

Complete or Provide Photo Copies of the Documents Listed Below

This employment packet contains all the required paperwork to become enrolled as the Member's employee in the Community First Choice/Personal Assistance Services program. The prospective employee will need to complete all of the enrollment documents and trainings listed below, and provide photocopies of some documents. Use the checklists below to keep track of which forms you have completed.



1. Enrollment Forms.

- ☐ Employee Data Form – Employee provides contact information and answers all questions. *Ensure you have included a valid email address for CDCN to contact you.*
- ☐ Equal Employment Opportunity Disclosure Form – Completed at Employee's discretion.
- ☐ Form I-9 – Employee completes section 1. Member/PR completes section 2 and verifies identification provided by Employee. **See supplemental materials for I-9 instructions.**
- ☐ Form W-4 – Employee completes to determine amount of federal taxes withheld from pay.
- ☐ Form MW-4 – Employee completes to determine amount of state taxes withheld from pay.
- ☐ Wage Memo – Reviewed and signed by Employee.
- ☐ Pay Selection Form – Employee selects how pay will be issued. Direct deposit is recommended. **See supplemental materials for Pay Card information.**
- ☐ Employee Agreement – Reviewed and signed by Employee and Member/PR.
- ☐ Health Questionnaire – Employee completes.
- ☐ Driving Confirmation OR No Driving Confirmation – submit only one of these two forms, depending on whether or not you will be providing driving related services as a part of your duties. **Attachments required with Driving Confirmation Form.**
- ☐ Authorization/Declination of Hepatitis B Vaccination – Employee completes the form, choosing to decline or accept the Hepatitis B Vaccination at no charge.
- ☐ New Employee Expected Weekly Hours – For internal use. Please complete only the top portion of the form.

2. Photocopy Attachments. Provide if required, see explanations below.

- ☐ Voided check – Required if selecting direct deposit to a bank or credit union account.
- ☐ Photocopy of driver's license - Required if you will be driving as part of your job.
- ☐ Photocopy of vehicle insurance for vehicle used for driving-related services – Required if you will be driving as part of your job.

3. Trainings. Complete the trainings using the training materials provided.

- ☐ Training Module Documentation – Review the associated training pamphlets and the Employee Handbook and complete the quizzes on Infection Control, Lifting and Moving Patients, and Reporting Work Place Injuries.
- ☐ HIPAA Quiz & Confidentiality Agreement – Review the HIPAA Training Guide and take the quiz.
- ☐ Exposure Control Plan Training Signature Page – Employee and Member/PR review the Exposure Control Plan. Both sign the signature page after the training is completed.

**Mail the Completed Documents in the Envelope
Provided to your Local Consumer Direct Care Network (CDCN) Office**

When you have completed all the forms and trainings above, mail them to your local CDCN office in the envelope provided. Please double check each form to ensure they are completed and have signatures.

When we receive your completed packet we will create a personnel and payroll file for you.

We will then send you a written “Okay to Work” form letting you know when you can officially begin. Please remember, we are unable to pay a caregiver for any services performed prior to the date stated on the Okay to Work form. Once you receive the “Okay to Work” form you can begin working for the Consumer and submit timesheets.

Supplemental Materials

Keep and refer to as needed:

- Three Important Things – Please read
- Status Change Form (send to CDCN if there is a change in name, address, etc.)
- Payroll Calendar
- Caregiver Benefits Summary
- Health Insurance Marketplace Coverage

Refer to these as needed when completing your enrollment packet forms:

- I-9 Instructions - *Additional I-9 instructions are available on the CDCN Montana Caregiving website under the Forms tab.*
- U.S. Bank Focus Pay Card information sheet

Training Materials

Reference when completing the training quizzes in the enrollment packet:

- Exposure Control Plan (Training Instructions, Caregiver Summary, Member/Caregiver Training)
- HIPAA Training Guide
- Employee Handbook
- Employee Handbook Appendix
- Infection Control pamphlet
- Lifting and Moving Patients pamphlet

ASSISTANCE WITH THE HIRING PROCESS: Any employee who needs reasonable accommodation in any step of the hiring process should ask the Member, their Personal Representative or Consumer Direct Care Network (CDCN).

EMPLOYEE CONTACT INFORMATION					
Name: _____					
First		Middle		Last	
Physical Address: _____					
Street		Apt/Unit #	City	State	Zip
Mailing Address: _____					
<i>(if different than physical)</i>					
Street		Apt/Unit #	City	State	Zip
Phone Numbers: _____					
Home		Cell			
Do you consent to receiving text messages from CDCN? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Email Address*: _____ <i>*A valid email address is required. CDCN will communicate with you regularly via email; your background check questionnaire will be sent to this address as well.</i>					
Date of Birth: _____		Social Security Number: _____			
Emergency Contact: _____					
Name			Phone		
Position: The position being applied for is Caregiver					
This Employee Application is for me to work as a: <input type="checkbox"/> Primary Caregiver <input type="checkbox"/> Back-Up Caregiver					

PHYSICAL CAPACITY

Caregivers may be called upon to perform physically demanding work in the performance of their duties. A typical caregiver position will involve a variety of physical requirements, including the ability to:

- Lift 75 pounds, push 75 pounds, pull 50 pounds.
- Stand, walk, kneel, squat, bend, reach, reach overhead, sit, twist.
- Grasp, hold or manipulate objects with hands.

Are you able to perform the above physical tasks? ☐ Yes ☐ No

Please explain any exceptions:

CRIMINAL BACKGROUND

Have you ever been convicted of a crime or are charges pending? ☐ Yes ☐ No

If yes, please list each charge or conviction, nature of the offense leading to conviction, how recently the offense was committed, sentence imposed, and type of rehabilitation. Such convictions will not absolutely prohibit employment, but may be considered in relation to specific job requirements.





EMPLOYEE DATA FORM

PROFESSIONAL STANDARDS AND LICENSING

Have you ever had a professional license, certificate, or driver's license in any state revoked, suspended, or had disciplinary action applied?

