. Box 201
Baton Rouge, La 70821-0201
For Questions:
Phone: (855) 307-3893

PART I. POWER OF ATTORNEY

Taxpayer(s) must sign and date this form below.

PLEASE TYPE OR PRINT

Your Name or Name of Entity	Spouse's Name, if a joint return <i>(or corporate officer, partner or fiduciary, if a business)</i>		
Street Address	City	State	ZIP
Social Security/Louisiana or Federal ID Number	Spouse's Social Security Number <i>(if a joint return)</i>		

I/we appoint the following representative as my/our true and lawful agent and attorney-in-fact to represent me/us before the Louisiana Department of Revenue. The representative is authorized to receive and inspect confidential information concerning my/our tax matters and to perform any and all acts that I/we can perform with respect to my/our tax matters, unless noted below. **Modes of communication for requesting and receiving information may include telephone, e-mail, or fax. The authority does not include the power to receive refund checks, the power to substitute another representative, the power to add additional representatives, or the power to execute a request for disclosure of tax returns or return information to a third party.**

Representative must sign and date this form on page 3, Part II.

Name Sunny Hudson/Alma Stewart/Yusra Gulfan			
Firm Acumen Fiscal Agent LLC			
Street Address 5416 E Baseline Rd Ste 200	City Mesa	State AZ	ZIP 85206
Telephone Number (623) 792-6100	Fax number (480) 371-2241		
E-mail Address tax-la@acumen2.net			

NOTICES AND COMMUNICATIONS. Original notices and other written communications will be sent only to you, the taxpayer. Your representative may request and receive information by telephone, e-mail, or fax. Upon request, the representative may be provided with a copy of a notice or communication sent to you. If you want the representative to request and receive a copy of notices and communications sent to you, **check this box.**

Signature of Taxpayer(s). If a tax matter concerns a joint return, both husband and wife must sign if joint representation is requested. If signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, or trustee on behalf of the taxpayer, I certify that I have the authority to execute this form on behalf of the taxpayer.

IF THIS POWER OF ATTORNEY IS NOT SIGNED AND DATED, IT WILL BE RETURNED.

Taxpayer signature	Date (mm/dd/yyyy)
Spouse signature	Date (mm/dd/yyyy)
Signature of duly authorized representative, if the taxpayer is a corporation, partnership, executor, or administrator	Title
Date (mm/dd/yyyy)	



Acts Authorized. Mark only the boxes that apply. By marking the boxes, you authorize the representative to perform any and all acts on your behalf, including the authority to sign tax returns, with respect only to the indicated tax matters:

Tax Type	Year(s) or Period(s)	Tax Type	Year(s) or Period(s)
<input type="checkbox"/> Audit - Motor Vehicle Sales	_____	<input type="checkbox"/> FT-Interstate Motor Fuel User	_____
<input type="checkbox"/> Audit - Natural Gas Franchise	_____	<input type="checkbox"/> FT-Motor Fuel Backup Tax	_____
<input type="checkbox"/> Automobile Rental	_____	<input type="checkbox"/> FT-Motor Fuel Floor Stock Tax	_____
<input type="checkbox"/> Corporation Income & Franchise	_____	<input type="checkbox"/> FT-Motor Fuel Transporter	_____
<input type="checkbox"/> Consumable Hemp Products	_____	<input type="checkbox"/> FT-Supplier	_____
<input type="checkbox"/> Direct Marketer	_____	<input type="checkbox"/> FT-Terminal Operator	_____
<input type="checkbox"/> Electric Co-op	_____	<input type="checkbox"/> IFTA	_____
<input type="checkbox"/> Ernest N. Morial Convention Center Service Contractor Tax	_____	<input type="checkbox"/> IFTA Jurisdiction	_____
<input type="checkbox"/> Excise - Alcohol	_____	<input type="checkbox"/> Individual Income	_____
<input type="checkbox"/> Excise - Beer	_____	<input type="checkbox"/> Natural Gas Franchise	_____
<input type="checkbox"/> Excise - Dyed Diesel Violation	_____	<input type="checkbox"/> New Orleans Exhibition Hall	_____
<input type="checkbox"/> Excise - Gas Dealer	_____	<input type="checkbox"/> NO Hotel/Motel (4 col)	_____
<input type="checkbox"/> Excise - Gas Jobber	_____	<input type="checkbox"/> Oil Spill Contingency Fee	_____
<input type="checkbox"/> Excise - HZ Waste	_____	<input type="checkbox"/> Oilfield Site Restoration Oil	_____
<input type="checkbox"/> Excise - Inspection/Sup.	_____	<input type="checkbox"/> Oilfield Site Restoration Gas	_____
<input type="checkbox"/> Excise - SF Decal	_____	<input type="checkbox"/> Partnership	_____
<input type="checkbox"/> Excise - SF Supplier	_____	<input type="checkbox"/> Sales	_____
<input type="checkbox"/> Excise - Telecommunication	_____	<input type="checkbox"/> Sales Prepaid Cell Phone	_____
<input type="checkbox"/> Excise - Tobacco (retired)	_____	<input type="checkbox"/> Severance - Gas	_____
<input type="checkbox"/> Excise - Tobacco Returns	_____	<input type="checkbox"/> Severance - Minerals	_____
<input type="checkbox"/> Excise - Tobacco Stamps	_____	<input type="checkbox"/> Severance - Oil	_____
<input type="checkbox"/> Excise - Trans/Comm.	_____	<input type="checkbox"/> Severance - Timber	_____
<input type="checkbox"/> Excise - Vapor Retailers	_____	<input type="checkbox"/> Special Fuels	_____
<input type="checkbox"/> Excise - Wine DS	_____	<input type="checkbox"/> Statewide Hotel/Motel	_____
<input type="checkbox"/> Fiduciary	_____	<input type="checkbox"/> Surface Mining	_____
<input type="checkbox"/> FT-Aviation Fuel Dealer	_____	<input type="checkbox"/> Tour Tax	_____
<input type="checkbox"/> FT-Diesel Refund	_____	<input type="checkbox"/> Transportation Network Fee	_____
<input type="checkbox"/> FT-Distrib./Export/Blender	_____	<input checked="" type="checkbox"/> Withholding	2025-2030
<input type="checkbox"/> FT-Gas Refund	_____	<input type="checkbox"/> Withholding Non-emp. Cmp	_____
<input type="checkbox"/> FT-Importer	_____	<input type="checkbox"/> Other	_____

DELETIONS. Mark or list any of the following actions that you do NOT authorize your representative to complete on your behalf.

<input type="checkbox"/> Sign the return(s) for the above tax matters.	<input checked="" type="checkbox"/> Obtain a private letter ruling on behalf of the taxpayer.
<input type="checkbox"/> Execute an agreement to suspend prescription of tax.	<input checked="" type="checkbox"/> Other prohibited acts (<i>List prohibited acts.</i>)
<input type="checkbox"/> File a protest to a proposed assessment.	_____
<input type="checkbox"/> Execute offers in compromise or settlements of tax liability.	_____
<input checked="" type="checkbox"/> Represent the taxpayer before the department in any proceeding, including protest hearings.	_____



Part II. DECLARATION OF REPRESENTATIVE

Under penalties of perjury, I declare the following:

- I am not currently under suspension or disbarment from practice before the Internal Revenue Service.
- I am authorized to represent the taxpayer(s) identified in Part I for the tax matters specified there.
- I am one of the following: *(Insert applicable letter in table below.)*
 - a. Attorney—a member in good standing of the highest court of the jurisdiction shown below
 - b. Certified Public Accountant—duly qualified to practice as a certified public accountant in the jurisdiction shown below
 - c. Enrolled Agent—a person enrolled to practice before the Internal Revenue Service
 - d. Officer—a bona fide officer of the taxpayer organization
 - e. Employee—an employee of the taxpayer
 - f. Family Member—a member of the taxpayer’s immediate family *(State the relationship, i.e., spouse, parent, child, brother, or sister.)*

- g. Other *(State the relationship, i.e., bookkeeper or friend.)* _____
- h. Former Louisiana Department of Revenue Employee — As a representative, I cannot accept representation in a matter with which I had direct involvement while I was a public employee.

IF THIS DECLARATION OF REPRESENTATIVE IS NOT SIGNED AND DATED, THE POWER OF ATTORNEY WILL BE RETURNED.

Designation-Insert Above Letter (a-h)	State Issuing License	State License Number	Signature	Date (mm/dd/yyyy)



Self-Assessment for Self-Direction Option Community Choices Waiver (CCW)

Your assessment indicates that you want Personal Assistance Services (PAS). Under the Community Choices Waiver, PAS can either be self-directed or provided by a Direct Service Provider (DSP).

What is self-direction?

Self-direction is an option which allows you to choose and become the “employer” of the individuals who will provide your Personal Assistance Services. This gives you the opportunity to make your own decisions concerning how best to hire, schedule, train and reimburse your worker(s)/employee(s).

REMEMBER: This option gives you the **MOST CONTROL** over the people you choose to hire and more flexibility with employee pay rates, but also requires the **MOST RESPONSIBILITY**.

Determining the best choice for you

Below is a list of self-direction employer responsibilities. Please review, and make a mark under either the “Yes” or the “No” column to indicate your decision that you are either able or not able to fulfill each responsibility. Your support coordinator is available to assist you with this self assessment as needed.

Employer Responsibilities	Yes	No
Recruiting, hiring, training, and managing your worker(s)/employee(s)		
Following non-discrimination policies		
Completing all employer-related paperwork and duties related to payroll		
Making sure your worker completes the required documentation such as service logs, progress notes, and timesheets		
Providing your worker with guidance so they are able to meet your individual preferences		
If your worker will be transporting you in his/her own car, making certain he/she provides proof of current automobile insurance		
Developing an agreeable work schedule with your worker		

Employer Responsibilities (continued)	Yes	No
Establishing a list of daily tasks your worker will perform based on your Plan of Care		
Meeting all of your staffing needs by providing a workable, written Back-up Staffing Plan that describes how your care will be provided if your worker(s) does not show up for work		
Developing a workable Emergency Plan in the event of a disaster		
Participating in all applicable training required by the Office of Aging and Adult Services (OAAS) or its designee		
Following all rules, policies, and requirements pertaining to the Community Choices Waiver program		
Negotiating an hourly pay rate for your worker, and it cannot be less than the legal minimum wage		
Being willing to fire your worker, if you are not satisfied with his/her performance		
Informing your support coordinator and the Fiscal Employer Agent immediately if your worker is injured on the job or fired		

Choosing the self-direction option

If it is decided that the self-direction option is for you, your support coordinator will give you a more detailed overview, a copy of the *OAAS Community Choices Waiver (CCW) Self-Direction Employer Handbook* and the enrollment materials. Your support coordinator will also give you on-going support and assistance as needed.

SELF-DIRECTION ROLES AND RESPONSIBILITIES

Support Coordinator:	Employer (Participant or Responsible Representative):	Fiscal Employer Agent (FEA):
<ul style="list-style-type: none"> • Explains the rules of the program and covered services. • Conducts assessments to identify needs. • Develops the Plan of Care (POC). • Informs the FEA that the participant chose Self-Direction. • Assists with completing employer forms. • Reviews the participant’s “Home Book” to ensure that it contains the required documents. • Reviews service logs quarterly to ensure services are being provided as per the POC. • Submits Critical Incident Reports. • Completes POC Revisions (When there is a change in the employee’s pay wage, routine changes and emergency situations). • In the event of a participant’s death, obtains records and delivers to OAAS Regional Office. 	<ul style="list-style-type: none"> • Completes all enrollment forms and gives to the FEA. • Follows all employment laws, program rules and keeps a safe working environment. • Hires and fires employees. • Sets schedule and pay for employees. • Trains employees on how to provide the needed services. • Ensures employees complete service logs and/or documentation according to policy requirements. • Manages the service budget. • Verifies time entries in the Electronic Visit Verification (EVV) system. • Reviews account statements from FEA for accuracy. • Reports Critical Incidents to the support coordinator. • Participates in assessment and care planning meetings. • Keeps the “Home Book” current with the required documents. • Conducts monthly for exclusion checks AND checks on the adverse actions list once every 6 months. • Reports possible fraud (e.g. payroll fraud by the worker, etc.) to LDH. • Retains ALL documents for a minimum of 6 years (from the date on the document). 	<ul style="list-style-type: none"> • Sets up participant and employer in the payroll system. • Processes all employee(s) paperwork and sets them up in the payroll system. • Conducts the required initial direct service worker checks: <ul style="list-style-type: none"> ○ Criminal conviction history and background check; ○ Worker registry/Adverse actions list; & ○ Exclusion database • Pays employees according to the approved budget. • Withholds and pays all taxes. • Arranges for workers’ compensation and other benefits. • Provides reports to the employer. • Provides reports to LDH and/or OAAS. • Answers questions about enrollment and payroll. • Ensures compliance with other program rules. • Submits billing timely to the Fiscal Intermediary (FI) for services and reviews the EVV system for blocked services. • Reports possible fraud to LDH.

Critical Incident Reporting (CIR) Quick Guide for Self-Directed Community Choices Waiver (CCW) Participants

A critical incident is any actual or reported event or situation that could cause serious harm to a waiver participant's physical health, mental health, safety or welfare. The Office of Aging and Adult Services (OAAS) must track all critical incidents to make sure follow-up and recommendations are made to try to keep it from happening again. This is important to make sure waiver participants are safe and for OAAS to meet federal requirements.

