Please fill out the Data Form on page 3 prior to printing.
This packet is set up for double-sided paper printing.

CONSUMER DIRECT CARE NETWORK

EMPLOYEE ENROLLMENT PACKET INSTRUCTIONS

Complete or Provide Photocopies 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. Complete all the documents and trainings listed below, and provide photocopies if needed. Use the checklists below to keep track of completed forms.

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 – Issued by CDCN.
   - ☐ 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.
   - ☐ Privacy Awareness Quiz & Confidentiality Agreement – Review the Privacy Awareness 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 Member 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.*
- Wisely 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)
- Privacy Awareness Guide
- Employee Handbook
- Employee Handbook Appendix
- Infection Control pamphlet
- Lifting and Moving Patients pamphlet

CONSUMER DIRECT CARE NETWORK

Clear Form

EMPLOYEE DATA FORM

Member (Service Recipient) Name: _____

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: _____ (Street) (Apt/Unit #) (City) (State) (Zip)
(*if different than physical*)

Phone Numbers: _____ (Home) _____ (Cell)

Do you consent to receiving text messages from CDCN? ☐ Yes ☐ No

Email Address*: _____ **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.*

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: ☐ Primary Caregiver ☐ 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.

_____

_____

CONSUMER DIRECT CARE NETWORK

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? ☐ Yes ☐ No
If yes, please explain:

_____

_____

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

CONSUMER DIRECT CARE NETWORK

EQUAL EMPLOYMENT OPPORTUNITY DISCLOSURE

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

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:

☐ Hispanic or Latino	A person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.

-OR-

☐ White (not Hispanic or Latino)	A person having origins in any of the original people of Europe, North Africa, or the Middle East.
☐ American Indian or Alaska Native (not 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.
☐ Black or African American (not Hispanic or Latino)	A person having origins in any of the original peoples of Africa.
☐ Asian (not 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.
☐ Native Hawaiian or Other Pacific Islander (not Hispanic or Latino)	A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
☐ Two or More Races (not 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	Employee's Email Address	Employee's Telephone Number
/ /			

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

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

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

Signature of Employee	Today's Date (mm/dd/yyyy)

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)
Managing Employer		

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
Consumer Direct Personal Care, LLC	100 Consumer Direct Way, Suite 120, Missoula MT 59808

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	**OR**	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

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

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

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

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

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

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

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

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

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

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

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

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

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

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2024

Step 1: Enter Personal Information

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

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

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

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

Step 3: Claim Dependent and Other Credits

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

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

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)

02227

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

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

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

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

1. Expect to work only part of the year;

2. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

3. Prefer the most accurate withholding for multiple job situations.

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

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

Specific Instructions

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

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

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

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

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

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

Step 4 (optional).

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

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

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

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

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

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

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

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

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . **2a** $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . **2b** $

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

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

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

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

1 Enter an estimate of your 2024 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $

2 Enter:
- $29,200 if you're married filing jointly or a qualifying surviving spouse
- $21,900 if you're head of household
- $14,600 if you're single or married filing separately

. . . . . **2** $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . **3** $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . **4** $

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

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$780	$850	$940	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,370
$10,000 - 19,999	0	780	1,780	1,940	2,140	2,220	2,220	2,220	2,220	2,220	2,570	3,570
$20,000 - 29,999	780	1,780	2,870	3,140	3,340	3,420	3,420	3,420	3,420	3,770	4,770	5,770
$30,000 - 39,999	850	1,940	3,140	3,410	3,610	3,690	3,690	3,690	4,040	5,040	6,040	7,040
$40,000 - 49,999	940	2,140	3,340	3,610	3,810	3,890	3,890	4,240	5,240	6,240	7,240	8,240
$50,000 - 59,999	1,020	2,220	3,420	3,690	3,890	3,970	4,320	5,320	6,320	7,320	8,320	9,320
$60,000 - 69,999	1,020	2,220	3,420	3,690	3,890	4,320	5,320	6,320	7,320	8,320	9,320	10,320
$70,000 - 79,999	1,020	2,220	3,420	3,690	4,240	5,320	6,320	7,320	8,320	9,320	10,320	11,320
$80,000 - 99,999	1,020	2,220	3,620	4,890	6,090	7,170	8,170	9,170	10,170	11,170	12,170	13,170
$100,000 - 149,999	1,870	4,070	6,270	7,540	8,740	9,820	10,820	11,820	12,830	14,030	15,230	16,430
$150,000 - 239,999	1,960	4,360	6,760	8,230	9,630	10,910	12,110	13,310	14,510	15,710	16,910	18,110
$240,000 - 259,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$260,000 - 279,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$280,000 - 299,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,380
$300,000 - 319,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,980	17,980	19,980
$320,000 - 364,999	2,040	4,440	6,840	8,310	9,710	11,280	13,280	15,280	17,280	19,280	21,280	23,280
$365,000 - 524,999	2,720	6,010	9,510	12,080	14,580	16,950	19,250	21,550	23,850	26,150	28,450	30,750
$525,000 and over	3,140	6,840	10,540	13,310	16,010	18,590	21,090	23,590	26,090	28,590	31,090	33,590