☐ Yes ☐ No

In the past three years, have you had moving violations or motor vehicle accidents?
If yes, please explain:

☐ Yes ☐ No

PREVIOUS EXPERIENCE WITH COMPANY

Have you previously worked for Consumer Direct Personal Care, LLC, Consumer Direct Management Solutions or Nightingale Nursing & Caregiving?

☐ Yes ☐ No

ALIASES OR PREVIOUSLY HELD NAMES

Please list any aliases or previously held names: _____

PLEASE READ CAREFULLY

Neither the acceptance of this data form nor entry into any type of employment relationship or employment agreement with a Member for the consideration of employment shall serve to create an actual or implied contract of employment with Consumer Direct Personal Care, LLC doing business as Consumer Direct Care Network Montana Caregiving (CDCN).

An employment relationship cannot be altered except by a written instrument signed by the President of this Company. I understand that CDCN may unilaterally change or revise benefits, policies or procedures, and such changes may include a reduction in benefits.

I authorize investigation of all statements provided to the Member or contained in this data form. I understand that misrepresentation or omission of facts called for is cause for dismissal at any time without notice. I hereby give CDCN permission to contact schools, previous employers (unless otherwise indicated), references, and others, and hereby release CDCN from any liability as a result of such contact.

The Fair Credit Reporting Act requires us to advise you that we may request an investigative consumer report from a consumer reporting agency, including information on your background, as deemed necessary. Upon written request from you, we will provide you with additional information concerning the nature and scope of any report requested by us.

I further understand that employment with CDCN shall be probationary for the first 180 days, during which time my relation with CDCN is terminable at will for any reason by either party.

I understand I may begin working once I have received an Okay to Work Form from CDCN.

Applicant Printed Name

Applicant Signature

Date

Consumer Direct Care Network is an equal opportunity employer





EQUAL EMPLOYMENT OPPORTUNITY DISCLOSURE

Name: _____ Social Security # (last 4 digits): _____ Company: _____

The purpose of this questionnaire is to aid in complying with required governmental record keeping and/or reporting requirements. **This information will not be considered in the employment/selection process.** The information requested is voluntary, and you will not be subjected to any adverse treatment for choosing not to complete the questionnaire. When reported, the data will be used for statistical and reporting purposes not to identify a specific individual.

Gender (Please select the gender you most closely identify with):

☐ Male ☐ Female

Race/Ethnic Identification:

Please mark the **one box** that describes the race/ethnicity category (as defined by the Equal Employment Opportunity Commission) with which you primarily identify:

<input type="checkbox"/> Hispanic or Latino	A person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.
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-OR-

<input type="checkbox"/> White (<u>not</u> Hispanic or Latino)	A person having origins in any of the original people of Europe, North Africa, or the Middle East.
<input type="checkbox"/> American Indian or Alaska Native (<u>not</u> Hispanic or Latino)	A person having origins in any of the original peoples of North or South America, and who maintain cultural identification through tribal affiliation or community attachment.
<input type="checkbox"/> Black or African American (<u>not</u> Hispanic or Latino)	A person having origins in any of the original peoples of Africa.
<input type="checkbox"/> Asian (<u>not</u> Hispanic or Latino)	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander (<u>not</u> Hispanic or Latino)	A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
<input type="checkbox"/> Two or More Races (<u>not</u> Hispanic or Latino)	A person who identifies with more than one of the above races.

Decline Self Identification:

☐ I do not wish to self-identify.
Although I do not wish to self-identify my gender, ethnicity and/or race, I understand that my employer is required by the federal government to determine this information (complete this form) by visual survey and/or other available information.

Employee Signature: _____ **Date:** _____

Staff Option:

Only sign here if employee declined to self-identify their gender, ethnicity and/or race, and you were the employee who determined this information by "visual survey" and/or other available information.

Staff Signature (completed this form): _____ **Date:** _____





Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

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

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

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

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

Last Name (Family Name)		First Name (Given Name)		Middle Initial (if any)	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number (if any)	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number <div></div>		Employee's Email Address			Employee's Telephone Number
I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.		Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):				
		<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)		Additional Information			
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)		<input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.			
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.			First Day of Employment (mm/dd/yyyy):		
Last Name, First Name and Title of Employer or Authorized Representative			Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)
Employer's Business or Organization Name			Employer's Business or Organization Address, City or Town, State, ZIP Code		

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



LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.

* Documents extended by the issuing authority are considered unexpired.

Employees may present one selection from List A or a combination of one selection from List B and one selection from List C.

Examples of many of these documents appear in the Handbook for Employers (M-274).

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND LIST C Documents that Establish Employment Authorization
<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 		<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 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 	<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>

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.

For receipt validity dates, see the M-274.

<ul style="list-style-type: none"> • Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee. 	OR	<p>Receipt for a replacement of a lost, stolen, or damaged List B document.</p>	<p>Receipt for a replacement of a lost, stolen, or damaged List C document.</p>
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*Refer to the Employment Authorization Extensions page on [I-9 Central](#) for more information.





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

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

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

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

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

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

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

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

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

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

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

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



Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.

Give Form W-4 to your employer.

Your withholding is subject to review by the IRS.

2023**Step 1:**
Enter
Personal
Information

(a) First name and middle initial	Last name	(b) Social security number
Address		Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov .
City or town, state, and ZIP code		
(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

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

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) Reserved for future use.
- (b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**
- (c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate ☐

TIP: If you have self-employment income, see page 2.

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

Step 3: Claim Dependent and Other Credits	If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly): Multiply the number of qualifying children under age 17 by \$2,000 \$ _____ Multiply the number of other dependents by \$500 \$ _____ Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here	3	\$
	Step 4 (optional): Other Adjustments (a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income	4(a)	\$
	(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here	4(b)	\$
	(c) Extra withholding. Enter any additional tax you want withheld each pay period . .	4(c)	\$

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)
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General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2023 if you meet both of the following conditions: you had no federal income tax liability in 2022 **and** you expect to have no federal income tax liability in 2023. You had no federal income tax liability in 2022 if (1) your total tax on line 24 on your 2022 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2023 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2024.

Your privacy. If you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c).