Below are the types of critical incidents that you or your employer **MUST** report to your Support Coordinator (SC) within 2 hours of when it happened or within 2 hours of finding out about the incident:

- Major Injury;
- Loss or Destruction of Home;
- Falls;
- Major Medical Event, including Emergency Room and Hospital Admissions;
- Death;
- Major Medication Incident;
- Involvement with Law Enforcement;
- Participant is a Victim of a Crime; and
- Major Behavioral Incident.

Below are the types of critical incidents that you or your employer **MUST** report **IMMEDIATELY** to **BOTH** your SC **AND** Protective Services, either Adult Protective Services (APS) or Elderly Protective Services (EPS):

- Abuse;
- Neglect (this includes self-neglect and caregiver neglect);
- Exploitation; and
- Extortion.

Your SC will review the incident and decide if it needs to be reported in the system. If it does, your SC will enter the incident into a secure database. Your SC will call you for updates until the incident is resolved. Once resolved, your SC will mail you a summary of what happened and what can be done to try to prevent it from happening again.

You or your employer **MUST** report ALL incidents that need law enforcement involvement, or may be sign of abuse or neglect to the right people. The following is a list of important contact information:

- For incidents that need law enforcement, contact your local law enforcement agency (police or sheriff).
- For suspected abuse, neglect, exploitation or extortion of an adult aged 18-59, or an individual under the age of 18 who has been legally declared an adult, contact APS at 1-800-898-4910.
- For suspected abuse, neglect, exploitation or extortion of an individual aged 60 or over, contact EPS at 1-833-577-6532.
- For suspected child abuse or mistreatment, contact the Department of Children & Family Services (DCFS) Child Protection Hotline at 1-855-452-5437.

If you need more information on CIRs, you can look in the following manuals:

- OAAS Community Choices Waiver (CCW) Self-Direction Employer Handbook - [Self-Direction-Manual.pdf \(la.gov\)](#); and
- OAAS Critical Incident Reporting Manual - [OAAS MAN 19 002 Critical Incident Reporting Manual for SIMS I 5 3 19.pdf \(la.gov\)](#).

CHANGE INFORMATION FORM: PARTICIPANT or EMPLOYER



Please complete this form and return to Acumen by one of the following methods:

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

Fax: (866) 923-5334

Email: enrollment@acumen2.net

Change PARTICIPANT Information

Complete this section when there is a change in participant information. The participant is the individual receiving services. If the participant is also the employer, please complete this section **only**. For a name change, please provide the current and new name. For all other changes, only the new information is required.

Change In (select all that apply): Name <input type="checkbox"/> Address <input type="checkbox"/> Phone Number <input type="checkbox"/> E-mail Address <input type="checkbox"/>	
Current/Previous Name:	New Name (if changed):
Street Address:	
City/State/Zip:	
Phone Number:	
E-mail Address:	
Participant ID Number:	
Signature (Employer or Authorized Rep):	
Date:	

Change EMPLOYER Information

Complete this section when there is a change in employer information. The employer is the individual who hires, trains, and manages staff. If the participant is also the employer, please complete the participant section only. For a name change, provide the current and new name and please fax or mail a copy of a legal document for name change. For all other changes, only the new information is required.

Change In (select all that apply): Name <input type="checkbox"/> Address <input type="checkbox"/> Phone Number <input type="checkbox"/> E-mail Address <input type="checkbox"/>	
Current/Previous Name:	New Name (if changed):
Street Address (if changed):	
City/State/Zip (if changed):	
Phone Number (if changed):	
E-mail Address:	
Participant ID Number:	
Signature (Employer or Authorized Rep):	
Date:	



Worker's Compensation Claim Reporting Guidelines for Employees

If there has been a workplace injury or accident, please take the following action:

- If the injury or accident is of a serious nature, seek medical attention immediately.
- Employees must report the injury immediately to their employer.
- Employers must report the injury as soon as possible even if it is a weekend or holiday to the Acumen Workers' Compensation Department.
- To report to Acumen, call 866-472-2297. If you get voicemail when you call, leave a message with your name, call back number, state you are located in, a brief description of the incident and if the injury is of a serious nature (including hospitalization (not ER room & home release), immediate surgery status, critical care or death) .
- Messages of injuries of a serious nature will be returned even on a weekend or holiday. All other messages will be returned the following business day.

Timely reporting of any injury that goes beyond First Aid treatment to Acumen's Workers' Compensation Department is important. When reporting, be prepared with the following information:

- Time & place the incident occurred as well as how it occurred.
- Explain in as much detail as possible what happened to cause the injury.
- Take pictures of the area where the incident occurred, if you are able to do so, and any other photos you are able to obtain that may be helpful to the claim.

Contact Acumen's Workers' Compensation Administrator. Direct line is 866-472-2297.



Acumen Fiscal Agent
Innovation • Opportunity • Freedom



LEARN, SHOP, CUSTOMIZE & ENROLL

with



A free insurance resource made available exclusively to all Acumen Fiscal Agent members and their family members.

Major Medical
Short-Term Medical
Dental
Vision
Critical Illness

Accident
Auto & Home
Life
Disability
Free Prescription Card

Customized Coverage from Carriers You Know

Allstate

vsp
vision care

Ameritas

OSCAR

Humana

United
Healthcare



Anthem
BlueCross BlueShield

BlueCross
BlueShield

OPEN ENROLLMENT HAS ENDED, BUT YOU STILL HAVE OPTIONS

Here's How We Can Help:

Special Enrollment Period

Does your life change qualify you for a special enrollment period? A licensed agent can help you decide. If you qualify, you can enroll into the major medical plan of your choosing.

Visit our online Insurance Resource Center at acumen.augeobenefits.com for a full list of qualifications.

Short Term Medical Coverage

If you haven't experienced a qualifying life change, you and your family can still get covered by enrolling into a Short-Term Medical plan. Our licensed agents will go through your options and enroll you into the best plan for your situation.

 Individual plans from \$60.60/mo*

 Family plans from \$123.02/mo*

*Dates subject to change. Sample rates were calculated on 11/2024 using the zip code 85050. Actual rates may vary. All eligibles were non-smokers.

WHO WE ARE

Powered by Augeo Benefits, our health insurance marketplace provides an insurance resource to all **Acumen Fiscal Agent members and their family members.**

With one call to Augeo Benefits, you will be able to shop, compare and enroll in health insurance plans both on and off the federal and state marketplaces; allowing you to find the individualized coverage that fits your specific situation.



DID YOU MISS THE OPEN ENROLLMENT DEADLINE? We Can Help.

866.248.9991

acumen.augeobenefits.com

Our Online Insurance Resource Center provides 24/7 access to all things insurance, including an Affordable Care Act (ACA) overview, important dates to remember, a tax credit calculator and much more.



FAQS

Q Who is eligible?

A All Acumen Fiscal Agent members and thier family members are eligible for this service.

Q How is Augeo Benefits different than the federal and state health insurance marketplaces/exchanges?

A We have created a one-stop shop for you and your family members to receive professional assistance in shopping for, comparing, and enrolling in health insurance plans, both on and off the federal and state marketplaces. Our goal is to expand your options by giving you access to plans located on the government marketplaces as well as options off of those marketplaces.

Q Do I need to purchase a federal or state marketplace health insurance plan?

A No. We offer access to qualified insurance plans, both on and off the government marketplaces.

Q What if I have pre-existing conditions?

A Pre-existing conditions no longer limit your Major Medical Insurance. It's the same plans, at the same rates, as those without pre-existing conditions.

Q Can I apply for a subsidy or tax credit through Augeo Benefits?

A Yes. If you qualify to purchase a health insurance plan from a federal or state marketplace, you can apply for a subsidy/tax credit through Augeo Benefits.

WE'VE GOT YOU COVERED

866.248.9991

acumen.augeobenefits.com



Augeo Benefits is a division of Augeo Affinity Insurance Services, Inc. The Augeo Benefits plan is only available in the 50 United States, Washington D.C., Puerto Rico and U.S. territories. Due to state regulations, some products may not be available in all areas.

CA license #: 0G38852



Looking For Caregivers In All The Wrong Places? HireMyCare.org Can Help



HireMyCare.org is the nation's premiere directory of in-home caregivers, designed for people who manage their own care.



**Find The Care You Need.
Hire Who Want.**

support@hiremycare.org / 1-855-285-HIRE (4473)

10 Reasons to Use HireMyCare.org

1. Connects Caregivers with Care Seekers
2. In-site messaging system for safe communications
3. Quick and easy to locate nearby caregivers
4. Available 24/7 from any web-connected device
5. Post a job and have caregivers apply or search our database of caregivers yourself
6. Saved searches and "favorites" make it easy to fill recurring needs
7. Sort caregivers on 20 different skills and qualifications based on your requirements
8. Rate the service of caregivers and vendors
9. Caregivers can list their certifications and qualifications and search for jobs
10. Find businesses, services and home care supplies in your area

Acumen Fiscal Agent Proudly Supports HireMyCare.org



Employee Packet For Self-Direction Option in OAAS-CCW (keep this folder for your records)

Inside this folder you will find the necessary forms to hire an employee in this program.

Please refer to the information provided in Sections III and IV of your Employee Handbook.

Before a person can be hired as an employee, that person must be able to provide the services you need (Applicant Verification Form) and pass a criminal background check.

You will need to complete the following steps in order to hire an employee:

- Interview applicants and decide who you think would be the best fit for your particular needs.
- Have the person you decide to hire complete and send the following to Acumen:
 - Applicant Verification Form (your support coordinator will complete this with you)
 - I-9 Employment Eligibility Verification
 - Your employee fills out **Section I**.
 - As the Employer, you fill out **Section II**. Employers must enter the date the employee began or will begin work for pay on the I-9. If the actual date of hire (first date of providing services for pay) for the employee changes from the date entered, it is the employer's responsibility to correct and re-submit the form to Acumen within three days of the actual date of hire.
 - To review Frequently Asked Questions about Form I-9, please visit www.acumenfiscalagent.com, choose your state, and then find your program.
 - W-4 Employee's Withholding Allowance Certificate
 - L-4 State of Louisiana Employee Withholding Exemption Certificate
 - Employee Wage Notice
 - Pay Selection Agreement
 - Authorization for Direct Deposit/Pay Card (*send voided check or bank letter for direct deposit*)
 - Employment Application (optional)
 - Provider Agreement
 - Criminal Background Check Authorization
 - Employee Information Form

Examples of completed forms can be found in the back of this packet.

Your employee must clear a background check prior to working in this program. Acumen is not authorized to process payments to employees that do not meet this requirement. Acumen will notify you, the employer, when this process has been completed and your employee can begin working. Do not allow any work to be performed prior to this notification. It will take approximately 3-4 business days before an applicant is clear for hire. However, it could take longer due to the background check process. Please allow two weeks before scheduling your employee's first day of work to be sure all federal and state clearances have been received.

Employee State and Local Tax Withholding

Louisiana state and local income tax will be withheld from all employees' pay based on state and local income tax withholding guidelines. Employees who live in another state may be required to file and pay state withholding tax in Louisiana 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. Fax or mail completed forms to Acumen. Remember, you must notify Acumen when you terminate an employee or when an employee stops working for you. You must also mail a completed "*Verification of Employment or Termination*" form to the Self Directed Program Manager. Please refer to Section V of your Employer Handbook.

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. Please refer to Section II of your Employer Handbook.

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.

Benefits

Your employees may be eligible for healthcare benefits such as Major Medical, Limited Medical, Dental and other health benefits. Acumen has partnered with a company that provides these benefits to employees even if your employee does not work full time. Please contact us for more information.

Earned Income Credit

Some employees are eligible for Earned Income Tax Credit (EITC). EITC is a refundable federal income tax credit for low to moderate income working individuals and families. To qualify, taxpayers must meet certain requirements and file a tax return, even if they do not have a filing requirement. To learn more about the rules and income limits to qualify for EITC, contact the IRS at www.irs.gov/eitc or call (800) 829-1040.

Progress Notes and Service Logs

Progress notes and service logs do **not** need to be submitted to Acumen. Your support coordinator will review your progress notes every quarter to monitor how you are progressing toward your personal goals. Please refer to Section II (Service Documentation) in your Employer Handbook.

**Louisiana Workforce Commission
 UI Tax Liability and Adjudication
 Employer Authorization of Designated Representative/ Power of Attorney
 Please Fax completed form to (225) 346-6073**

EMPLOYER NAME	STATE UI NO.		FEDERAL ID NO.
DBA NAME			TELEPHONE
ADDRESS	CITY	STATE	ZIP CODE

This written authorization shall serve to notify the Louisiana Workforce Commission that the above named employer hereby appoints and designates the following named individual or entity as its representative. If no agent is designated, all correspondence will be sent to the employer.

Add agent account

Agent Name: ACUMEN FISCAL AGENT	Contact Person SUNNY HUDSON
Address 5416 E BASELINE RD STE 200	
City MESA	State AZ
	Zip 85206

This written authorization shall serve to notify the Louisiana Workforce Commission that the above named employer hereby revokes the following named individual or entity as its representative. If no agent is designated above, all correspondence will be sent to the employer.

Revoke existing employer

Agent Name	Contact Person
Address	
City	State
	Zip

Employer designated agent to specifically transact any and all business between this named employer and LWC and to do any and all acts necessary in connection with the below matters of the unemployment in the state of Louisiana as follows:

Tax matters (all automated forms and notices)

Benefit matters (all automated forms and notices)

This authorization further authorizes the above named representative to submit the request to LWC for information on behalf of the named employer to the extent to which such employer has a right to access in regard to the designated above matters.