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$240	$870	$1,020	$1,020	$1,020	$1,540	$1,870	$1,870	$1,870	$1,870	$1,910	$2,040
$10,000 - 19,999	870	1,680	1,830	1,830	2,350	3,350	3,680	3,680	3,680	3,720	3,920	4,050
$20,000 - 29,999	1,020	1,830	1,980	2,510	3,510	4,510	4,830	4,830	4,870	5,070	5,270	5,400
$30,000 - 39,999	1,020	1,830	2,510	3,510	4,510	5,510	5,830	5,870	6,070	6,270	6,470	6,600
$40,000 - 59,999	1,390	3,200	4,360	5,360	6,360	7,370	7,890	8,090	8,290	8,490	8,690	8,820
$60,000 - 79,999	1,870	3,680	4,830	5,840	7,040	8,240	8,770	8,970	9,170	9,370	9,570	9,700
$80,000 - 99,999	1,870	3,690	5,040	6,240	7,440	8,640	9,170	9,370	9,570	9,770	9,970	10,810
$100,000 - 124,999	2,040	4,050	5,400	6,600	7,800	9,000	9,530	9,730	10,180	11,180	12,180	13,120
$125,000 - 149,999	2,040	4,050	5,400	6,600	7,800	9,000	10,180	11,180	12,180	13,180	14,180	15,310
$150,000 - 174,999	2,040	4,050	5,400	6,860	8,860	10,860	12,180	13,180	14,230	15,530	16,830	18,060
$175,000 - 199,999	2,040	4,710	6,860	8,860	10,860	12,860	14,380	15,680	16,980	18,280	19,580	20,810
$200,000 - 249,999	2,720	5,610	8,060	10,360	12,660	14,960	16,590	17,890	19,190	20,490	21,790	23,020
$250,000 - 399,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$400,000 - 449,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$450,000 and over	3,140	6,450	9,110	11,610	14,110	16,610	18,430	19,930	21,430	22,930	24,430	25,870

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$510	$850	$1,020	$1,020	$1,020	$1,020	$1,220	$1,870	$1,870	$1,870	$1,960
$10,000 - 19,999	510	1,510	2,020	2,220	2,220	2,220	2,420	3,420	4,070	4,070	4,160	4,360
$20,000 - 29,999	850	2,020	2,560	2,760	2,760	2,960	3,960	4,960	5,610	5,700	5,900	6,100
$30,000 - 39,999	1,020	2,220	2,760	2,960	3,160	4,160	5,160	6,160	6,900	7,100	7,300	7,500
$40,000 - 59,999	1,020	2,220	2,810	4,010	5,010	6,010	7,070	8,270	9,120	9,320	9,520	9,720
$60,000 - 79,999	1,070	3,270	4,810	6,010	7,070	8,270	9,470	10,670	11,520	11,720	11,920	12,120
$80,000 - 99,999	1,870	4,070	5,670	7,070	8,270	9,470	10,670	11,870	12,720	12,920	13,120	13,450
$100,000 - 124,999	2,020	4,420	6,160	7,560	8,760	9,960	11,160	12,360	13,210	13,880	14,880	15,880
$125,000 - 149,999	2,040	4,440	6,180	7,580	8,780	9,980	11,250	13,250	14,900	15,900	16,900	17,900
$150,000 - 174,999	2,040	4,440	6,180	7,580	9,250	11,250	13,250	15,250	16,900	18,030	19,330	20,630
$175,000 - 199,999	2,040	4,510	7,050	9,250	11,250	13,250	15,250	17,530	19,480	20,780	22,080	23,380
$200,000 - 249,999	2,720	5,920	8,620	11,120	13,420	15,720	18,020	20,320	22,270	23,570	24,870	26,170
$250,000 - 449,999	2,970	6,470	9,310	11,810	14,110	16,410	18,710	21,010	22,960	24,260	25,560	26,860
$450,000 and over	3,140	6,840	9,880	12,580	15,080	17,580	20,080	22,580	24,730	26,230	27,730	29,230