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 income and self-employment taxes through withholding from your wages, you should enter the self-employment income on Step 4(a). Then compute your self-employment tax, divide that tax by the number of pay periods remaining in the year, and include that resulting amount per pay period on Step 4(c). You can also add half of the annual amount of self-employment tax to Step 4(b) as a deduction. To calculate self-employment tax, you generally multiply the self-employment income by 14.13% (this rate is a quick way to figure your self-employment tax and equals the sum of the 12.4% social security tax and the 2.9% Medicare tax multiplied by 0.9235). See Pub. 505 for more information, especially if the sum of self-employment income multiplied by 0.9235 and wages exceeds \$160,200 for a given individual.

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.

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 roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.



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

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

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2023 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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



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

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

Note: If more than one job has annual wages of more than \$120,000 or there are more than three jobs, see Pub. 505 for additional tables.

- 1 Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 **1** \$ _____
- 2 Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.
 - a** Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a **2a** \$ _____
 - b** Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b **2b** \$ _____
 - c** Add the amounts from lines 2a and 2b and enter the result on line 2c **2c** \$ _____
- 3** Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3** _____
- 4 Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) **4** \$ _____

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

- 1** Enter an estimate of your 2023 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 7.5% of your income **1** \$ _____
- 2** Enter: $\left\{ \begin{array}{l} \bullet \$27,700 \text{ if you're married filing jointly or a qualifying surviving spouse} \\ \bullet \$20,800 \text{ if you're head of household} \\ \bullet \$13,850 \text{ if you're single or married filing separately} \end{array} \right\}$ **2** \$ _____
- 3** If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" **3** \$ _____
- 4** Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information **4** \$ _____
- 5 Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 **5** \$ _____

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

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

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

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



Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$0	\$850	\$850	\$1,000	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,870
\$10,000 - 19,999	0	930	1,850	2,000	2,200	2,220	2,220	2,220	2,220	2,220	3,200	4,070
\$20,000 - 29,999	850	1,850	2,920	3,120	3,320	3,340	3,340	3,340	3,340	4,320	5,320	6,190
\$30,000 - 39,999	850	2,000	3,120	3,320	3,520	3,540	3,540	3,540	4,520	5,520	6,520	7,390
\$40,000 - 49,999	1,000	2,200	3,320	3,520	3,720	3,740	3,740	4,720	5,720	6,720	7,720	8,590
\$50,000 - 59,999	1,020	2,220	3,340	3,540	3,740	3,760	4,750	5,750	6,750	7,750	8,750	9,610
\$60,000 - 69,999	1,020	2,220	3,340	3,540	3,740	4,750	5,750	6,750	7,750	8,750	9,750	10,610
\$70,000 - 79,999	1,020	2,220	3,340	3,540	4,720	5,750	6,750	7,750	8,750	9,750	10,750	11,610
\$80,000 - 99,999	1,020	2,220	4,170	5,370	6,570	7,600	8,600	9,600	10,600	11,600	12,600	13,460
\$100,000 - 149,999	1,870	4,070	6,190	7,390	8,590	9,610	10,610	11,660	12,860	14,060	15,260	16,330
\$150,000 - 239,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
\$240,000 - 259,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
\$260,000 - 279,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	18,140
\$280,000 - 299,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,870	17,870	19,740
\$300,000 - 319,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,470	15,470	17,470	19,470	21,340
\$320,000 - 364,999	2,040	4,440	6,760	8,550	10,750	12,770	14,770	16,770	18,770	20,770	22,770	24,640
\$365,000 - 524,999	2,970	6,470	9,890	12,390	14,890	17,220	19,520	21,820	24,120	26,420	28,720	30,880
\$525,000 and over	3,140	6,840	10,460	13,160	15,860	18,390	20,890	23,390	25,890	28,390	30,890	33,250

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	\$310	\$890	\$1,020	\$1,020	\$1,020	\$1,860	\$1,870	\$1,870	\$1,870	\$1,870	\$2,030	\$2,040
\$10,000 - 19,999	890	1,630	1,750	1,750	2,600	3,600	3,600	3,600	3,600	3,760	3,960	3,970
\$20,000 - 29,999	1,020	1,750	1,880	2,720	3,720	4,720	4,730	4,730	4,890	5,090	5,290	5,300
\$30,000 - 39,999	1,020	1,750	2,720	3,720	4,720	5,720	5,730	5,890	6,090	6,290	6,490	6,500
\$40,000 - 59,999	1,710	3,450	4,570	5,570	6,570	7,700	7,910	8,110	8,310	8,510	8,710	8,720
\$60,000 - 79,999	1,870	3,600	4,730	5,860	7,060	8,260	8,460	8,660	8,860	9,060	9,260	9,280
\$80,000 - 99,999	1,870	3,730	5,060	6,260	7,460	8,660	8,860	9,060	9,260	9,460	10,430	11,240
\$100,000 - 124,999	2,040	3,970	5,300	6,500	7,700	8,900	9,110	9,610	10,610	11,610	12,610	13,430
\$125,000 - 149,999	2,040	3,970	5,300	6,500	7,700	9,610	10,610	11,610	12,610	13,610	14,900	16,020
\$150,000 - 174,999	2,040	3,970	5,610	7,610	9,610	11,610	12,610	13,750	15,050	16,350	17,650	18,770
\$175,000 - 199,999	2,720	5,450	7,580	9,580	11,580	13,870	15,180	16,480	17,780	19,080	20,380	21,490
\$200,000 - 249,999	2,900	5,930	8,360	10,660	12,960	15,260	16,570	17,870	19,170	20,470	21,770	22,880
\$250,000 - 399,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
\$400,000 - 449,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
\$450,000 and over	3,140	6,380	9,010	11,510	14,010	16,510	18,010	19,510	21,010	22,510	24,010	25,330