The designated representative agrees to restrict access to any unemployment compensation information provided by LWC to specifically authorize personnel and to instruct such personnel as to the confidentiality of such data. The provided information shall be used and safeguarded by the representative solely for the specific purpose authorized by the agent contact, and shall not be stored for resale. All employees or personnel of the representative shall be subject to the same sanctions and penalties for violation of confidential requirements as would employees of the state agency. The representative agrees to bear all the costs arising from any claims for any unauthorized use of such employer information.

This authorization additionally serves to revoke any prior authorization in regard to the same matters designated above and shall remain in full force and effect until and unless written notice is provided by the above named employer or agent to LWC. This authorization shall be executed in triplicate original one of which shall be retained by the above named employer, one by the representative, and one by LWC and shall become effective within five (5) working days of the date of receipt by LWC.

Signature of Owner/Partner/Corporate Officer	Print or Type Name and Title	Date
--	------------------------------	------



Acumen Fiscal Agent, LLC.
5416 E. Baseline Rd., Suite 200
Mesa, AZ 85206
Toll-Free Phone: (855) 514-9938
Toll-Free Fax: (866) 923-5334
TTY: (888) 853-0010
customerservice@acumen2.net
www.acumenfiscalagent.com

EMPLOYMENT APPLICATION

PARTICIPANT'S NAME: _____

PERSONAL INFORMATION:

APPLICANT'S NAME: _____ DATE: _____
STREET ADDRESS: _____ CITY: _____
STATE: _____ ZIP: _____ SOCIAL SECURITY #: _____
HOME PHONE NUMBER: _____ OTHER: _____
E-MAIL ADDRESS: _____

EMPLOYMENT ELIGIBILITY:

Are you interested in serving as a (check all that apply):
_____ Full-time employee? _____ Part-time employee? _____ Backup employee?
Are you currently employed: _____ YES _____ NO
Date available for employment: _____ How many hours a week can you work? _____
Are you 18 years of age or older? _____ YES _____ NO

LICENSES AND CERTIFICATIONS:

Do you have a valid Louisiana driver's license? _____ YES _____ NO
Are you willing to complete all required training? _____ YES _____ NO

EDUCATION:

High School Graduate or equivalent (GED)? _____ YES _____ NO
Vocational/Business School? _____ YES _____ NO
if yes, field of study: _____ # of months: _____ completion date: _____
College? _____ YES _____ NO College Graduate? _____ YES _____ NO
if yes, degree: _____ completion date: _____

LIST THREE PERSONAL REFERENCES:

_____ (Name)	_____ (Address)	_____ (Phone Number)
_____ (Name)	_____ (Address)	_____ (Phone Number)
_____ (Name)	_____ (Address)	_____ (Phone Number)

LIST PREVIOUS JOBS YOU HAVE HAD (BEGINNING WITH MOST RECENT):

EMPLOYER'S NAME: _____
DATES OF EMPLOYMENT: _____
EMPLOYER'S ADDRESS: _____
SUPERVISOR'S NAME: _____ PHONE NUMBER: _____
LIST OF JOB DUTIES: _____
REASON FOR LEAVING: _____

EMPLOYER'S NAME: _____
DATES OF EMPLOYMENT: _____
EMPLOYER'S ADDRESS: _____
SUPERVISOR'S NAME: _____ PHONE NUMBER: _____
LIST OF JOB DUTIES: _____
REASON FOR LEAVING: _____

EMPLOYER'S NAME: _____
DATES OF EMPLOYMENT: _____
EMPLOYER'S ADDRESS: _____
SUPERVISOR'S NAME: _____ PHONE NUMBER: _____
LIST OF JOB DUTIES: _____
REASON FOR LEAVING: _____

BRIEFLY LIST REASONS YOU SHOULD BE CONSIDERED FOR THIS JOB:

APPLICANT ACKNOWLEDGEMENT

You ___ may ___ may not contact my current employer. If not, reason: _____

If offered a position, will you be able to be at work on time and according to the schedule discussed? ___ Yes ___ No

Comments: _____

I, _____ (print name), the applicant certify that the *information provided is true and correct* to the best of my knowledge. I understand that any false statement, omission, or misrepresentation on this application is sufficient cause for refusal to hire, or dismissal if employer has employed me, no matter when discovered by employer. I also acknowledge that *a criminal background history check is required* and that some convictions prevent employment. I also acknowledge that I may be required to keep certain certifications current and may be required to complete additional training as a condition of my employment.

I authorize this potential employer to investigate all statements contained in this application, and I authorize my former employers and references to disclose information regarding my former employment, character and general reputation, without giving me prior notice of such disclosure.

I understand and agree that nothing contained in this application, or conveyed during any interview, is intended to create an employment contract. I further understand and agree that if I am hired, my employment will be "at will" and without fixed term, and may be terminated at any time, with or without cause and without prior notice, at the option of either myself or this employer. No promises regarding employment have been made to me, and I understand that no such promise or guarantee is binding upon this employer unless made in writing.

Signature: _____ Date: _____

Louisiana Self Directed Option
Community Choices Waiver
Applicant Verification Form

APPLICANT NAME:
PARTICIPANT NAME:
SUPPORT COORDINATOR NAME:

Please mark the relationship between the Applicant and the Participant below.

- | | | |
|---------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Spouse | <input type="checkbox"/> Grandparent | <input type="checkbox"/> Niece/Nephew |
| <input type="checkbox"/> Parent | <input type="checkbox"/> Grandchild | <input type="checkbox"/> Other Relative |
| <input type="checkbox"/> Child | <input type="checkbox"/> Sibling | <input type="checkbox"/> None of the Above |

Employment Qualifications:

- The applicant is at least 18 years old.
- The applicant has a high school diploma, GED, trade school diploma or has verifiable work experience in providing support to people with disabilities.
- The applicant is not the employer or the employer's spouse.
- The applicant is not the participant or the participant's spouse.
- The applicant is not the curator, tutor, legal guardian, or responsible representative, of the participant.
- The applicant is not the person to whom the recipient has given Representative and Mandate authority (also known as Power of Attorney).

The fiscal agent will verify that the applicant is not barred from employment based on the results of the criminal background check. **The participant/employer may not allow any potential employee to begin working for him/her until the fiscal agent clears the potential employee for hire.** It will take approximately four (4) business days for the fiscal agent to clear an applicant to begin working once completed and correct required paperwork is received.

By signing below, I attest that the employee meets the listed qualifications above.

EMPLOYER'S NAME (PLEASE PRINT)

EMPLOYER'S SIGNATURE

DATE



Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No.1615-0047
Expires 05/31/2027

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

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

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

Last Name (Family Name)		First Name (Given Name)		Middle Initial (if any)	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number (if any)	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number		Employee's Email Address		Employee's Telephone Number	
<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>				
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)	<p><input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.</p>				
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	<ul style="list-style-type: none"> • Receipt for a replacement of a lost, stolen, or damaged List B document. 	AND	<ul style="list-style-type: none"> • Receipt for a replacement of a lost, stolen, or damaged List C document.

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



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

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

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 05/31/2027

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 05/31/2027

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.)

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.)

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.)

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.

2026

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.)		
Caution: To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.		

TIP: Consider using the estimator at www.irs.gov/W4App to determine the most accurate withholding for the rest of the year if you: are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

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 the 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 Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(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):

- (a) Multiply the number of qualifying children under age 17 by \$2,200 **3(a)** \$
- (b) Multiply the number of other dependents by \$500 **3(b)** \$

Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here **3** \$

Required field even if "0"

Step 4: 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.** Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) 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, and check this box

Exempt from withholding

I claim exemption from withholding for 2026, and I certify that I meet **both** of the conditions for exemption for 2026. See *Exemption from withholding* on page 2. I understand I will need to submit a new Form W-4 for 2027

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 unless otherwise noted.

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 2026 if you meet both of the following conditions: you had no federal income tax liability in 2025 and you expect to have no federal income tax liability in 2026. You had no federal income tax liability in 2025 if (1) your total tax on line 24 on your 2025 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), 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 2026 tax return. To claim exemption from withholding, certify that you meet both of the conditions by checking the box in the *Exempt from withholding* section. 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 16, 2027.

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. Are submitting this form after the beginning of the year;
2. Expect to work only part of the year;
3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;
4. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or
5. Prefer the most accurate withholding for multiple job situations.

TIP: Have your most recent pay stub(s) from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

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. Submit a separate Form W-4 for each job.

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 of tax withheld 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 (and/or your spouse if married filing jointly) must have the required social security number to claim certain credits. 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.

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 15, if you expect to claim deductions other than the basic standard deduction on your 2026 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for qualified tips, overtime compensation, and passenger vehicle loan interest; student loan interest; IRAs; and seniors. You (and/or your spouse if married filing jointly) must have the required social security number to claim certain deductions. For additional eligibility requirements, see Pub. 501.

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 when you file your tax return.

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 5. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 **1** \$ _____

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

a Find the amount from the appropriate table on page 5 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a **2a** \$ _____

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 5 and enter this amount on line 2b **2b** \$ _____

c Add the amounts from lines 2a and 2b and enter the result on line 2c **2c** \$ _____

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3** _____

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

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



See the Instructions for Schedule 1-A (Form 1040) for more information about whether you qualify for the deductions on lines 1a, 1b, 1c, 3a, and 3b.

1 Deductions for qualified tips, overtime compensation, and passenger vehicle loan interest.

a **Qualified tips.** If your total income is less than \$150,000 (\$300,000 if married filing jointly), enter an estimate of your qualified tips up to \$25,000 **1a** \$ _____

b **Qualified overtime compensation.** If your total income is less than \$150,000 (\$300,000 if married filing jointly), enter an estimate of your qualified overtime compensation up to \$12,500 (\$25,000 if married filing jointly) of the “and-a-half” portion of time-and-a-half compensation **1b** \$ _____

c **Qualified passenger vehicle loan interest.** If your total income is less than \$100,000 (\$200,000 if married filing jointly), enter an estimate of your qualified passenger vehicle loan interest up to \$10,000 **1c** \$ _____

2 Add lines 1a, 1b, and 1c. Enter the result here **2** \$ _____

3 **Seniors age 65 or older.** If your total income is less than \$75,000 (\$150,000 if married filing jointly):

a Enter \$6,000 if you are age 65 or older before the end of the year **3a** \$ _____

b Enter \$6,000 if your spouse is age 65 or older before the end of the year and has a social security number valid for employment **3b** \$ _____

4 Add lines 3a and 3b. Enter the result here **4** \$ _____

5 Enter an estimate of your student loan interest, deductible IRA contributions, educator expenses, alimony paid, and certain other adjustments from Schedule 1 (Form 1040), Part II. See Pub. 505 for more information **5** \$ _____

6 **Itemized deductions.** Enter an estimate of your 2026 itemized deductions from Schedule A (Form 1040). Such deductions may include qualifying:

a **Medical and dental expenses.** Enter expenses in excess of 7.5% (0.075) of your total income **6a** \$ _____

b **State and local taxes.** If your total income is less than \$505,000 (\$252,500 if married filing separately), enter state and local taxes paid up to \$40,400 (\$20,200 if married filing separately) **6b** \$ _____

c **Home mortgage interest.** If your home acquisition debt is less than \$750,000 (\$375,000 if married filing separately), enter your home mortgage interest expense (including mortgage insurance premiums) **6c** \$ _____

d **Gifts to charities.** Enter contributions in excess of 0.5% (0.005) of your total income **6d** \$ _____

e **Other itemized deductions.** Enter the amount for other itemized deductions **6e** \$ _____

7 Add lines 6a, 6b, 6c, 6d, and 6e. Enter the result here **7** \$ _____

8 **Limitation on itemized deductions.**

a Enter your total income **8a** \$ _____

b Subtract line 4 from line 8a. If line 4 is greater than line 8a, enter -0- here and on line 10. Skip line 9 **8b** \$ _____

9 Enter: { • \$768,700 if you’re married filing jointly or a qualifying surviving spouse } **9** \$ _____
 { • \$640,600 if you’re single or head of household }
 { • \$384,350 if you’re married filing separately }

10 If line 9 is greater than line 8b, enter the amount from line 7. Otherwise, multiply line 7 by 94% (0.94) and enter the result here **10** \$ _____

11 **Standard deduction.**

Enter: { • \$32,200 if you’re married filing jointly or a qualifying surviving spouse } **11** \$ _____
 { • \$24,150 if you’re head of household }
 { • \$16,100 if you’re single or married filing separately }

12 **Cash gifts to charities.** If you take the standard deduction, enter cash contributions up to \$1,000 (\$2,000 if married filing jointly) **12** \$ _____

13 Add lines 11 and 12. Enter the result here **13** \$ _____

14 If line 10 is greater than line 13, subtract line 11 from line 10 and enter the result here. If line 13 is greater than line 10, enter the amount from line 12 **14** \$ _____