MONTANA DEPARTMENT OF REVENUE

Montana Employee's Withholding and Exemption Certificate

MW-4
V4 10/2023

Employee's first name and middle initial	Last name	Social Security Number

Physical address		
City	State	ZIP Code

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

1. Federal filing status

- ☐ a. Single or married filing separately (If you have multiple jobs, complete the Multiple Jobs Worksheet.)
- ☐ b. Married filing jointly or qualifying widower (If you and your spouse have multiple jobs, see line 2.)
- ☐ c. Head of household

2. ☐ **Married Filing Jointly with Both Spouses Working.** If you are married and you and your spouse are both working and earn similar incomes, mark the box. If you and your spouse have multiple jobs, and your spouse earns significantly more or less than you, do not mark this box. Instead, mark box 1b, then complete the Multiple Jobs Worksheet on page 2 and enter the result on line 3.

3. Extra withholding. Enter any additional tax you want withheld from each pay period, including any amount you want withheld from retirement distributions. **3.** _____

4. Reduced withholding. If you expect to report large federal adjustments, federal itemized deductions, Montana subtractions, and/or Montana tax credits, you can direct your employer to withhold the amount you report on this line. *(Caution:* Requesting a reduced amount of withholding may result in a tax due when you file your tax return.) **4.** _____

5. Exemptions for Tax Year 2024

You may be entitled to claim an exemption from Montana income tax withholding if your income is exempt from Montana income tax. Mark the box to indicate the reason you believe you are exempt from Montana income tax.

- ☐ a. I am exempt because I am an enrolled member of a registered tribe, I live on the reservation of that tribe, and I earn wages from work performed on that reservation. (You must complete line 1 or 2.)
- ☐ b. I am exempt because I am a member of the Reserve or National Guard and my compensation is earned under U.S.C. Title 10. (You must complete line 1 or 2.)
- ☐ c. I am exempt because I am a North Dakota resident.
- ☐ d. I am exempt because 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.

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. (This form is not valid unless you sign it.)

_____ _____

Employee's Signature **Date**

Employer Information

Name	Federal Employer Identification Number

Mailing Address	MT Withholding Account ID
	- - WTH

City	State	ZIP Code

10206

Multiple Jobs Worksheet

Complete this worksheet if you have multiple jobs, or if you are married filing jointly with both spouses working. This worksheet calculates the total extra withholding for all jobs. Complete this worksheet on the Form MW-4 for the highest paying job for the most accurate results. The amount on line 4 is the additional amount to withhold from your wages.

1. **Two jobs.** If you have two jobs or you are married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 5 or 6. 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 here. **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.

2a. Find the amount from the appropriate table on page 5 or 6 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 here. **2a.** _____

2b. 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 or 6 and enter this amount on line 2b. **2b.** _____

2c. Add lines 2a and 2b. **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. **3.** _____

4. Divide the annual amount on line 1 or line 2c by the amount of pay periods on line 3. Enter this amount here and on Form MW-4, line 3 of the Form MW-4 for the highest paying job (along with any other additional amount you want withheld). **4.** _____

Beginning in Tax Year 2024, Montana's income tax system will change significantly. Taxpayers will see changes to filing statuses, tax brackets, and the calculation of Montana taxable income.

As a result of these changes, wage withholding determined before January 1, 2024, may not accurately reflect an employee's actual tax liability under the new system.

Employees should complete a new Form MW-4 beginning January 1, 2024, to ensure the correct amount of Montana income tax is withheld from their wages.

Employee Instructions

Purpose

Complete Form MW-4 so that your employer can withhold the correct Montana income tax from your pay. You should complete the form when you:

- Start a new job.
- Claim to be exempt from Montana income tax withholding.

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

Line Instructions

Line 1 – Federal filing status. Select the federal filing status you will use when you file your income tax return. This will determine the standard deduction and tax rates used to compute your wage withholding. If you have multiple jobs, complete the Multiple Jobs Worksheet, and report the additional amount from line 4 of the worksheet on page 1, line 3.