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	\$620	\$860	\$1,020	\$1,020	\$1,020	\$1,020	\$1,650	\$1,870	\$1,870	\$1,890	\$2,040
\$10,000 - 19,999	620	1,630	2,060	2,220	2,220	2,220	2,850	3,850	4,070	4,090	4,290	4,440
\$20,000 - 29,999	860	2,060	2,490	2,650	2,650	3,280	4,280	5,280	5,520	5,720	5,920	6,070
\$30,000 - 39,999	1,020	2,220	2,650	2,810	3,440	4,440	5,440	6,460	6,880	7,080	7,280	7,430
\$40,000 - 59,999	1,020	2,220	3,130	4,290	5,290	6,290	7,480	8,680	9,100	9,300	9,500	9,650
\$60,000 - 79,999	1,500	3,700	5,130	6,290	7,480	8,680	9,880	11,080	11,500	11,700	11,900	12,050
\$80,000 - 99,999	1,870	4,070	5,690	7,050	8,250	9,450	10,650	11,850	12,260	12,460	12,870	13,820
\$100,000 - 124,999	2,040	4,440	6,070	7,430	8,630	9,830	11,030	12,230	13,190	14,190	15,190	16,150
\$125,000 - 149,999	2,040	4,440	6,070	7,430	8,630	9,980	11,980	13,980	15,190	16,190	17,270	18,530
\$150,000 - 174,999	2,040	4,440	6,070	7,980	9,980	11,980	13,980	15,980	17,420	18,720	20,020	21,280
\$175,000 - 199,999	2,190	5,390	7,820	9,980	11,980	14,060	16,360	18,660	20,170	21,470	22,770	24,030
\$200,000 - 249,999	2,720	6,190	8,920	11,380	13,680	15,980	18,280	20,580	22,090	23,390	24,690	25,950
\$250,000 - 449,999	2,970	6,470	9,200	11,660	13,960	16,260	18,560	20,860	22,380	23,680	24,980	26,230
\$450,000 and over	3,140	6,840	9,770	12,430	14,930	17,430	19,930	22,430	24,150	25,650	27,150	28,600





Montana Employee's Withholding Allowance and Exemption Certificate

MONTANA
MW-4

Employee's first name and middle initial	Last name	Social Security Number
Current mailing address		City, state and ZIP code
Under penalty of false swearing, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.		
Employee's signature _____		Date _____
(This form is not valid unless you sign it.)		

Complete Form MW-4 so that your employer can withhold the correct Montana income tax from your pay. See "Employee Instructions" on back of this form before beginning.

Section 1: Montana Allowances

- A. Enter "1" for **yourself** A. _____
- B. Enter "1" if you have only one job B. _____
- C. Enter "1" for your **spouse** if you expect to file as **married filing jointly** on your Montana tax return. But, you may choose to enter "-0-" if you have a working spouse. (Entering "-0-" may help you avoid having too little tax withheld.) C. _____
- D. Enter the number of **dependents** (other than your spouse or yourself) you will claim on your Montana tax return D. _____
- E. Enter "1" if you will file as **head of household** on your Montana tax return E. _____
- F. Enter "1" if you expect to report large itemized deductions (medical, child and dependent care, etc.) (Caution: An additional allowance could result in tax due when you file your return.) F. _____
- G. Add lines A through F and enter the total here. **This is your total number of allowances.** (Note: This number may be different from the number of exemptions you claim on your Montana tax return.) G. _____
- H. Additional amount, if any, you want withheld from each paycheck or pension and annuity payment. H. \$ _____

Section 2: Exemption from Montana Withholding for Tax Year _____

You may be entitled to claim an exemption from Montana income tax withholding. If applicable, mark one box below to indicate the reason why you believe you are exempt. See instructions for Section 2 on back of this form for more information.

- ☐ a. I am an enrolled member of a registered tribe, I live on the reservation of that tribe, AND I claim exemption from withholding on the wages derived from work performed on the reservation where I live. (*You must also complete Section 1.*)
- ☐ b. I am a member of the Reserve or National Guard, and I claim to be exempt from withholding on my compensation determined under USC Title 10. (*You must also complete Section 1.*)
- ☐ c. I am a resident of North Dakota, and claim exemption from withholding on my wages.
- ☐ d. I am a resident of another state living in Montana solely to be with my spouse, who is a resident of the same state and a member of the U.S. armed forces assigned to a military location in Montana, and I claim exemption from withholding on my wages.

Employer name	Employer EIN	Employer MT withholding account ID
Employer address	City, state and ZIP code	



10206



Employee Instructions

Due to changes in federal tax laws, the current federal Form W-4 should not be used for the calculation of Montana income tax withholding.

This new Form MW-4 replaces the federal form for Montana employees.

Employees who already claimed allowances in previous years do not have to submit this form unless they are claiming an exemption from withholding in Section 2.

Should I complete Form MW-4?

Complete Form MW-4 and provide to your employer, if you:

- are a newly hired employee, or
- claim to be exempt from Montana income tax withholding. *See Section 2 instructions.*

Consider completing a new Form MW-4 if your personal or financial situation changes. If you have not had sufficient income tax withheld from your wages, interest and/or penalties may be assessed when you file your individual income tax return.

Section 1: Montana Allowances

Complete this section to determine the number of withholding allowances to claim. Withholding on your wages is required unless you can claim an exemption from Montana withholding. *See Section 2 instructions.*

C. Spouse – If you are married and planning to file your Montana income tax return jointly with your spouse, add an allowance to reduce the amount of withholding.

In general, employees with a working spouse file their Montana return separately to lower their tax liability. If you are planning to file separately, enter zero on this line.

E. Head of household. – Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50 percent of the cost of keeping up a home for yourself and your dependent(s) or other qualifying individuals.

F. Itemized deductions. – If your income mainly consists of wages or pensions, and you expect to report large itemized deductions, you may consider adding an additional allowance. Adding an allowance will reduce the amount of tax withheld. Caution: If you do not withhold enough to cover your income tax obligation, you may owe taxes and interest when you file your return. *See Montana Publication 1 for more information.*

H. Additional amount withheld. – You may request to have an additional amount of taxes withheld from your paycheck on Line H. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments.

If you receive pensions or annuities, you may ask the payer to withhold a flat amount that you report on this line.