15 Add lines 2, 4, 5, and 14. Enter the result here and in Step 4(b) of Form W-4 **15** \$ _____

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$0	\$480	\$850	\$850	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020
\$10,000 - 19,999	0	480	1,480	1,850	2,050	2,220	2,220	2,220	2,220	2,220	2,220	2,620
\$20,000 - 29,999	480	1,480	2,480	3,050	3,250	3,420	3,420	3,420	3,420	3,420	3,820	4,820
\$30,000 - 39,999	850	1,850	3,050	3,620	3,820	3,990	3,990	3,990	3,990	4,390	5,390	6,390
\$40,000 - 49,999	850	2,050	3,250	3,820	4,020	4,190	4,190	4,190	4,590	5,590	6,590	7,590
\$50,000 - 59,999	1,020	2,220	3,420	3,990	4,190	4,360	4,360	4,760	5,760	6,760	7,760	8,760
\$60,000 - 69,999	1,020	2,220	3,420	3,990	4,190	4,360	4,760	5,760	6,760	7,760	8,760	9,760
\$70,000 - 79,999	1,020	2,220	3,420	3,990	4,190	4,760	5,760	6,760	7,760	8,760	9,760	10,760
\$80,000 - 99,999	1,020	2,220	3,420	4,240	5,440	6,610	7,610	8,610	9,610	10,610	11,610	12,610
\$100,000 - 149,999	1,870	4,070	6,270	7,840	9,040	10,210	11,210	12,210	13,210	14,210	15,360	16,560
\$150,000 - 239,999	1,870	4,100	6,500	8,270	9,670	11,040	12,240	13,440	14,640	15,840	17,040	18,240
\$240,000 - 319,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,780	14,980	16,180	17,380	18,580
\$320,000 - 364,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,860	15,860	17,860	19,860	21,860
\$365,000 - 524,999	2,720	5,920	9,390	12,260	14,760	17,230	19,530	21,830	24,130	26,430	28,730	31,030
\$525,000 and over	3,140	6,840	10,540	13,610	16,310	18,980	21,480	23,980	26,480	28,980	31,480	33,990

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$90	\$850	\$1,020	\$1,020	\$1,020	\$1,070	\$1,870	\$1,870	\$1,870	\$1,870	\$1,870	\$1,970
\$10,000 - 19,999	850	1,780	1,980	1,980	2,030	3,030	3,830	3,830	3,830	3,830	3,930	4,130
\$20,000 - 29,999	1,020	1,980	2,180	2,230	3,230	4,230	5,030	5,030	5,030	5,130	5,330	5,530
\$30,000 - 39,999	1,020	1,980	2,230	3,230	4,230	5,230	6,030	6,030	6,130	6,330	6,530	6,730
\$40,000 - 59,999	1,020	2,880	4,080	5,080	6,080	7,080	7,950	8,150	8,350	8,550	8,750	8,950
\$60,000 - 79,999	1,870	3,830	5,030	6,030	7,100	8,300	9,300	9,500	9,700	9,900	10,100	10,300
\$80,000 - 99,999	1,870	3,830	5,100	6,300	7,500	8,700	9,700	9,900	10,100	10,300	10,500	10,700
\$100,000 - 124,999	2,030	4,190	5,590	6,790	7,990	9,190	10,190	10,390	10,590	10,940	11,940	12,940
\$125,000 - 149,999	2,040	4,200	5,600	6,800	8,000	9,200	10,200	10,950	11,950	12,950	13,950	14,950
\$150,000 - 174,999	2,040	4,200	5,600	6,800	8,150	10,150	11,950	12,950	13,950	14,950	16,170	17,470
\$175,000 - 199,999	2,040	4,200	6,150	8,150	10,150	12,150	13,950	15,020	16,320	17,620	18,920	20,220
\$200,000 - 249,999	2,720	5,680	7,880	10,140	12,440	14,740	16,840	18,140	19,440	20,740	22,040	23,340
\$250,000 - 449,999	2,970	6,230	8,730	11,030	13,330	15,630	17,730	19,030	20,330	21,630	22,930	24,240
\$450,000 and over	3,140	6,600	9,300	11,800	14,300	16,800	19,100	20,600	22,100	23,600	25,100	26,610

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$280	\$850	\$950	\$1,020	\$1,020	\$1,020	\$1,020	\$1,560	\$1,870	\$1,870	\$1,870
\$10,000 - 19,999	280	1,280	1,950	2,150	2,220	2,220	2,220	2,760	3,760	4,070	4,070	4,210
\$20,000 - 29,999	850	1,950	2,720	2,920	2,980	2,980	3,520	4,520	5,520	5,830	5,980	6,180
\$30,000 - 39,999	950	2,150	2,920	3,120	3,180	3,720	4,720	5,720	6,720	7,180	7,380	7,580
\$40,000 - 59,999	1,020	2,220	2,980	3,570	4,640	5,640	6,640	7,750	8,950	9,460	9,660	9,860
\$60,000 - 79,999	1,020	2,610	4,370	5,570	6,640	7,750	8,950	10,150	11,350	11,860	12,060	12,260
\$80,000 - 99,999	1,870	4,070	5,830	7,150	8,410	9,610	10,810	12,010	13,210	13,720	13,920	14,120
\$100,000 - 124,999	1,870	4,270	6,230	7,630	8,900	10,100	11,300	12,500	13,700	14,210	14,720	15,720
\$125,000 - 149,999	2,040	4,440	6,400	7,800	9,070	10,270	11,470	12,670	14,580	15,890	16,890	17,890
\$150,000 - 174,999	2,040	4,440	6,400	7,800	9,070	10,580	12,580	14,580	16,580	17,890	18,890	20,170
\$175,000 - 199,999	2,040	4,440	6,400	8,510	10,580	12,580	14,580	16,580	18,710	20,320	21,620	22,920
\$200,000 - 249,999	2,720	5,920	8,680	10,900	13,270	15,570	17,870	20,170	22,470	24,080	25,380	26,680
\$250,000 - 449,999	2,970	6,470	9,540	12,040	14,410	16,710	19,010	21,310	23,610	25,220	26,520	27,820
\$450,000 and over	3,140	6,840	10,110	12,810	15,380	17,880	20,380	22,880	25,380	27,190	28,690	30,190



LOUISIANA
DEPARTMENT
of REVENUE

Employee's Withholding Certificate (L-4)

This form must be filed with your employer.

For Questions:

Phone: (855) 307-3893

Send an email by visiting

<https://revenue.louisiana.gov/contact-us/>.

Purpose: Complete Form L-4 so that your employer can withhold the correct amount of state income tax from your salary.

Instructions: Employees who are subject to state withholding must provide their expected tax return filing status in Block A.

- Employees must file a new certificate within 10 days if the number of their deductions decreases, except if the change is the result of the death of a spouse.
- Employees may file a new certificate any time the number of their deductions increases.
- Line 7 should be used to increase or decrease the tax withheld for each pay period. Decreases should be indicated as a negative amount.

Penalties will be imposed for willfully supplying false information or willfully failing to supply information that would reduce the withholding amount.

This form must be filed with your employer. If an employee fails to complete this withholding certificate, the employer must withhold Louisiana income tax from the employee's wages without any standard deduction.

Note to Employer: Keep this certificate with your records.

Block A

- Enter "0" to claim no standard deduction and check the appropriate box under number 3 below. You may enter "0" if you are married, and have a working spouse or more than one job to avoid having too little tax withheld.
- Enter "1" to claim a standard deduction if your filing status is single or married filing separate and check the appropriate box under number 3 below if you did not claim this deduction in connection with other employment or if your spouse has not claimed a deduction.
- Enter "2" to claim a standard deduction if your filing status is married filing jointly, head of household, or qualifying surviving spouse and check the appropriate box under number 3 below.

A.

Cut here and give the bottom portion of certificate to your employer. Keep the top portion for your records.

Form **L-4**
Louisiana
Department of
Revenue

Employee's Withholding Certificate

1. First name and middle initial		Last name	
2. Social security number	3. Select one: <input type="checkbox"/> No deduction <input type="checkbox"/> Single or married filing separately <input type="checkbox"/> Married filing jointly, qualifying surviving spouse, or head of household		
4. Home address (number and street or rural route)			
5. City		State	ZIP
6. Total number of deductions claimed in Block A			6.
7. Adjustments. Enter any increase or decrease in the amount of tax to be withheld each pay period. Decreases should be indicated as a negative amount and cannot result in an amount less than zero to be withheld each pay period.			7.

I declare under the penalties imposed for filing false reports that the number of deductions claimed on this certificate do not exceed the number to which I am entitled.

Employee's signature	Date
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The following is to be completed by employer.

8. Employer's name and address	9. Employer's state withholding account number
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State of Louisiana Exemption from Withholding Louisiana Income Tax

Form L-4E

This form must be filed with your employer.

For Questions:

Phone: (855) 307-3893

Send an email by visiting <https://www.revenue.louisiana.gov/Contact/ContactUs>.

TAX YEAR 20 _____

For use by employees who meet the following requirements: *(Check all that apply.)*

- incurred no tax liability in the prior year and anticipate no tax liability for the current year
- meet the conditions set forth under the Servicemember Civil Relief Act, as amended by the Military Spouses Residency Relief Act and the Veterans Benefits and Transitions Act of 2018 with a tax domicile in the State of _____.

PLEASE PRINT OR TYPE

First name, middle initial, and last name	Social security number
Home address <i>(Number and Street)</i>	
City	State ZIP

EMPLOYEE'S CERTIFICATION

Under penalty of perjury, I declare that I anticipate that I will incur no liability for Louisiana income tax for the current year based on the exemption checked above and to the best of my knowledge and belief, this form is true, correct, and complete.

Signature	Date <i>(mm/dd/yyyy)</i>
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Employee - File this certificate with your employer. Otherwise, your employer must withhold Louisiana income tax from your wages.

Employer - Keep this certificate with your records. This certificate may be used instead of Form L-4, *Employee's Withholding Certificate*, by those employees qualified to claim the exemption.

INSTRUCTIONS

Who may claim exemption from withholding of income tax

You may be entitled to claim exemption from withholding Louisiana income tax if you meet one of the three qualifications below.

1. You incurred no liability for Louisiana income tax for the prior year and you anticipate that you will incur no liability for such income tax for the current year. For this purpose, you incur tax liability if your joint or separate return shows tax before the allowance of any credit for income tax withheld. If you claim this exemption, your employer will not withhold Louisiana income tax from your wages.
2. You are exempt from Louisiana income taxes under the Servicemember Civil Relief Act, as amended by the Military Spouses Residency Relief Act and the Veterans Benefits and Transitions Act of 2018. For your wages to be exempt from Louisiana income taxes, (a) your spouse must be a member of the armed forces stationed in Louisiana in compliance with military orders; (b) you are here in Louisiana solely to be with your spouse; and (c) you and your spouse maintain your domicile in another state.
3. **Exceptions:** You are exempt from Louisiana income taxes as a nonresident mobile worker if you meet the qualifications. For your wages to be exempt from Louisiana income taxes, (a) you must be a nonresident of Louisiana; (b) you will be paid wages for employment duties performed in Louisiana for 25 or fewer days in the calendar year; (c) you performed employment duties in more than one state during the calendar year; (d) the wages are not paid for employment as a professional athlete, staff member of a professional athletic team, professional entertainer, public figure, or qualified production employee; (e) your state of residence either provides a substantially similar exemption or does not impose an individual income tax; and (f) you did not have any other income derived from sources within Louisiana during the calendar year. If you meet the qualifications, an exemption certificate is not needed. However, within 10 days

from the 26th day of performing employment duties within Louisiana during the current year you must file Form L-4 with your employer.

When to claim exemption

File this certificate with your employer as soon as you determine you are entitled to claim this exemption. You must file a certificate each year if you wish to continue to claim the exemption.

Multiple employers

If you are employed by more than one employer, you may claim the exemption from withholding with each employer, provided that the total of your anticipated income will not cause you to incur any liability for Louisiana income tax for the current year and you incurred no liability for Louisiana income tax for the previous year.

When to revoke exemption

You must revoke this exemption certificate:

1. within 10 days from the day you anticipate you will incur Louisiana income tax liability for the current year; or
2. by the first day of the last month of your current taxable year if you anticipate you will incur Louisiana income tax liability for the following year;
3. within 10 days from the day you no longer meet the provisions of the Servicemember Civil Relief Act, as amended by the Military Spouses Residency Relief Act; or
4. within 10 days from the 26th day of performing employment duties within Louisiana during the current year.

If you want to discontinue, or are required to revoke this exemption, you must file a new L-4 with your employer.



Employee Wage Notice Louisiana OAAS-CCW

The Louisiana OAAS-CCW Employee Wage Notice serves as a request for Acumen to establish or change the wage you pay your employee. You must complete this form and submit it to Acumen. This will allow for proper payments to be made to the employee for the services provided. Rate change forms **must be received by Acumen two weeks prior to the effective date** for which the rate change is to take effect. If a two week notice is not provided, the form will **not** be processed. Retroactive (backdated) rate changes are **not** allowed. Please consult the "Show me the Money" for rate information.

Employee Name (please print): _____

Employee SSN (last 4 digits): _____

Service: PAS Wage:\$ _____

Service: PA2 Wage:\$ _____

Service: PA3 Wage:\$ _____

PAS = Personal Assistance Services
PA2 (PAS-2) = Personal Assistance Services Shared by 2 Participants
PA3 (PAS-3) = Personal Assistance Services Shared by 3 Participants

Effective Date (must be 1st or 16th of the month): _____

**rate changes cannot be retroactive*

I hereby acknowledge that as the employer, it is my responsibility to comply with Federal minimum wage and overtime requirements. I am also authorizing the wage(s) accordingly. I also understand and acknowledge that increasing wages and/or paying overtime reduces how many hours or units of service I have available and/or how much of my budget is available in other services.

Employer Name (please print): _____

Participant Name (if different from employer): _____

Employer Signature: _____ Date: _____

- Please complete this form for each new employee.
- Please complete this form for each employee that you wish to have the payroll wage changed.
- This form must be received by Acumen **two weeks** prior to the effective date. If a two week notice is not provided, the form will **not** be processed.