Line 2 – Married Filing Jointly with Both Spouses Working. If you are married, both spouses work, and earn similar amounts, mark this box on this form and all Forms MW-4 for the other jobs. If this box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This is roughly accurate for jobs with similar pay; otherwise more tax than necessary will be withheld.

If you or your spouse have multiple jobs, or if one spouse earns significantly more than the other, do not mark this box. Instead, mark box 1b, and complete the Multiple Jobs Worksheet on the Form MW-4 of the highest paid job. Report the additional amount to withhold on line 3 on the Form MW-4 of the highest paid job.

Line 3 – Extra withholding. You may request to have an additional amount of taxes withheld from your paycheck on this line. If you want to receive a refund, you may enter an additional amount on this line.

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

You can choose to have Montana income tax withheld from your unemployment compensation. Report the amount you want the payer to withhold on this line.

Line 4 – Reduced withholding. If your income mainly consists of wages, and you expect to report large federal adjustments, federal itemized deductions, Montana subtractions, and/or Montana tax credits, you may direct your employer to only withhold the amount you report on this line. Your employer will not use the standard calculations for withholding. To calculate the amount needed, divide the amount of your expected tax by the number of pay periods in a year. Enter the amount to be withheld rather than the standard calculation. If this line is blank, your withholding will be calculated based on the standard calculations.

CAUTION. This will reduce the amount of tax withheld and may result in a balance owing on your income tax return.

Line 5 – Exemptions. You must meet one of the following requirements to claim an exemption from Montana wage withholding:

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 line 1 or 2 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 for active duty in the U.S. military under USC Title 10 orders. You must also complete line 1 or 2 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 marked on line 5 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 line 1 or 2 completed.

If you claim one of the exemptions from withholding, your employer must file an electronic copy of this form 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

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.

Newly hired employees must complete this form when they begin working for you. Employees claiming to be exempt from Montana wage withholding must complete this form when they begin working for you and every year thereafter. Employees may file a new Form MW-4 if their personal or financial situation changes.

Keep the copies of all Forms MW-4 you receive from your employees with your records.

Exemptions from Montana Withholding

You must file your employee's Form MW-4 with the department if the employee is claiming one of the withholding exemptions listed on line 5. The form is due to the department by the last day of the payroll period in which the form was received and annually thereafter by January 31.

File online using the department's TransAction Portal (TAP) at https://tap.dor.mt.gov. Simply click on "File Form MW-4." Do not mail the Form MW-4 to the department.

If an exemption is claimed on line 5a or 5b, you must withhold taxes on any wages paid that do not meet the requirements of these exemptions.

Example: If 5a 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 filing status on line 1 or 2. If line 1 or 2 is not completed, the withholding is calculated using the single filing status until a new Form MW-4 is provided for the calculation of the withholding.

Invalid Forms MW-4

A Form MW-4 is invalid if the form is incomplete or lacks the necessary signatures. If your employee's Form MW-4 is invalid or incomplete, withhold Montana tax as if the employee is single.

Questions? Call us at (406) 444-6900, or Montana Relay at 711 for the hearing impaired.

Multiple Jobs Wage Tables

Single or Married Filing Sparately

Higher Paying Job		Lower Paying Job									
		$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
$0	$9,999	$254	$470	$529	$590	$590	$590	$590	$590	$590	$590
$10,000	$19,999	$470	$745	$865	$926	$926	$926	$926	$926	$926	$926
$20,000	$29,999	$529	$865	$985	$1,046	$1,046	$1,046	$1,046	$1,046	$1,046	$1,046
$30,000	$39,999	$590	$926	$1,046	$1,107	$1,107	$1,107	$1,107	$1,107	$1,107	$1,107
$40,000	$49,999	$590	$926	$1,046	$1,107	$1,107	$1,107	$1,107	$1,107	$1,107	$1,107
$50,000	$59,999	$590	$926	$1,046	$1,107	$1,107	$1,107	$1,107	$1,107	$1,107	$1,107
$60,000	$69,999	$590	$926	$1,046	$1,107	$1,107	$1,107	$1,107	$1,107	$1,107	$1,107
$70,000	$79,999	$590	$926	$1,046	$1,107	$1,107	$1,107	$1,107	$1,107	$1,107	$1,107
$80,000	$89,999	$590	$926	$1,046	$1,107	$1,107	$1,107	$1,107	$1,107	$1,107	$1,107
$90,000	$99,999	$590	$926	$1,046	$1,107	$1,107	$1,107	$1,107	$1,107	$1,107	$1,107
$100,000	$149,999	$590	$926	$1,046	$1,107	$1,107	$1,107	$1,107	$1,107	$1,107	$1,107
$150,000	$199,999	$590	$926	$1,046	$1,107	$1,107	$1,107	$1,107	$1,107	$1,107	$1,107
$200,000	$249,999	$590	$926	$1,046	$1,107	$1,107	$1,107	$1,107	$1,107	$1,107	$1,107
$250,000	$299,999	$590	$926	$1,046	$1,107	$1,107	$1,107	$1,107	$1,107	$1,107	$1,107
$300,000	$349,999	$590	$926	$1,046	$1,107	$1,107	$1,107	$1,107	$1,107	$1,107	$1,107
$350,000	$399,999	$590	$926	$1,046	$1,107	$1,107	$1,107	$1,107	$1,107	$1,107	$1,107
$400,000	$449,999	$590	$926	$1,046	$1,107	$1,107	$1,107	$1,107	$1,107	$1,107	$1,107
$450,000	$499,999	$590	$926	$1,046	$1,107	$1,107	$1,107	$1,107	$1,107	$1,107	$1,107