Section 2: Exemption from Montana Withholding

You must meet one of the following requirements to claim exemption:

- a. You are an enrolled member of an American Indian tribe living and working on the reservation of which you are an enrolled member. You must also complete Section 1 because your exemption may not cover all the wages you earned in Montana.
- b. You are a member of the Montana National Guard and are receiving pay or for active duty in the U.S. military under USC Title 10 orders. You must also complete Section 1 because your exemption only applies to your pay derived from your USC Title 10 orders.
- c. Your wages are exempt from withholding because you are a resident of North Dakota. This exemption is available for residents of North Dakota because of the reciprocity agreement in place between North Dakota and Montana.
- d. You are the spouse of a military member assigned to duty in Montana, you and your spouse are domiciled in another state (the same state as one another) and you are present in Montana solely to be with your spouse.

To claim an exemption, give this form to your employer upon the start of your employment, or as soon as you qualify for an exemption. If it remains applicable, your exemption needs to be renewed before the beginning of the next year. Provide a new Form MW-4 to your employer each year or your employer will begin withholding. Do not forget to indicate the year.

Montana does not recognize the federal exempt status available on the federal Form W-4. Therefore, exemption from withholding for federal purposes does not exempt you from Montana income tax withholding.

An exemption from withholding is available only if the entire statement you checked in Section 2 is true. If your situation changes, and your exemption is no longer valid, you must provide a new Form MW-4 to your employer with Section 1 completed.

If you claim one of the exemptions from withholding, an electronic copy of this form will be filed by your employer with the Department of Revenue.

An exemption from withholding is not an automatic exemption from filing a Montana income tax return.

See Montana Individual Income Tax Return (Form 2) instructions for more guidance.

Employer instructions are on the next page.



00540



Employer Instructions

Montana wage withholding is required when wages are earned in Montana. Employers are liable for Montana withholding taxes and are only relieved of that liability once they have withheld the correct amount of taxes from the employees' wages for a given pay period.

Should my employee complete Form MW-4?

Your employee must complete Form MW-4 if one or both of the following applies:

- They are a newly hired employee, or
- They are claiming to be exempt from Montana income tax withholding. *See Section 2 instructions.*

Employees should also consider completing a new Form MW-4 if their personal or financial situation changes.

Your employee is not required to complete Form MW-4 if they are already employed and are not claiming exemption from Montana income tax withholding.

Do I need to file Form MW-4 with the department?

You must file your employee's Form MW-4 with the Department of Revenue *only* if one or both of the following applies:

- The employee is claiming more than 10 allowances, or
- The employee is claiming one of the withholding exemptions listed in Section 2.

If an employee provides you with a Form MW-4 that meets one or both of the conditions above, you must submit this form to the department by the *last day of the payroll period* in which the form was received.

File online using the department's TransAction Portal (TAP) at <https://tap.dor.mt.gov>. Simply click on "File Form MW-4." For more information about this process, visit revenue.mt.gov.

Do not mail the Form MW-4 to the department.

You should keep a copy of all Forms MW-4 you receive from your employees with your records.

How should I determine Montana withholding for an employee that doesn't complete Form MW-4?

Withhold Montana tax as if the employee is single with zero withholding allowances.

Why must an employee complete Section 1 when claiming exemption 2(a) or 2(b)?

If an exemption is claimed under Section 2(a) or 2(b), you must withhold taxes on any wages paid that do not meet the requirements of these exemptions.

Example: If (a) is marked, the exemption does not apply to wages earned from an enrolled member of a tribe, residing on his or her reservation, when the work is performed outside the reservation. Withholding is required on the wages derived from work performed outside the reservation, based on the number of allowances reported in Section 1. If Section 1 was not completed, the withholding is calculated using zero allowances until a new Form MW-4 is provided for the calculation of the withholding.

Invalid Forms MW-4

The following situations make the Form MW-4 invalid:

- The form is incomplete or lacks the necessary signatures, or
- The employer information is incomplete when the Form MW-4 is filed with the department.

If, after a review of the Form MW-4, the department revises the number of allowances allowed for the employee or disallows an exemption claimed, you must withhold based on that determination for the remainder of the calendar year, unless:

- The employee subsequently files a new Form MW-4 with fewer than 11 allowances, or
- The department changes its initial determination based on justifications provided by the employee.

Questions?

Go to revenue.mt.gov for more information about the Form MW-4, or call our help line at (406) 444-6900.



00540





**Self-Directed CFC/PAS Caregiving
PCA WAGE MEMORANDUM**

Employee Name (please print)	Effective Date

Position: Personal Care Attendant (PCA)

Wage Information:

Service Description	Service Code	Wage/Mileage Reimbursement
Personal Assistant Services (PAS) Caregiving, Specialized Childcare, Private Pay	CFCPAS, CFCSHOPCI, CFCMEDESC, MEDESCORT, CHILDCARE T2027 UA, PCA	\$13.99* /hour regular services, orientation, in-service and training wage. *Increased to \$14.29 /hour after six months of service.
PAS Social Supervision	SOCSUP	
Homemaker, Respite	HOMEMAKER, RESPITE	\$12.46 /hour regular services, orientation, in-service and training wage.
HAB Aide	HABAIDE	\$14.73 /hour regular services, orientation, in-service and training wage.
Specially Trained Attendant 1	STA1	
Specially Trained Attendant 2	STA2	
Behavioral Intervention Assistant	BIA	
PAS and Waiver Mileage	CFCA0080, CFCPAS, CFCMEDESC, MEDESCORT, WAIVER MILEAGE	\$0.33 /mile

Working more than 40 hours in a work week is not authorized. I understand it is my responsibility to monitor hours worked and anticipate and resolve any such potential unauthorized hours worked situations.

Employee Signature

Date

CDCN Representative Signature

Date





PAY SELECTION FORM

Employee Name: _____

Date of Birth: _____

Consumer Direct Care Network (CDCN) issues pay by direct deposit to a bank account or pay card. Pay stubs and W-2s are sent to you by mail to your address on file or electronically.

Please check one pay option below.

Note: You will be enrolled in the Wisely Pay card option if (1) you make no selection below, or (2) you select direct deposit to a bank account but provide invalid account information or your account is closed.

- ☐ **Direct Deposit to a Wisely Pay Card Account.** I authorize CDCN to issue me a Wisely Pay card. The card will be tied to my identification on file. CDCN will make payroll deposits to my card account. I will receive the card in 7 to 10 business days after initial processing.
- ☐ **Direct Deposit to an Existing Checking, Savings or Pay Card Account.** I authorize CDCN to initiate payroll deposits to my bank or financial institution.