EMAIL, FAX or MAIL to:

enrollment@acumen2.net

1-866-923-5334

Acumen Fiscal Agent, LLC

5416 E. Baseline Rd., Suite 200

Mesa, Arizona 85206



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 in your Good-to-Go letter. **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:** If you choose to have a percentage of your check deposited into two accounts, you must indicate the percentage to be deposited into both the Primary Account and the Secondary Account, and the combined deposit amount must equal 100%. If no percentage is indicated for the Primary Account, 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 delivered via DCI messaging 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@acumen2.net

Fax: (866)923-5334

Mail: 5416 E Baseline Rd., Ste 200, Mesa, AZ 85206

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 if Account 1 deposit is less than 100%) Account Type: <input type="checkbox"/> Checking (attach a voided check) <input type="checkbox"/> Savings (attach routing & account information printout)
Financial Institution Name	Financial Institution Name
Account Holder Name	Account Holder Name
Routing Number	Routing Number
Account Number	Account Number
Percentage of check to be deposited: _____ % (Deposit amount must be 100% unless adding Secondary Account)	Percentage of check to be deposited: _____ % (Primary & Secondary Account deposits combined must equal 100%)

Please check this box to allow funds to be deposited into another person’s account if you are not the listed account holder.

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/Employer Relationship Disclosure for Tax Exemptions

Based on Age, Student Status, and Family Relationship

Employee Name _____ Employee SSN _____

Employer Name _____

Participant Name _____

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

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

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

Employee Signature _____

Date _____

Employee/Employer Relationship Disclosure for Tax Exemptions

Employee Copy – Keep for your records

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

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

IMPORTANT:

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

Question #1: Tax Exemptions for Non-Resident Students

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

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

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

Question #3: Tax Exemptions for Spouses Employed Spouses

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

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

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

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

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

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

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

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

FOOTNOTES:

- (1) A foreign student in the United States on an F-1 or J-1 visa is exempt from SUTA in PA and WA. MT and WI exempt F-1, J-1, M-1 and Q-1 visas from SUTA tax.
- (2) A child under age 18 employed by his or her parent is exempt from SUTA in the following states: CA, IL, MA, ME, MN, NJ, NV, OH, OR, PA, SC, TN, WA, WV. A child under age 21 employed by his or her parent is exempt from SUTA in the following states: AL, AZ, GA, HI, ID, IN, KS, LA, MO, NC, NY, OK, TX, UT, VA, WY and the District of Columbia. GA defines a child as “natural, legally adopted, step, and foster except that foster must be living in the same home as the employer”. MO and WY define a child as “natural, legally adopted, foster, and step”. MT exempts anyone classified as a dependent
- (3) AL exempts common law marriages created prior to 1/1/2017.
 CA, NV, and WA exempt a domestic partner employed by his or her domestic partner.
 GA exempts common law marriages created prior to 1/1/1997.
 HI exempts reciprocal beneficiary relationships and civil unions.
 ID exempts common law marriages created prior to 1/1/1996.
 IN exempts common law marriages created before 1/1/1958.
 KS, MT and TX exempt all common law marriages.
 NJ exempts civil unions.
 OH exempts common law marriages created prior to 10/10/1991.
 SC exempts common law marriages created prior to 07/24/2019
 All states recognize common law marriages created in a different state.
- (4) A parent employed by his or her child is exempt from SUTA in the District of Columbia and all states except NY and WA. MO defines parents as natural, foster, or step”.



Self-Direction Option for the Community Choices Waiver Employee Agreement

DESCRIPTION/DEFINITIONS:

Self-Direction is a service delivery option which allows eligible Medicaid waiver participants (or their responsible representative) to become the employer of the employees they choose to hire to provide supports and work for them.

Self-Direction is supported by both federal and state funds. These funds are used to pay **employees** to provide specific services to eligible participants as authorized by OAAS.

The **Plan of Care** (POC) is a document which specifies:

- The participant's needs and the types of tasks required to meet those needs;
- The amount of time, frequency, and duration required for delivery of the participant's services;
- The participant's personal outcomes, or goals, and the strategies to help them achieve or maintain their personal outcomes; and
- The people who will assist the participant in meeting their personal outcomes.

The participant's POC must be updated at least annually and be approved by the OAAS Regional Office or its designee.

The **Fiscal Employer Agent** (FEA) is a private entity which will process the employment-related payroll and withhold the necessary taxes on behalf of the employer.

The **Support Coordination Agency/Support Coordinator** is a resource to assist participants and/or their responsible representatives in the coordination of needed services. The support coordinator monitors the participant's service delivery to ensure that services meet their needs.

I, as the employee, agree/understand the following:

1. Neither the Louisiana Department of Health (LDH) nor the FEA has the role of employer and therefore bears no responsibility for the actions of my employer.
2. To accept payment from the FEA as payment in full for services provided.
3. To provide only the services authorized on the POC.
4. I must meet the necessary skills and requirements to be able to perform the services that I was hired to perform.
5. I may not transport participants as part of my employment responsibilities unless I have a valid driver's license, current state inspection sticker, and current proof of automobile insurance as required by the State of Louisiana.
6. The funds that I receive as an employee are Medicaid funds. The submission of false information on service logs, including progress notes, may subject me to criminal action, in addition to repayment of any funds.

7. Federal income tax withholding, Medicare, social security, and Louisiana state income tax withholding (as applicable) must be withdrawn from the my wages per state and federal laws.
8. I must complete any requested training (if applicable).
9. Any work that I perform in excess of the authorized amount or service limits will not be paid by LDH nor the FEA.
10. I must provide only the services that are authorized in the participant's POC. My duties must be consistent with the service specifications for the services provided in accordance with the Community Choices Waiver (CCW) program policies and procedures and the OAAS CCW Self-Direction Employer Handbook.
11. I must use the Electronic Visit Verification (EVV) system when I clock in and begin providing services to the participant and use the EVV system to clock out when I finish providing services to the participant.
12. I must complete service logs, including progress notes, each time that I provide a paid service.
13. I cannot provide care to the participant and/or receive payments when they are admitted to a hospital or nursing home as a patient.
14. I must provide information to LDH or its designee regarding the service for which payment was received, if requested.
15. I must maintain all information regarding the employer, participant, and/or their family in a confidential manner.
16. I must immediately notify a person, designated by the employer, of any medical emergency, illness, and/or visits to a physician.
17. If I suspect an adult (ages 18 - 59 or a person under 18 who has been legally declared an adult) has been abused or mistreated, I am required to report it to Adult Protective Services (APS) at 1-800-898-4910.
18. If I suspect an adult who is age 60 or older and has been abused or mistreated, I am required to report to Elderly Protective Services (EPS) at 1-833-577-6532.
19. I must report all critical incidents, as specified in the OAAS CCW Self-Direction Employer Handbook, to the participant's support coordinator.
20. My employment is contingent upon the participant/employer's participation in Self- Direction.

**Self-Direction Option for the Community Choices Waiver
Employee Agreement
Signature Page**

My signature below confirms my understanding and agreement to abide by the terms, conditions and responsibilities as stated above. I also agree to follow the OAAS CCW program and Self-Direction policies and procedures.

Name of Participant (Print): _____

Name of Employer (if other than participant) (Print): _____

Employer's Signature

Date

Name of Employee (Print): _____

Employee's Signature

Date



AccuScreen Systems™

1038 Main Street
Baton Rouge, Louisiana 70802
(225) 343-TEST



CRIMINAL BACKGROUND SEARCH AUTHORIZATION FORM

As a condition of employment with the self-directed program with the State of Louisiana, I have been informed Louisiana State Law, Title 40 R.S. 1300.51, requires a State Police records check be performed prior to employment. I hereby authorize AccuScreen Systems through Larry Bruce Childers and/or Darin N. Morgan, authorized agents under Title 40 R.S. 1300.51 to perform this check. I hereby hold harmless AccuScreen Systems, Larry Bruce Childers, and Darin N. Morgan, and **Acumen Fiscal Agent LLC, OAAS, and OCDD** from any cause of action that may arise from inaccurate information contained in State Police records. I also understand any adverse information contained within the files of State Police and released to the authorized agency will be provided to me upon written request within ten (10) business days of receiving notice that a record exists. **By signing this form, applicant authorizes Acumen Fiscal Agent LLC, OAAS, and OCDD to release information to the self-directed program with the State of Louisiana and my prospective employer as it pertains to my potential employment. Also by signing this form, applicant acknowledges it is unlawful to provide false or misleading information concerning a criminal history or security check to an employer.**

Fax this form to: 866-923-5334

Applicant's Signature: _____ Date: _____

*To ensure an accurate and timely search, please **print clearly** and complete this form **entirely**.*

Print Complete Name: _____

Date of Birth: _____ Race: _____ Sex: _____

SSN: _____

Driver's Lic. #: _____ State Where Issued: _____

Street Address: _____

City, State, Zip: _____

If you have lived in any state other than Louisiana in the LAST 7 YEARS ONLY, complete the following:

_____ (City, State)	_____ (County/Parish)	_____ (All LAST names YOU used while living here)	_____ (Mo./ Yr.) - (Mo./ Yr.)
_____ (City, State)	_____ (County/Parish)	_____ (All LAST names YOU used while living here)	_____ (Mo./ Yr.) - (Mo./ Yr.)
_____ (City, State)	_____ (County/Parish)	_____ (All LAST names YOU used while living here)	_____ (Mo./ Yr.) - (Mo./ Yr.)

Person Submitting this Search: _____ **Phone Number & Area Code:** _____

Participant's Name: _____

CHANGE INFORMATION FORM: EMPLOYEE



Please complete this form and return to Acumen by one of the following methods:

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

Fax: (866) 923-5334

Email: enrollment@acumen2.net

Change Employee Information

Complete this section when there is a change in employee information. The employee is the person providing service.

For a change in name, fax or mail this form, a copy of the new Social Security card, and the employee's original I-9 form with Section 3 completed.

For a name change, please provide the previous and new name. For all other changes, only the new information is required.

Change In (select all that apply): Name Address Phone Number E-mail Address

Current/Previous Name:

New Name:

Street Address (if changed):

City/State/Zip (if changed):

Phone Number (if changed):

E-mail Address:

Participant Name and ID Number:

Employee ID Number:

Signature (Employer or Authorized Rep):

Date:



EMPLOYEE TERMINATION FORM

Employers must complete the following information when an employee stops working for them. Please complete this form and return it to Acumen in one of the following ways:

Mail: 5416 E. Baseline Rd., Suite 200, Mesa, AZ 85206
Fax: (866) 923-5334
E-mail: Payroll-LA@acumen2.net

Your state has laws regarding how quickly an employee's final paycheck must be issued. Please make sure the final hours owed to your employee have been approved and submitted so Acumen can help you comply with the final paycheck laws in your state.

EMPLOYEE NAME:	
EMPLOYEE ID #:	
LAST DATE OF EMPLOYMENT:	CHECK ONE
	VOLUNTARY <input type="checkbox"/> INVOLUNTARY <input type="checkbox"/>
REASON FOR ENDING EMPLOYMENT:	
IF YOUR EMPLOYEE RECEIVES PAYCHECKS IN THE MAIL, THE FINAL PAYCHECK WILL BE SENT TO THE ADDRESS ON FILE. IF THE CHECK NEEDS TO BE SENT TO A DIFFERENT ADDRESS, PLEASE PROVIDE THAT ADDRESS BELOW:	
IF YOUR EMPLOYEE RECEIVES PAYCHECKS ELECTRONICALLY (DIRECT DEPOSIT OR PAYCARD), THE FINAL PAYCHECK WILL BE DELIVERED ELECTRONICALLY. IF A PAPER CHECK IS NEEDED INSTEAD, PLEASE PROVIDE THE ADDRESS WHERE THAT CHECK SHOULD BE SENT BELOW:	
PARTICIPANT NAME AND ID #:	
EMPLOYER NAME:	
EMPLOYER SIGNATURE:	DATE:

Paying For Your Supports



Payment Schedule

A Payment Schedule has been provided in this folder. Please remember to follow this schedule so your employees get paid on time. Late submissions will be processed in the next payment cycle according to the schedule.

Reporting Employees' Time

Anytime your employee performs work, you and the employee need to report that work to Acumen. There are two ways you can report work performed to Acumen, Web Time Entry / DCI and Employee Time Sheets. However, we strongly recommend that you manage your employee's time through our Web Time Entry / DCI system.

Web Time Entry / DCI

Acumen encourages you to use our Web Time Entry / DCI system for reporting and payroll submission. DCI is an Internet-based application that allows you to submit your employee hours online and provides real-time time entry submission, service authorization information, and employee details. Choosing DCI eliminates the need for paper time sheets, and provides additional safeguards against incomplete and/or incorrect submissions.

DCI also gives you an added layer of fraud protection. As an employer, it is your responsibility to ensure the accuracy of all time sheets prior to approval and submission. The DCI site is password protected, which means that no information can be modified without your password entered. It is your responsibility as the employer to keep this password confidential. Available reports will show you hours paid out, allowing you to keep a close eye on your account. You can compare these reports with your personal records to verify that there have been no unauthorized payment requests. If you are interested in using DCI or would like more information, visit www.acumenfiscalagent.com, or call our customer service team at 1(855) 514-9938.

Even though you use DCI, you MUST also complete paper timesheets. These paper timesheets are for your documentation and MUST be maintained for billing purposes. You DO NOT need to send these paper timesheets to Acumen.

Employee Time Sheets

You can send a paper time sheet by email, fax or mail. If you are using a time sheet, please email the time sheet to customerservice@acumen2.net, or fax to 1(866) 923-5334 according to the Payment Schedule. You should review the time sheet for accuracy before submitting the time sheet as errors will cause a delay in payment.