Married Filing Jointly or Qualifying Widower

Higher Paying Job		Lower Paying Job									
		$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
$0	$9,999	$0	$38	$470	$470	$470	$470	$588	$590	$590	$590
$10,000	$19,999	$38	$508	$940	$940	$940	$1,058	$1,178	$1,180	$1,180	$1,180
$20,000	$29,999	$470	$940	$1,372	$1,372	$1,490	$1,610	$1,730	$1,732	$1,732	$1,732
$30,000	$39,999	$470	$940	$1,372	$1,490	$1,610	$1,730	$1,850	$1,852	$1,852	$1,852
$40,000	$49,999	$470	$940	$1,490	$1,610	$1,730	$1,850	$1,970	$1,972	$1,972	$1,972
$50,000	$59,999	$470	$1,058	$1,610	$1,730	$1,850	$1,970	$2,090	$2,092	$2,092	$2,092
$60,000	$69,999	$588	$1,178	$1,730	$1,850	$1,970	$2,090	$2,210	$2,212	$2,212	$2,212
$70,000	$79,999	$590	$1,180	$1,732	$1,852	$1,972	$2,092	$2,212	$2,215	$2,215	$2,215
$80,000	$89,999	$590	$1,180	$1,732	$1,852	$1,972	$2,092	$2,212	$2,215	$2,215	$2,215
$90,000	$99,999	$590	$1,180	$1,732	$1,852	$1,972	$2,092	$2,212	$2,215	$2,215	$2,215
$100,000	$149,999	$590	$1,180	$1,732	$1,852	$1,972	$2,092	$2,212	$2,215	$2,215	$2,215
$150,000	$199,999	$590	$1,180	$1,732	$1,852	$1,972	$2,092	$2,212	$2,215	$2,215	$2,215
$200,000	$249,999	$590	$1,180	$1,732	$1,852	$1,972	$2,092	$2,212	$2,215	$2,215	$2,215
$250,000	$299,999	$590	$1,180	$1,732	$1,852	$1,972	$2,092	$2,212	$2,215	$2,215	$2,215
$300,000	$349,999	$590	$1,180	$1,732	$1,852	$1,972	$2,092	$2,212	$2,215	$2,215	$2,215
$350,000	$399,999	$590	$1,180	$1,732	$1,852	$1,972	$2,092	$2,212	$2,215	$2,215	$2,215
$400,000	$449,999	$590	$1,180	$1,732	$1,852	$1,972	$2,092	$2,212	$2,215	$2,215	$2,215
$450,000	$499,999	$590	$1,180	$1,732	$1,852	$1,972	$2,092	$2,212	$2,215	$2,215	$2,215