The Name of my bank is:

The Account Type is (check one): ☐ Checking ☐ Savings ☐ Pay Card

AN ATTACHMENT IS REQUIRED.

For a Checking Account. Please attach a voided check. This is preferred. A bank-issued direct deposit form or bank letter* is ok too.

For a Savings Account or Pay Card. Please attach a bank-issued direct deposit form or bank letter.*

**Do not submit a deposit slip. The routing numbers differ from direct deposit routing numbers.*

Acknowledgement. I authorize CDCN to process my selected method of pay. I understand that:

- CDCN reserves the right to refuse any direct deposit request.
- I am responsible to confirm that each deposit has occurred. I must pay any fees caused by overdrafts on my account.
- All direct deposits are made through an Automated Clearing House (ACH). Processing is subject to ACH terms. The terms of my bank also apply.
- If funds are deposited to my account in error, or an improper payment is made, I authorize CDCN to debit my account to correct the error. If my account cannot be debited due to closure or insufficient balance, then CDCN may withhold future payments until the erroneous deposited amounts are repaid.
- I may receive a paper check while my selected method of pay is being set up.
- I must submit a new Pay Selection Form to CDCN if I wish to change my Direct Deposit option.

Employee Signature

Date





EMPLOYEE AGREEMENT

I, _____, agree to and acknowledge the following:
(Employee Print Name)

_____ has elected to hire me for the position of Caregiver. I will
(Member or Personal Representative (PR) Print Name)

perform personal care services for the Member according to Medicaid's self-directed programs.

1. Caregiver Handbook

I have received a copy of the Consumer Direct Care Network Montana Caregiving (CDCN) Caregiver Handbook. It provides employment guidelines on CDCN's policies, procedures, and programs. The Handbook is not a contract for employment.

I agree to read and understand the information in the Handbook. It is my responsibility to follow all the policies and procedures in the Handbook. I can ask the Member/PR and CDCN if I have questions. CDCN can change or update policies, procedures or any information in the Handbook at any time.

2. Co-Employment Service Model

Under the co-employment service model, the Member is my Managing Employer. They select, schedule, manage and dismiss caregivers. CDCN is my legal Employer of Record. They provide administrative and payroll services. CDCN can terminate a caregiver's CDCN employment without the Member's permission.

3. Status Change Form

I have received a blank Status Change Form and agree to notify CDCN within ten (10) days of any change in name, addresses, and telephone number. Pending criminal charges occurring after my hire date must also be disclosed within 10 days.

4. Training

I have received the following training and agree to understand the information covered. I will complete and submit the following quizzes or signature page to CDCN:

- Infection Control, Guidelines for Healthcare Workers (quiz)
- Lifting and Moving Patients (quiz)
- HIPAA Training Guide (quiz)
- Exposure Control (signature page)

Current CPR and TB screening are recommended, but not required by CDCN. The Member/PR may require them.

5. Automobile Insurance

Current automobile liability insurance is required if transporting the Member is authorized. Verification of insurance must be filed with CDCN and updated as required.

6. Wage Information and Acknowledgment

- I will be paid at an hourly rate for approved services I provide to the Member. Hourly rate is identified in the CDCN wage memo and payments will be processed according to the CDCN pay schedule.



- Overtime is not authorized. Overtime is defined as more than 40 hours in a workweek. I understand it is my responsibility to monitor hours worked and avoid overtime situations.

I understand CDCN is not responsible to pay me if:

- The Member becomes ineligible for Medicaid.
- The Member/PR allows me to work overtime (hours more than 40 per week).
- The Member/PR allows me to work time outside the approved Profile.
- There is misrepresentation on the timesheet, CDCN has the right to withhold future payments.

7. Automatic (Direct) Deposit

CDCN wants all employees to be paid in a timely and consistent manner. There are two direct deposit pay options. I can specify a bank account for the direct deposit or choose a pay card. Pay stubs (summary of pay) are sent by first class mail to my address on file or electronically. I understand I can choose to receive checks by mail. Receiving checks by mail is dependent upon federal holidays, other U.S. mail disruptions and payroll corrections.

8. Effective Date

Employment can start once I complete the CDCN Employee Enrollment Packet and it is approved by CDCN. I must receive CDCN's *Okay to Work* form before I can begin work.

9. Caregiver Responsibilities

- Program compliance
- Documents and Record Keeping
- Confidentiality
- Status Change Notification
- Refusal of Prohibited Payments
- Disclosure to Law Enforcement Officers

10. Non-Emergent Care

Services provided under this program are not meant to be emergency or acute medical services. I understand any potential risky health situations need to be reported to the Member's attending physician and/or to local emergency services, such as 911, as appropriate.

11. Member Relationship

I am not the Member's legal guardian, spouse, or parent (if the Member is under 18 years old).

12. Inactive Status

I understand if I do not work for a CDCN Member for six (6) months, I will become inactive. If this happens, I must re-apply through the Member and receive a new *Okay to Work* form.

Employee Signature

Date

Member/PR Signature

Date



Employee Name: _____
(please print)

Background: You have been conditionally hired to provide services for the service recipient in accordance with their authorized plan of care. You may be required to perform physical tasks. The purpose of this Health Questionnaire is to assess your ability to safely perform the authorized tasks. The information provided on this Questionnaire will be used to help manage your employment in a safe manner. Your responses are considered *Confidential*.

Instructions: Respond to each item as to whether you have a medical or physical activity restriction or limitation. **Please explain each "Yes" answer on the backside of this form and attach additional information as necessary.**

Return this completed form and other employment forms to the Consumer Direct Care Network (CDCN) office.