Within this folder you will find instructions as to how to correctly fill out a time sheet. A sample time sheet has been provided in the samples section of this packet.

Remember, only hours that are approved in the Plan of Care (POC) will be paid through this program. As an employer, if you cause work to be performed over and above your hours, **you** are responsible for paying your employee(s) for those hours.

Employee Pay Rate and Changes

If you want to establish or change an employee's hourly pay wage, you must turn in an Employee Wage Notice. Please email, fax or mail the completed form to Acumen. Make sure you refer to the "Show Me the Money" chart so you can see the total "Cost to You" and stay within your budget allocation.

Overtime

If your employee works more than 40 hours in a work week, they MUST be paid overtime at one and a half (1 ½) times their normal wage. Acumen will automatically pay your employee one and a half times their normal wage if you submit an approved time sheet for an employee that shows more than 40 hours in a work week. A work week begins on Sunday at 12:00 AM (midnight) and goes through the following Sunday at 12:00 AM (midnight).

Overtime pay will affect the amount of money and units left in your budget for the rest of the quarter. You should monitor the impact of overtime on your budget and adjust your hours and/or wages accordingly. Your support coordinator can assist you, but will **NOT** be authorized to increase your budget due to use of overtime.

Earned Income Credit

Some employees are eligible for the Earned Income Tax Credit (EITC). EITC is a refundable federal income tax credit for low to moderate income working individuals and families. To qualify, taxpayers must meet certain requirements and file a tax return, even if they do not have a filing requirement.

To learn more about the rules and income limits that apply to your employee(s) to qualify for EITC, visit the IRS website at www.irs.gov/eitc or call 1-800-829-1040.

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.

Please refer to Section 2 of your Employer Handbook.

As required by the State of Louisiana, suspected cases of fraud will be referred to OCDD and Medicaid's fraud unit for further investigation and possible prosecution.

Acumen's False Claims Policy – Fraud Protocol for the State of Louisiana, go to <https://www.acumenfiscalagent.com/louisiana/> or go to www.acumenfiscalagent.com.



PROVIDER'S NAME:		DIRECT SERVICE WORKER'S NAME (PRINT):					
PARTICIPANT'S NAME:				PARTICIPANT'S DOB:			
Week Of:		Through:					
Day Of Week:	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Date→							
Tasks:	Indicate Tasks Completed Each Day by Signing with Worker's Initials.						
Eating							
Bathing							
Dressing							
Grooming							
Transferring							
Ambulation							
Toileting							
Light Housekeeping							
Food Preparation & Storage							
Shopping							
Laundry							
Medication Reminders							
Assist To Scheduled Medical Appointment							
Assist To Arrange Medical Transportation							
Accompany To Medical Appointments							
Protective Supervision							
Supervision/Assistance with Health Tasks							
Escort for Assistance with Community Tasks							
Extension of Therapy Services							

PARTICIPANT/RESPONSIBLE REPRESENTATIVE/LEGAL REPRESENTATIVE'S SIGNATURE : _____ **DATE:** _____

DIRECT SERVICE WORKER'S SIGNATURE: _____ **DATE:** _____

NOTE: TIMES OF SERVICE DELIVERY, AS WELL AS LOCATION AT TIME OF CHECK IN/OUT, ARE DOCUMENTED THROUGH THE ELECTRONIC VISIT VERIFICATION (EVV) SYSTEM.

Instructions for OAAS Service Logs for Long Term – Personal Care Services (LT-PCS) and Community Choices Waiver (CCW) Personal Assistance Services (PAS)

Service Logs must be used to document services provided to OAAS participants receiving Long Term-Personal Care Services (LT-PCS) or Community Choices Waiver (CCW) Personal Assistance Services (PAS). Each Direct Service Worker (DSW) must complete his/her own Service Log for the participant being served. If providing Shared PAS, each participant must have his/her own Service Log reflecting services provided by a single DSW.

When an error is made, **only the individual who made the entry is allowed to correct the error.** Corrections must be made by drawing a single line through the incorrect entry, writing “error” above the entry, initialing the correction, and placing the correct information on the form.

This form can be printed two-sided or printed as a carbon copy.

PAGE 1 OF THE SERVICE LOG

Items 1-7 may be completed by the provider. This information may even be typed onto the form.

PROVIDER'S NAME: <input type="text"/>	DIRECT SERVICE WORKER'S NAME (PRINT): <input type="text"/>						
PARTICIPANT'S NAME: <input type="text"/>	PARTICIPANT'S DOB: <input type="text"/>						
Week Of: 11/12/17 Through: 11/18/17							
Day Of Week:	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Date→	<input type="text"/>	11/13/17	11/14/17	11/15/17	11/16/17	11/17/17	<input type="text"/>

- 1) Enter the name of the provider.
- 2) Print the name of the Direct Service Worker (DSW).
- 3) Enter the participant's name.
- 4) Enter the participant's date of birth.
- 5) Enter the beginning date of the prior authorization week (Example: 11/12/17).
- 6) Enter the ending date of the prior authorization week (Example: 11/18/17).
- 7) Enter the date for each day of the week on which services are scheduled to be performed. (Example: If services are scheduled to be delivered Monday through Friday, begin by placing the correct date of the prior authorization week on Monday, 11/13. Continue filling in the dates as applicable for the remainder of the week.)

The prior authorization week begins on Sunday at 12:00 a.m. (midnight) and ends on the following Saturday at 11:59 p.m.

NOTE: The DSW will be utilizing the Electronic Visit Verification (EVV) system to record the actual beginning and end times of service delivery, as well as the location at check in/out.

Items in 8 MUST be completed EACH DAY by hand by the Direct Service Worker (DSW).

Day Of Week:	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Date→		11/13/17	11/14/17	11/15/17	11/16/17	11/17/17	
Tasks:	Indicate Tasks Completed Each Day by Signing with Worker's Initials.						
Eating				FL	FL		
Bathing			FL				
Dressing			FL				
Grooming			FL				
Transferring			FL		FL		
Ambulation					FL		
Toileting					FL		
Light Housekeeping				FL			
Food Preparation & Storage				FL			
Shopping							
Laundry				FL			
Medication Reminders			FL	FL	FL		
Assist To Scheduled Medical Appointments					FL		
Assist To Arrange Medical Transportation							
Accompany To Medical Appointments			FL				

Additional possible tasks under PAS:

Protective Supervision			FL	FL	FL		
Supervision/Assistance with Health Tasks			FL				
Escort for Assistance with Community Tasks							
Extension of Therapy Services							

8) The DSW **must** enter his/her **signed initials** next to each task **actually performed**. A signed initial in the appropriate block will indicate that the task was completed on that day. Only those tasks that were performed that day should be indicated with signed initials. If the task was **NOT** performed for that particular day, the box should be left blank.

NOTE: All entries must be completed on the Service Log by the DSW on the day that he/she performs the task(s).

Items 9 and 10 are to be completed **ONLY AFTER** the form has been fully completed for the given week.

PARTICIPANT/ RESPONSIBLE REPRESENTATIVE/LEGAL REPRESENTATIVE'S SIGNATURE : _____ DATE: _____

DIRECT SERVICE WORKER'S SIGNATURE: _____ DATE: _____

9) The signature of the participant or the participant's Responsible Representative or the participant's legal representative and the date of that signature must appear on this line. This signature should be obtained at the end of the prior authorized week.

10) The DSW must also sign and date the form at the end of the prior authorized week. **The DSW should NOT complete this section until the work for that prior authorized week has been completed.**

PAGE 2 OF THE SERVICE LOG - PROGRESS NOTES

This page of the Service Log is to be used to document progress notes, as applicable.

This page may be duplicated as needed and may be printed as a carbon copy.

Items 11-16 are to be completed the same way as described in the Instructions for items 1-6 for Page 1 of the Service Log.

PROVIDER'S NAME: [REDACTED] 11

DIRECT SERVICE WORKER'S NAME (PRINT): 12

PARTICIPANT'S NAME: [REDACTED] 13 PARTICIPANT'S DOB: [REDACTED] 14

WEEK OF: [REDACTED] 15 THROUGH: [REDACTED] 16

Items 17 and 18 MUST be completed by the DSW when applicable and must be HANDWRITTEN.

DATE: 17	PROGRESS NOTES: 18 - Observed changes in physical and mental condition (if applicable) - Documentation of any SIGNIFICANT DEVIATION from what is in the Plan of Care (POC) - Important information for the next worker or caregiver
11/13/17	Ms.Xxxx called and declined all services today since her sister was visiting from Houston.
11/14/17	Got to Ms. Xxxx's home early today because she has a doctor's appointment. Brought her to Dr. Smith at 123 Sunshine Lane; Baton Rouge, LA. I did not assist with eating or cooking today because Ms. Xxxx was told not eat before her doctor's appointment. Also, I did not do any laundry because I brought Ms. Xxxx to the doctor.
11/15/17	Ms. Xxxx declined assistance with bathing and dressing today. She chose to stay in her pajamas. She stated that she was not feeling well and chose to stay in bed. I washed her laundry because I didn't wash yesterday (Tuesday).
11/16/17	Ms. Xxxx was still not feeling well but wanted to get out of bed. She was weak so I had to help her up to go to the bathroom and walk her to her chair in the next room. Called the doctor's office to make an appointment.
11/17/17	Did not provider services. Ms. Xxxx went to the hospital late Thursday night.

17) Write the date of the applicable progress note.

18) Use this area to write documentation of: (a) observed changes in physical and mental condition (e.g. – Participant more irritable or confused, needed more or less assistance than usual, etc.); (b) anything significantly different from what is in the POC (e.g. – flexing schedule to meet participant's needs, providing services in a different setting, etc.); (c) any important information for the next worker or caregiver (e.g.- noticed sore starting to form on foot and need to monitor, etc.)

Items 19 and 20 are to be completed on EACH page of narrative notes (if applicable) AFTER the form has been fully completed for the given week.

PARTICIPANT/RESPONSIBLE REPRESENTATIVE/LEGAL REPRESENTATIVE'S INITIALS: [REDACTED] 19 DATE: [REDACTED] 19

DIRECT SERVICE WORKER'S INITIALS: [REDACTED] 20 DATE: [REDACTED] 20

- 19) The participant, the participant's Responsible Representative, or the participant's Legal Representative (same person who signed on page 1 of the service log) must sign his/her initials and date **EACH** page of the Progress Notes.
- 20) The DSW must also sign his/her initials and date **EACH** page of the progress notes at the end of the prior authorized week.

Items 21 and 22 are to indicate the total number of pages for a given prior authorized week's documentation. This is important since page 2 of the service log may be duplicated as needed.

Page 21 of 22

Example: Page 1 of 5, Page 2 of 5, Page 3 of 5, etc.

Show Me the Money



It costs you, the employer, more to employ someone than just his/her wages. By law, employers must pay a portion of an employee's Social Security and Medicare taxes, Federal and State unemployment taxes and Workers' Compensation Insurance. Acumen calls these employer-related costs the "Cost to You."

What this means is that for every \$1.00 you pay in wages, you must add approximately 14 cents to pay for taxes and Workers' Compensation. The "Cost to You" is simply the employee's wage multiplied by 1.135 (the 14 cents per dollar mentioned above). Acumen calculates and pays these taxes and Workers' Compensation on your behalf. It is important for you to understand how this impacts your authorized allocation/budget. This "Show Me the Money" form is a tool you can use to calculate the "Cost to You." Be sure that you always round up your calculation to the next penny.

If you have any questions or need assistance with this tool, you can call Acumen's customer service team at 1-866-514-9938 and they will help you.

NOTE: The employee(s) wage (before any "Cost to You") **MUST** be at least the current minimum wage.

Simply fill in the blanks below to determine the "Cost to You."

$$\boxed{} \times \boxed{1.135} = \boxed{}$$

Employee Wage Taxes & Workers' Comp Cost to You (always round up)

Example 1:

Jane wants to pay her new employee, Don, the wage rate of \$7.25 per hour. Using the tool described above, Jane calculates her costs:

$$\boxed{\$7.25} \times \boxed{1.135} = \boxed{\$8.23 (8.22875)}$$

Employee Wage Taxes & Workers' Comp Cost to You (always round up)

It will cost Jane \$8.23 per hour to pay her employee a wage of \$7.25 per hour. Jane determines how this will impact her budget. She then fills out the *Employee Wage Notice* with a wage of \$7.25 per hour for Don and returns it to Acumen before Don's first day of employment.

Example 2:

Jake wants to give his employee, Maria, a wage increase. He spoke with his support coordinator and knows that \$9.80 per hour is an allowable rate for his approved service code. Jake calculates what it would cost him to pay Maria a wage of \$9.80 per hour using the tool described above:

$$\boxed{\$9.80} \times \boxed{1.135} = \boxed{\$11.13 (11.123)}$$

Employee Wage Taxes & Workers' Comp Cost to You (always round up)

It would cost Jake \$11.13 per hour to pay his employee, Maria, a wage of \$9.80 per hour. Jake determines how this will impact his budget. He decides he can afford to increase Maria's wage to \$9.80 per hour. Jake completes an *Employee Wage Notice* for Maria with the new rate of \$9.80 per hour. Jake sends the *Employee Wage Notice* so that Acumen receives it one week prior to the pay period end date for which the new wages are to take effect.



Louisiana Payroll Schedule Effective July 2025

Acumen acts as a fiscal service provider and **does not** monitor, review, or correct entries. Employers are responsible for **correcting** and **approving** employee entries by the date listed under the column, **“Payroll Entries DUE NO LATER THAN.”** All time entries approved **after the payroll due date** will be processed in the next payroll cycle. **NO EXCEPTIONS!**

Please keep the payroll calendar in a safe place and share with your employee.

MONTH	PAYROLL PAY PERIOD Bi-Weekly	PAYROLL ENTRIES DUE NO LATER THAN	PAYDAY Direct Deposit/Check
JULY	07/13/2025 - 07/26/2025	Mon, 07/28/2025	Fri, 08/08/2025
	07/27/2025 - 08/09/2025	Mon, 08/11/2025	Fri, 08/22/2025
AUGUST	08/10/2025 - 08/23/2025	Mon, 08/25/2025	Fri, 09/05/2025
	08/24/2025 - 09/06/2025	Mon, 09/08/2025	Fri, 09/19/2025
SEPTEMBER	09/07/2025 - 09/20/2025	Mon, 09/22/2025	Fri, 10/03/2025
	09/21/2025 - 10/04/2025	Mon, 10/06/2025	Fri, 10/17/2025
OCTOBER	10/05/2025 - 10/18/2025	Mon, 10/20/2025	Fri, 10/31/2025
	10/19/2025 - 11/01/2025	Mon, 11/03/2025	Fri, 11/14/2025
NOVEMBER	11/02/2025 - 11/15/2025	Mon, 11/17/2025	Fri, 11/28/2025
	11/16/2025 - 11/29/2025	Mon, 12/01/2025	Fri, 12/12/2025
DECEMBER	11/30/2025 - 12/13/2025	Mon, 12/15/2025	Fri, 12/26/2025
	12/14/2025 - 12/27/2025	Mon, 12/29/2025	Fri, 01/09/2026
JANUARY	12/28/2025 - 01/10/2026	Mon, 01/12/2026	Fri, 01/23/2026
	01/11/2026 - 01/24/2026	Mon, 01/26/2026	Fri, 02/06/2026
FEBRUARY	01/25/2026 - 02/07/2026	Mon, 02/09/2026	Fri, 02/20/2026
	02/08/2026 - 02/21/2026	Mon, 02/23/2026	Fri, 03/06/2026
MARCH	02/22/2026 - 03/07/2026	Mon, 03/09/2026	Fri, 03/20/2026
	03/08/2026 - 03/21/2026	Mon, 03/23/2026	Fri, 04/03/2026
APRIL	03/22/2026 - 04/04/2026	Mon, 04/06/2026	Fri, 04/17/2026
	04/05/2026 - 04/18/2026	Mon, 04/20/2026	Fri, 05/01/2026
MAY	04/19/2026 - 05/02/2026	Mon, 05/04/2026	Fri, 05/15/2026
	05/03/2026 - 05/16/2026	Mon, 05/18/2026	Fri, 05/29/2026
JUNE	05/17/2026 - 05/30/2026	Mon, 06/01/2026	Fri, 06/12/2026
	05/31/2026 - 06/13/2026	Mon, 06/15/2026	Fri, 06/26/2026

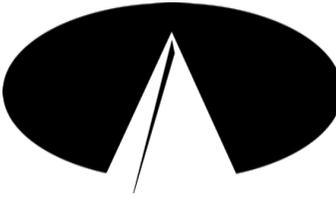
“MONTH”
refers to the month that services were provided.

“PAYROLL PAY PERIOD Bi-Weekly”
refers to a payroll cycle employees receive their pay every two weeks.

“PAYDAY Direct Deposit/Check”
refers to the date direct deposit will be issued. ****Please allow 3-5 business days from the payroll check for mailed paper checks delivered via postal service.****

“PAYROLL ENTRIES DUE NO LATER THAN”
refers to the last date to submit your employee’s approved hours.

Visit our website at <https://www.acumenfiscalagent.com/state/louisiana/> for trainings resources, EVV options, and employee application packets. Training resources can be found in the DCI Portal by clicking the **HELP** button. Send documents, questions and concerns to enrollment-la@acumen2.net. Louisiana Customer Service Hotline: **1-855-514-9938**.



Acumen Fiscal Agent Account Statement

Employer: [REDACTED]
[REDACTED]
[REDACTED]

Employer: Person who manages employees and/or represents the client for the account in this program

Activity Period: Reports activity of checks issued during date range. Does **NOT** represent dates employee worked

Activity Period: 11/16/2015 to 11/30/2015

Participant ID: 38730
Program: CCW

Participant ID: ID number used for participant/client on timesheets and Web Time Entry. The participant/client is the person receiving the services.

Total Allotments: Units or dollars your state/program has authorized Acumen to pay on your behalf

Period Utilization: Units/dollars used during Activity Period

Total Utilization: Units/dollars used from start of your Plan of Care through the Activity Period end date.

Account Information

	Total Allotments		Period Utilization		Total Utilization		Balance	
	Units	Dollars	Units	Dollars	Units	Dollars	Units	Dollars
PAS 10/01/15 - 12/31/15	805.00	\$8,983.80	151.00	\$1,686.28	462.75	\$5,164.29	342.25	\$3,819.51
Totals	805.00	\$8,983.80	151.00	\$1,686.28	462.75	\$5,164.29	342.25	\$3,819.51

Information for the **active** participant Plan of Care is shown. Plans of Care that are not active or that have not started are not displayed. If **future** periods are indicated, it will show a zero balance until they become available for spending.

Balance: Total units/dollars remaining as of the Activity Period end date

Employee Information

Name	Pay Type	Status	EE Number	Good to Go Date
[REDACTED]	Direct Deposit	Active	[REDACTED]	06/26/2015

Employee Information: Lists all employees, even those that did not work during the Activity Period

Code and Rate Information: Lists approved service codes and rates for each employee based on client service plan received by Acumen

Code and Rate Information

Name	Description	Start Date	End Date	Rate
[REDACTED]	PAS	06/26/2015	12/31/2222	\$9.82

Payroll Check Information: Details of each check issued for each employee based on timesheets submitted.

Payroll Check Information

Check #: [REDACTED]

Date: 11/30/2015

Payee: [REDACTED]

Net: [REDACTED]

Gross: [REDACTED]

Medicare: [REDACTED]

FICA: [REDACTED]

SUTA: [REDACTED]

FUTA: [REDACTED]

Work Comp: [REDACTED]

Batch #: 2194

Billing: [REDACTED]

Type: Direct Deposit

OT Hours: The hours an employee worked over 40 hours in a work week (Sunday at 12am (midnight) through the following Sunday at 12am (midnight)). Hours are multiplied by 1.5 when calculating the balance (found on 1st page) remaining in your allocation/budget.

OT Wage: Wage employee earns per hour for overtime. (time and a half)

Code	Work Date	Time In	Time Out	Wage	OT Wage	Hours	OT Hours
PAS	10/15/2015	9:00 AM	5:00 PM	\$9.82	-----	-8.00	-----
PAS	10/15/2015	9:00 AM	5:00 PM	-----	\$14.73	-----	8.00
PAS	11/01/2015	9:00 AM	5:00 PM	\$9.82	-----	8.00	-----
PAS	11/02/2015	9:00 AM	5:30 PM	\$9.82	-----	8.50	-----
PAS	11/03/2015	9:00 AM	5:30 PM	\$9.82	-----	8.50	-----
PAS	11/04/2015	9:00 AM	5:30 PM	\$9.82	-----	8.50	-----
PAS	11/05/2015	3:30 PM	5:00 PM	-----	\$14.73	-----	1.50
PAS	11/05/2015	9:00 AM	3:30 PM	-----	\$14.73	-----	6.50
PAS	11/06/2015	9:00 AM	5:00 PM	-----	\$14.73	-----	8.00
PAS	11/07/2015	9:00 AM	5:00 PM	-----	\$14.73	-----	8.00
PAS	11/08/2015	9:00 AM	5:00 PM	\$9.82	-----	8.00	-----
PAS	11/09/2015	9:00 AM	5:30 PM	\$9.82	-----	8.50	-----
PAS	11/10/2015	9:00 AM	5:30 PM	\$9.82	-----	8.50	-----
PAS	11/11/2015	9:00 AM	5:30 PM	\$9.82	-----	8.50	-----
PAS	11/12/2015	3:30 PM	5:00 PM	-----	\$14.73	-----	1.50
PAS	11/12/2015	9:00 AM	3:30 PM	-----	\$14.73	-----	6.50
PAS	11/13/2015	9:00 AM	5:00 PM	-----	\$14.73	-----	8.00
PAS	11/14/2015	9:00 AM	5:00 PM	-----	\$14.73	-----	8.00
PAS	11/15/2015	9:00 AM	5:00 PM	\$9.82	-----	8.00	-----
						67.00	56.00

Training and Certification	
Employee Name	Vehicle Insurance Expire Date
[REDACTED]	04/26/2016

Training and Certification: Shows important expiration/renewal dates for your employees.



Authorization Form

Complete each item and fax (866) 923-5334 or mail 4542 E. Inverness Ave., Suite 210, Mesa, AZ 85206 to Acumen. Please call (866) 514-9938 if you have any questions.

I hereby authorize Acumen Fiscal Agent (Acumen) to:

1. File Form SS-4 on my behalf to obtain an Employer Identification Number (EIN), if I do not already have one, and allow the IRS to mail EIN information to Acumen once obtained. **Note: If you currently have or have had an EIN, please contact the above phone number before proceeding with the employer enrollment paperwork.**
2. Represent me as an employer for employer-related tax reporting purposes, by signing Form 2678.
3. Handle all correspondence regarding employer tax reporting issues.
4. Serve as my Full Service Agent for unemployment and withholding tax purposes. As such, Acumen shall provide all services for me, the employer, (tax, benefits, and appeals) and shall receive all documents related to my, the employer's, Louisiana unemployment and withholding tax account that would otherwise have been sent to me.
5. Receive confidential information and perform any and all acts the employer can perform relating to matters pertaining to Louisiana's unemployment compensation law and state tax withholding regulations effective signature date forward; subject to revocation.
6. Electronically send me (e.g. e-mail) information including, but not limited to: employer and/or employee enrollment information, account statement reports, good-to-go information, and new products or services.

Any limitations to this authorization must be specifically stated and attached. This authorization revokes all earlier authorizations and powers of attorney on file, and shall remain in effect until receipt of a written notice of revocation or a subsequent authorization or power of attorney by the Louisiana Workforce Commission and/or Louisiana Department of Revenue.

What am I really authorizing?

- Your appointment grants Acumen Fiscal Agent a limited power of attorney to act as your agent for acts required under Section 3504 and Chapters 21, 22, 23, and/or 25 of Subchapter C of the Internal Revenue Code, and for taxes required under 3301.
- You are appointing Acumen Fiscal Agent as your agent for the Louisiana Workforce Commission and Louisiana Department of Revenue in the fulfilling of domestic employer responsibilities relative to the employing of persons through initiatives funded by the State of Louisiana, Department of Health and Hospitals.

Employer

The person who hires, fires, trains and manages staff.

Name:	Ima Employer
Social Security Number:	987-65-4321
Street Address:	123 S. 8th Street
City/State/Zip:	Winnsboro, LA 71295
Mailing Address (if different):	
City/State/Zip (if different):	
Parish of Residence:	Franklin
Phone Number:	318-435-0000
E-mail Address:	employer@mail.com

Participant

The individual receiving services.

Name:	Joe Participant
Date of Birth:	01/15/1936
Physical Address (if different):	
City/State/Zip (if different):	

Support Coordinator

Name:	Ima Coordinator
E-mail Address:	coordinator@state.us
Phone Number:	318-435-1111

Your signature means that you have read and understand the above information.

Signature:	<i>Ima Employer</i>
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Date:	06/30/2014
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Form **2678** Employer/Payer Appointment of Agent

(Rev. December 2023) Department of the Treasury — Internal Revenue Service

OMB No. 1545-0748

Use this form if you want to request approval to have an agent file returns and make deposits or payments of employment or other withholding taxes or if you want to revoke an existing appointment.

- If you're an employer or payer who wants to request approval, complete Parts 1 and 2 and sign Part 2. Then give it to the agent. Have the agent complete Part 3 and sign it.

Note: This appointment isn't effective until we approve your request. See the instructions for more information.

- If you're an employer, payer, or agent who wants to revoke an existing appointment, complete all three parts. In this case, only one signature is required.

For IRS use:

Part 1: Why you're filing this form.

(Check one)

- You want to **appoint** an agent for tax reporting, depositing, and paying.
- You want to **revoke** an existing appointment.

Part 2: Employer or Payer Information: Complete this part if you want to appoint an agent or revoke an appointment.

1 Employer identification number (EIN)

<input type="text"/>	<input type="text"/>	-	<input type="text"/>					
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2 Employer's or payer's name
(not your trade name)

EMPLOYER'S FIRST AND LAST NAME

3 Trade name (if any)

EMPLOYER'S PHYSICAL STREET ADDRESS

4 Address

Number		Street	Suite or room number
--------	--	--------	----------------------

EMPLOYER'S PHYSICAL CITY

STATE

ZIP CODE

City

State

ZIP code

Foreign country name

Foreign province/county

Foreign postal code

5 Forms for which you want to appoint an agent or revoke the agent's appointment to file. (Check all that apply.)

	For ALL employees/ payees/payments	For SOME employees/ payees/payments
--	---------------------------------------	--

- Form 940, Employer's Annual Federal Unemployment (FUTA) Tax Return* (all 940 series)
- Form 941, Employer's QUARTERLY Federal Tax Return (all 941 series)
- Form 943, Employer's Annual Federal Tax Return for Agricultural Employees (all 943 series)
- Form 944, Employer's ANNUAL Federal Tax Return (all 944 series)
- Form 945, Annual Return of Withheld Federal Income Tax
- Form CT-1, Employer's Annual Railroad Retirement Tax Return
- Form CT-2, Employee Representative's Quarterly Railroad Tax Return

* Generally, you can't appoint an agent to report, deposit, and pay tax reported on Form 940, unless you're a home care service recipient.