	Do you currently have a Physical Activity Restriction for:	NO	YES
1	Sitting		
2	Stationary Standing		
3	Walking		
4	Ability to be Mobile		
5	Crouching (bending at knee)		
6	Kneeling/Crawling		
7	Stooping (bending at waist)		
8	Twisting (knees/waist/neck)		
9	Turning/Pivoting		
10	Climbing		
11	Balancing		
12	Reaching overhead		
13	Reaching extension		
14	Grasping		
15	Pushing/Pulling		
16	Lifting/Carrying		
17	Whole/Partial Loss of Hearing		
18	Blindness (partial or complete) or Eye Problems		
19	Have you ever been advised by a health care professional to restrict your physical activities in any way?		
	Personal Medical History – In the past 5 years, have you had or been treated for:	NO	YES
20	Epilepsy		
21	Fainting/Dizzy Spells		
22	Hernia		
23	Muscular Strain		
24	Neck or Back Injury		
25	Ruptured Intervertebral Disc		
26	Joint Injury or Pain		
27	Fractures		
28	Tuberculosis or Non-Negative TB Test		
29	Lung Problems/Disease		
30	Head Injury		
31	Other Current Problems, Diseases, Conditions		
32	Have you been hospitalized or undergone surgery, other than for childbirth?		
33	Have you refused a recommended surgical procedure?		
34	Are you currently taking any medication or drugs, whether by prescription or not, that could impair your judgment?		





DRIVING CONFIRMATION

Print Employee's Name

Print Member's Name

Instructions: Complete this form and provide the required attachments ONLY if driving-related services will be performed by the employee. If these services will not be provided by the employee, complete the No Driving Confirmation form. Please only submit one of these two forms, depending on your situation.

Driving-related services include the following:

- Community Integration
- Medical Escort
- Socialization
- Shopping

For an employee to be paid for driving-related services, program rules require:

1. Driving-related services must be authorized on the member's Service Plan.
2. The employee's driver's license and proof of insurance for the vehicle driven must be on file at Consumer Direct Care Network (CDCN). If these are not provided and updated when necessary, the employee cannot perform driving-related services.

Attachments Required

Please attach a photocopy of **BOTH** of the following documents:

Employee's Driver's License.

State: _____ Number: _____ Expiration Date: _____

Proof of Auto Insurance (For vehicle used for driving-related services. Must meet the State's minimum guidelines for auto insurance coverage.)

Expiration Date: _____ Vehicle owner: _____

I understand it is my responsibility to make sure that the vehicle I drive is insured (whether it is my own vehicle or the member's vehicle) if I will be transporting a member while employed with CDCN. I will not transport a member in an uninsured vehicle. By signing below I agree to comply with these requirements and will contact CDCN if there is a change in automobile insurance or driver's license status.

Employee Signature

Date

Member/PR Signature

Date





NO DRIVING CONFIRMATION

Print Employee's Name

Print Member's Name

Instructions: Complete this form ONLY if the employee will NOT be providing driving-related services. If driving-related services will be provided by the employee, complete the Driving Confirmation form and provide the required attachments. Please only submit one of these two forms, depending on your situation.

Driving-related services include the following:

- Community Integration
- Medical Escort
- Socialization
- Shopping

Acknowledgement

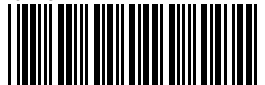
The member and employee hereby agree that the employee will not provide driving-related services at any time while providing program services. The member and employee also agree to contact Consumer Direct Care Network if there is any change in driving status.

Employee Signature

Date

Member/PR Signature

Date





Caregiving

AUTHORIZATION/DECLINATION HEPATITIS B VACCINATION

Employee Name: _____
(please print)

The above-named employee is authorized to receive or complete the **Hepatitis B vaccination series** through the Health Department. Please bill the charges to Consumer Direct Care Network (CDCN) the following address:

**Consumer Direct Care Network Montana Caregiving
100 Consumer Direct Way, Suite 145
Missoula, MT 59808**

You may also fax us the bill at 541-8704 or toll free at 1-866-541-8704

Please call us if you have any questions at 541-8700 or 1-866-438-8591.

This authorization is valid for 14 days from the date of issue below. If you are not able to use this authorization within 2 weeks you must request a new authorization.

*****HEALTH DEPARTMENT PERSONNEL*****

Please do not honor this authorization if presented after the authorization date expires. Please notify us of any requests made after that date.

THIS AUTHORIZATION IS NOT VALID UNLESS SIGNED

Name of CDCN Representative

Signature

Date of Issue

This authorization expires on: _____

HEPATITIS B DECLINATION

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to receive hepatitis B vaccination at no charge. I can choose to decline the hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. I understand that I may elect to receive the vaccine at a future date, while employed with CDCN.

I choose to: ☐ be vaccinated ☐ decline vaccination

Employee Signature

Date



Employee Name	Member Name

Instructions to the Employee: Review the training materials for each topic, discuss with the Member (Managing Employer). Ask questions as necessary to ensure you fully understand the information presented. Complete each training quiz, then sign and date page 2 (both Member and Employee). Return this form with your completed package to Consumer Direct Care Network (CDCN).

INFECTION CONTROL [Reference material: Krames #11386]	Score: _____ (minimum 80%)
---	--------------------------------------

- | | | |
|---|---|---|
| 1. By looking, you can tell if someone has an infection. | T | F |
| 2. You can get HIV if infected blood touches a break in your skin. | T | F |
| 3. A vaccine is available to protect you from the Hepatitis C virus. | T | F |
| 4. A person with inactive TB can't spread the disease to others. | T | F |
| 5. Standard precautions should only be used with patients who are known to have a bloodborne pathogen. | T | F |
| 6. Used sharps should be placed in a leak-proof, puncture-proof container. | T | F |
| 7. All PPE should be washed and disinfected so it can be used again. | T | F |
| 8. You don't need to wash your hands after removing gloves. | T | F |
| 9. Transmission-based precautions are used instead of standard precautions. | T | F |
| 10. Patients with scabies should have their own patient care equipment when possible. | T | F |
| 11. You must wear a respirator when you're around a patient who is suspected of having active TB. | T | F |
| 12. Germs in droplets can contaminate the objects on which they land. | T | F |
| 13. If you have a sharps exposure, you can reduce your chance of infection by seeking medical attention right away. | T | F |

Continued on the other side.