- Check here if you're a home care service recipient, and you want to appoint the agent to report, deposit, and pay FUTA tax for you. See the instructions.

I am authorizing the IRS to disclose otherwise confidential tax information to the agent relating to the authority granted under this appointment, including disclosures required to process Form 2678. The agent may contract with a third party, such as a reporting agent or certified public accountant, to prepare or file the returns covered by this appointment, or to make any required deposits and payments. Such contract may authorize the IRS to disclose confidential tax information of the employer/payer and agent to such third party. If a third party fails to file the returns or make the deposits and payments, the agent and employer/payer remain liable.

Sign your name here **EMPLOYER'S SIGNATURE**

Print your name here **EMPLOYERS FULL NAME**

Print your title here **HCSR EMPLOYER**

Date **CURRENT DATE**

Best daytime phone **ER'S PHONE #**

Now give this form to the agent to complete.

Form **SS-4**
(Rev. December 2025)
Department of the Treasury
Internal Revenue Service

Application for Employer Identification Number

(For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, Indian tribal entities, certain individuals, and others.)

See separate instructions for each line. Keep a copy for your records.
Go to www.irs.gov/FormSS4 for instructions and the latest information.

OMB No. 1545-0003

EIN

Type or print clearly.	1 Legal name of entity (or individual) for whom the EIN is being requested EMPLOYER'S FIRST AND LAST NAME		
	2 Trade name of business (if different from name on line 1)	3 Executor, administrator, trustee, "care of" name	
	4a Mailing address (room, apt., suite no. and street, or P.O. box) 5416 E BASELINE RD STE 200	5a Street address (if different) (Don't enter a P.O. box.) EMPLOYER'S PHYSICAL STREET ADDRESS	
	4b City, state, and ZIP code (if foreign, see instructions) MESA AZ 85206-4704	5b City, state, and ZIP code (if foreign, see instructions) EMPLOYER'S PHYSICAL CITY, STATE & ZIP CODE	
	6 County and state where principal business is located EMPLOYER'S PHYSICAL COUNTY AND STATE		
	7a Name of responsible party EMPLOYER'S FIRST AND LAST NAME		7b SSN, ITIN, or EIN EMPLOYER'S SOCIAL SECURITY NUMBER
8a Is this application for a limited liability company (LLC) (or a foreign equivalent)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		8b If 8a is "Yes," enter the number of LLC members	
8c If 8a is "Yes," was the LLC organized in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No			
9a Type of entity (check only one box). Caution: If 8a is "Yes," see the instructions for the correct box to check.			
<input type="checkbox"/> Sole proprietor (SSN) _____ <input type="checkbox"/> Estate (SSN of decedent) _____ <input type="checkbox"/> Partnership _____ <input type="checkbox"/> Plan administrator (TIN) _____ <input type="checkbox"/> Corporation (enter form number to be filed) _____ <input type="checkbox"/> Trust (TIN of grantor) _____ <input type="checkbox"/> Personal service corporation _____ <input type="checkbox"/> Military/National Guard <input type="checkbox"/> State/local government _____ <input type="checkbox"/> Church or church-controlled organization _____ <input type="checkbox"/> Farmers' cooperative <input type="checkbox"/> Federal government _____ <input type="checkbox"/> Other nonprofit organization (specify) _____ <input type="checkbox"/> REMIC <input type="checkbox"/> Indian tribal governments/enterprises _____ <input checked="" type="checkbox"/> Other (specify) HCSR EMPLOYER Group Exemption Number (GEN) if any _____			
9b If a corporation, name the state or foreign country (if applicable) where incorporated		State	Foreign country
10 Reason for applying (check only one box)			
<input type="checkbox"/> Started new business (specify type) _____ <input type="checkbox"/> Banking purpose (specify purpose) _____ <input type="checkbox"/> Hired employees (Check the box and see line 13.) <input type="checkbox"/> Changed type of organization (specify new type) _____ <input type="checkbox"/> Compliance with IRS withholding regulations <input type="checkbox"/> Purchased going business _____ <input checked="" type="checkbox"/> Other (specify) HCSR EMPLOYER <input type="checkbox"/> Created a trust (specify type) _____ <input type="checkbox"/> Created a pension plan (specify type) _____			
11 Date business started or acquired (month, day, year). See instructions.		12 Closing month of accounting year DECEMBER	
13 Highest number of employees expected in the next 12 months (enter -0- if none). If no employees expected, skip line 14.		14 If you expect your employment tax liability to be \$1,000 or less in a full calendar year and want to file Form 944 annually instead of Forms 941 quarterly, check here. (Your employment tax liability will generally be \$1,000 or less if you expect to pay \$5,000 or less, \$6,536 or less if you're in a U.S. territory, in total wages.) If you don't check this box, you must file Form 941 for every quarter <input type="checkbox"/>	
Agricultural		Household	Other
15 First date wages or annuities were paid (month, day, year). Note: If applicant is a withholding agent, enter date income will first be paid to nonresident alien (month, day, year)			
16 Check one box that best describes the principal activity of your business.			
<input type="checkbox"/> Construction <input type="checkbox"/> Rental & leasing <input type="checkbox"/> Transportation & warehousing <input type="checkbox"/> Health care & social assistance <input type="checkbox"/> Wholesale—agent/broker <input type="checkbox"/> Real estate <input type="checkbox"/> Manufacturing <input type="checkbox"/> Finance & insurance <input type="checkbox"/> Accommodation & food service <input type="checkbox"/> Wholesale—other <input type="checkbox"/> Retail <input checked="" type="checkbox"/> Other (specify) HCSR EMPLOYER			
17 Indicate principal line of merchandise sold, specific construction work done, products produced, or services provided. HCSR EMPLOYER			
18 Has the applicant entity shown on line 1 ever applied for and received an EIN? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes," write previous EIN here			

Third Party Designee	Complete this section only if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form.		
	Designee's name ALMA STEWART, SUNNY HUDSON		Designee's telephone number (include area code) (623) 792-6100
	Address and ZIP code 5416 E BASELINE RD STE 200, MESA AZ 85206-4704		Designee's fax number (include area code) (480) 371-2241
Under penalties of perjury, I declare that I have examined this application, and to the best of my knowledge and belief, it is true, correct, and complete.		Applicant's telephone number (include area code)	
Name and title (type or print clearly) EMPLOYER'S FIRST & LAST NAME HCSR EMPLOYER		EMPLOYER'S PHONE NUMBER	
Signature EMPLOYER'S SIGNATURE		Applicant's fax number (include area code)	
Date TODAY'S DATE		EMPLOYER'S FAX NUMBER	



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
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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.

2026

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 Maine 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.)		
Caution: To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.		

TIP: Consider using the estimator at www.irs.gov/W4App to determine the most accurate withholding for the rest of the year if you: are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

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 the 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 **Withholding Jobs Worksheet** on page 3 and enter the result in Step 2(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 Step 2(a) if the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(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):

(a) Multiply the number of qualifying children under age 17 by \$2,000	3(a) \$ 0	Required field even if "0"
(b) Multiply the number of other dependents by \$500	3(b) \$ 0	
Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here	3 \$ 0	

Step 4: 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. Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) 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, and check this

Exempt from withholding	I claim exemption from withholding for 2026, and I certify that I meet both of the conditions for exemption for 2026. See <i>Exemption from withholding</i> on page 2. I understand I will need to submit a new Form W-4 for 2027 <input type="checkbox"/>
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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.	
<i>Jane E. Employee</i>	01/01/2026
Employee's signature (This form is not valid unless you sign it.)	Date

Employers Only

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



Employee's Withholding Certificate (L-4)

This form must be filed with your employer.

For Questions:

Phone: (855) 307-3893

Send an email by visiting www.revenue.louisiana.gov/Contact/ContactUs.

Purpose: Complete Form L-4 so that your employer can withhold the correct amount of state income tax from your salary.

Instructions: Employees who are subject to state withholding must provide their expected tax return filing status in Block A.

- Employees must file a new certificate within 10 days if the number of their deductions decreases, except if the change is the result of the death of a spouse.
- Employees may file a new certificate any time the number of their deductions increases.
- Line 7 should be used to increase or decrease the tax withheld for each pay period. Decreases should be indicated as a negative amount.

Penalties will be imposed for willfully supplying false information or willfully failing to supply information that would reduce the withholding amount.

This form must be filed with your employer. If an employee fails to complete this withholding certificate, the employer must withhold Louisiana income tax from the employee's wages without any standard deduction.

Note to Employer: Keep this certificate with your records.

Block A

- Enter "0" to claim no standard deduction and check the appropriate box under number 3 below. You may enter "0" if you are married, and have a working spouse or more than one job to avoid having too little tax withheld.
- Enter "1" to claim a standard deduction if your filing status is single or married filing separate and check the appropriate box under number 3 below if you did not claim this deduction in connection with other employment or if your spouse has not claimed a deduction.
- Enter "2" to claim a standard deduction if your filing status is married filing jointly, head of household, or qualifying surviving spouse and check the appropriate box under number 3 below.

A. 1

SAMPLE

 Cut here and give the bottom portion of certificate to your employer. Keep the top portion for your records.

Form **L-4**
 Louisiana
 Department of
 Revenue

Employee's Withholding Certificate

1. First name and middle initial Jane E.		Last name Employee	
2. Social security number 111-22-3333	3. Select one: <input type="checkbox"/> No deduction <input checked="" type="checkbox"/> Single or married filing separately <input type="checkbox"/> Married filing jointly, qualifying surviving spouse, or head of household		
4. Home address (number and street or rural route) 111 Main St. Apt.2			
5. City Anytown, State 12345		State	ZIP 70000
6. Total number of deductions claimed in Block A			6.
7. Adjustments. Enter any increase or decrease in the amount of tax to be withheld each pay period. Decreases should be indicated as a negative amount and cannot result in an amount less than zero to be withheld each pay period.			7.

I declare under the penalties imposed for filing false reports that the number of deductions claimed on this certificate do not exceed the number to which I am entitled.

Employee's signature EMPLOYEE SIGNATURE	Date 01/14/2025
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The following is to be completed by employer.

8. Employer's name and address	9. Employer's state withholding account number
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I choose to receive my pay by (please check one box below):

Check Direct Deposit Pay Card

DIRECT DEPOSIT INFORMATION

Attach a voided check for checking 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 Account Type: <input checked="" type="checkbox"/> Checking (attach a voided check) <input type="checkbox"/> Savings (attach routing & account information printout)	Secondary Account (optional) Account Type: <input type="checkbox"/> Checking (attach a voided check) <input checked="" type="checkbox"/> Savings (attach routing & account information printout)
Bank One	Bank Two
Financial Institution Name 123 Oak Lane, Anytown, State 12345	Financial Institution Name 123 Oak Lane, Anytown, State 12345
Financial Institution Address 111222333	Financial Institution Address 111222333
Routing Number 9876543210	Routing Number 01234567890
Account Number 50	Account Number 50
% of check to be deposited	% of check to be deposited

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

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

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

Employee Signature

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.

Jane A. Employee
Print Name

111-22-3333
Social Security Number

01/02/1975
Date of Birth

test@example.com
Email Address for Payscale Delivery

Jane A. Employee
Signature

06/15/2018
Date

Return completed form by email enrollment@acumen2.net, fax (866) 923-5334 or mail to 4542 E. Inverness Ave., Ste. 210, Mesa, AZ 85206



Employee Wage Notice Louisiana OAAS-CCW

The Louisiana OAAS-CCW Employee Wage Notice serves as a request for Acumen to establish or change the wage you pay your employee. You must complete this form and submit it to Acumen. This will allow for proper payments to be made to the employee for the services provided. Rate change forms **must be received by Acumen two weeks prior to the effective date** for which the rate change is to take effect. If a two week notice is not provided, the form will **not** be processed. Retroactive (backdated) rate changes are **not** allowed. Please consult the "Show me the Money" for rate information.

Employee Name (please print): Jane A. Employee

Employee SSN (last 4 digits): 3333

Service: PAS Wage:\$ 10.00

Service: PA2 Wage:\$ _____

Service: PA3 Wage:\$ _____

PAS = Personal Assistance Services
PA2 (PAS-2) = Personal Assistance Services Shared by 2 Participants
PA3 (PAS-3) = Personal Assistance Services Shared by 3 Participants

Effective Date (must be 16th of the month): 07/01/2018
Rate changes cannot be retroactive

I hereby acknowledge that as the employer, it is my responsibility to comply with Federal minimum wage and overtime requirements. I am also authorizing the wage(s) accordingly. I also understand and acknowledge that increasing wages and/or paying overtime reduces how many hours or units of service I have available and/or how much of my budget is available in other services.

Employer Name (please print): Alice Smith

Participant Name (if different from employer): Patty Participant

Employer Signature: Alice Smith Date: 06/15/2018

- Please complete this form for each new employee.
- Please complete this form for each employee that you wish to have the payroll wage changed.
- This form must be received by Acumen **two weeks** prior to the effective date. If a two week notice is not provided, the form will **not** be processed.

EMAIL, FAX or MAIL to:
enrollment@acumen2.net
1-866-923-5334
Acumen Fiscal Agent, LLC
4542 Inverness Ave. Suite 210
Mesa, Arizona 85206