LIFTING AND MOVING PATIENTS [Reference material: Krames #11356]	Score: _____ (minimum 80%)
---	--------------------------------------

- | | | |
|--|----------|----------|
| 1. When lifting, you should flatten the curve of your back. | T | F |
| 2. To protect your back while lifting, use your leg and abdominal muscles. | T | F |
| 3. When moving patients, keep them close to your body. | T | F |
| 4. Ask for help from co-workers only with obese patients. | T | F |
| 5. Assistive devices are used only in emergencies. | T | F |
| 6. A short walk before work is a good warm-up. | T | F |
| 7. Stretching should be done only before starting work. | T | F |
| 8. Taking regular breaks helps relieve stiffness and reduce stress. | T | F |
| 9. ACE stands for Assess, Coordinate, & Execute. | T | F |
| 10. Using safe lifting techniques is important only at work. | T | F |
| 11. Long-term wear and tear has a serious effect on back health. | T | F |
| 12. Aerobic exercise can help improve fitness. | T | F |

REPORTING A WORKPLACE INJURY [Reference material: Employee Handbook]	Score: _____ (minimum 80%)
--	--------------------------------------

See the CDCN Employee Handbook under “Employee Injury Reporting” for information on reporting a workplace injury.

If you suffer an injury or workplace-related illness, you should:

- | | | |
|---|----------|----------|
| 1. Notify your Member of the injury or workplace-related illness immediately. | T | F |
| 2. Call CDCN to report the injury/illness immediately upon occurrence whether or not it seems serious at the time. | T | F |
| 3. Get medical help if you need it. | T | F |
| 4. Call CDCN’s Workplace Injury Hotline which allows workers to report on-the-job injuries. The Hotline is available 24 hours a day, seven days a week. | T | F |
| 5. The toll-free work-related Injury Hotline number is: _____ | | |

Employee Signature

Date

Member/PR Signature

Date





HIPAA QUIZ & CONFIDENTIALITY AGREEMENT

Employee Name	Member Name	Score (minimum 80%)

Employee: Review the HIPAA Training Guide, ask questions as required, complete the HIPAA Quiz below, and review & sign the confidentiality agreement.

- HIPAA stands for:
 - Health Insurance Protection and Accuracy
 - Health Insurance Portability and Accountability Act
 - Help Insurance company Profits - Always Applicable
- PHI stands for: P _____ H _____ I _____
- Under HIPAA, patients are generally not allowed to see their medical information:
 - True
 - False
- If a patient requests information from their medical record, you should:
 - Run to Kinko's, make a copy, & give it to the patient
 - Answer that the information is not available, sorry
 - Refer the request to a Program Manager or Privacy Officer
- HIPAA law includes penalties for non-compliance of (mark all that apply):
 - \$100 civil penalty up to a maximum of \$25,000 per year for each standard violated
 - A criminal penalty for knowingly disclosing PHI up to a maximum of \$250,000
 - Revocation of your driving license
- If you get a question from a patient about how their PHI is used and disclosed, you should:
 - Inform them that a sign has been posted on the door
 - Say everything is written in invisible ink to protect the information
 - Refer the patient to a Program Manager or Privacy Officer
- Patients will not be told of their rights under HIPAA, but rather have to look up information on a government web site:
 - True
 - False
- The HIPAA Privacy Rule (the law) took effect on: _____

Confidentiality Agreement: By signing below, I acknowledge that the disclosure of confidential information obtained through my employment with the Member and Consumer Direct Care Network is **PROHIBITED!** Furthermore, I understand that any information concerning a Member's illness, family, financial condition, or personal details is considered to be strictly confidential. When a Member's history or condition is reviewed, it must be done in private where only those persons involved with the care of the Member are present. Any information known by me concerning any Member, employee, or other person, is also considered confidential. I acknowledge that confidentiality is an important part of the job and that I will not release confidential information. Failure to follow confidentiality requirement is cause for termination.

Employee Signature

Date

Member/PR Signature

Date





EXPOSURE CONTROL PLAN TRAINING SIGNATURE PAGE

Please sign and date this form when Exposure Control Plan Training is complete.

Member Section:

My signature indicates that I have trained my employee to the Exposure Control Plan.

Member/PR Printed Name: _____

Member/PR Signature: _____ Date: _____

Employee Section:

My signature indicates that the above-named individual has trained me to the Exposure Control Plan.

Employee Printed Name: _____

Employee Signature: _____ Date: _____





EXPECTED WEEKLY HOURS - NEW HIRE

CAREGIVER/NURSE (Non-FEA)

Employee Name: _____

Entity: _____

Email Address: _____

-- Office Use Only --

Hire Date: _____

Anticipated Weekly Hours:

How many hours per week do you reasonably expect this employee to work for the foreseeable future?

- ☐ Full-time (30+ hours)
- ☐ Part-time (10-29 hours)
- ☐ Less than 10 hours
- ☐ Variable – unable to make a reasonable determination*

Comments:

CDCN Representative Name: _____

Benefits will be offered to employees on the first of the month following/coinciding with 30 days from their first day worked.

****Employees marked “variable” will not be offered benefits upon hire.***





Work Opportunity Tax Credits - Consumer Direct Care Network

Consumer Direct Care Network (CDCN) participates in the Work Opportunity Tax Credit (WOTC) program. WOTC is a Federal tax credit available to employers. ADP administers WOTC on behalf of CDCN. Please follow the steps listed below to screen for the WOTC program. We appreciate your cooperation.

Applicant Instructions

- Open <https://tcs.adp.com/consumerdirectcare> or scan the QR code below.
***Note: If using a shared screening device, ensure the device does not have an autofill/auto complete function enabled*
- Please answer each question to complete the voluntary screening.
- Eligible applicants will be asked to **Electronically Sign and click Submit** to complete the screening.
- Ineligible applicants will be asked to click **Submit** to finish the screening. You will not be asked to electronically sign.

****ADP will contact WOTC-eligible new hires via email or text to request proof of age or address documentation, when needed.***

*****If you are unable to screen via the Web Link please contact ADP at 1-800-237-3279 (1-800-ADP-EASY) available 6am-11 pm ET, 7 days a week and enter company code shown below to screen for Tax Credits.***

IVR CODE: 410849



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