Head of Household											
		Lower Paying Job									
Higher Paying Job		$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
$0	$9,999	$0	$381	$470	$470	$558	$590	$590	$590	$590	$590
$10,000	$19,999	$381	$851	$940	$1,028	$1,148	$1,180	$1,180	$1,180	$1,180	$1,180
$20,000	$29,999	$470	$940	$1,117	$1,237	$1,357	$1,389	$1,389	$1,389	$1,389	$1,389
$30,000	$39,999	$470	$1,028	$1,237	$1,357	$1,477	$1,509	$1,509	$1,509	$1,509	$1,509
$40,000	$49,999	$558	$1,148	$1,357	$1,477	$1,597	$1,629	$1,629	$1,629	$1,629	$1,629
$50,000	$59,999	$590	$1,180	$1,389	$1,509	$1,629	$1,661	$1,661	$1,661	$1,661	$1,661
$60,000	$69,999	$590	$1,180	$1,389	$1,509	$1,629	$1,661	$1,661	$1,661	$1,661	$1,661
$70,000	$79,999	$590	$1,180	$1,389	$1,509	$1,629	$1,661	$1,661	$1,661	$1,661	$1,661
$80,000	$89,999	$590	$1,180	$1,389	$1,509	$1,629	$1,661	$1,661	$1,661	$1,661	$1,661
$90,000	$99,999	$590	$1,180	$1,389	$1,509	$1,629	$1,661	$1,661	$1,661	$1,661	$1,661
$100,000	$149,999	$590	$1,180	$1,389	$1,509	$1,629	$1,661	$1,661	$1,661	$1,661	$1,661
$150,000	$199,999	$590	$1,180	$1,389	$1,509	$1,629	$1,661	$1,661	$1,661	$1,661	$1,661
$200,000	$249,999	$590	$1,180	$1,389	$1,509	$1,629	$1,661	$1,661	$1,661	$1,661	$1,661
$250,000	$299,999	$590	$1,180	$1,389	$1,509	$1,629	$1,661	$1,661	$1,661	$1,661	$1,661
$300,000	$349,999	$590	$1,180	$1,389	$1,509	$1,629	$1,661	$1,661	$1,661	$1,661	$1,661
$350,000	$399,999	$590	$1,180	$1,389	$1,509	$1,629	$1,661	$1,661	$1,661	$1,661	$1,661
$400,000	$449,999	$590	$1,180	$1,389	$1,509	$1,629	$1,661	$1,661	$1,661	$1,661	$1,661
$450,000	$499,999	$590	$1,180	$1,389	$1,509	$1,629	$1,661	$1,661	$1,661	$1,661	$1,661

CONSUMER DIRECT CARE NETWORK

Self-Directed CFC/PAS Caregiving

PCA WAGE MEMORANDUM

Employee Name: _____ **Effective Date:** _____

Position: Personal Care Attendant (PCA)

Wage Information:

Service Description	Service Code	Wage/Mileage Reimbursement			
		CCH	Base Pay	DCW	Total Pay
Personal Assistant Services (PAS) Caregiving, Specialized Childcare, Private Pay	CFCPAS, CFCSHOPCI, CFCMEDESC, MEDESCORT, CHILDCARE T2027 UA, PCA TRAINING	☐ **0 - 2000.99**	**$16.75**	**$3.19**	**$19.94**
		☐ **2001 - 4000.99**	**$17.00**	**$3.19**	**$20.19**
		☐ **4001 - 6000.99**	**$17.25**	**$3.19**	**$20.44**
PAS Social Supervision	SOCSUP	☐ **6001 - 8000.99**	**$17.50**	**$3.19**	**$20.69**
		☐ **8001 - 10000.99**	**$17.75**	**$3.19**	**$20.94**
		☐ **10001 - 12000.99**	**$18.00**	**$3.19**	**$21.19**
		☐ **12001 +**	**$18.25**	**$3.19**	**$21.44**
Homemaker, Respite	HOMEMAKER, RESPITE				
HAB Aide	HABAID				
Specially Trained Attendant	STAHAB				
Behavioral Intervention Assistant	BIA				
PAS and Waiver Mileage	CFCA0080 MILEAGE	**$0.51**/mile			
Private Pay Mileage	PCA Mileage	**$0.60/**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.

_____ _____

CDCN Representative Signature *Date*

CONSUMER DIRECT CARE NETWORK

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*

CONSUMER DIRECT CARE NETWORK

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)
   - Privacy Awareness 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*

CONSUMER DIRECT CARE NETWORK

EMPLOYEE HEALTH QUESTIONNAIRE

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?		

CONSUMER DIRECT CARE NETWORK

EMPLOYEE HEALTH QUESTIONNAIRE

Do you currently have, or have you ever been told by a health care professional that you have any physical limitations related to the list below?							
		NO	**YES**			**NO**	**YES**
A	Back	☐	☐	H	Arm	☐	☐
B	Shoulder	☐	☐	I	Hip	☐	☐
C	Neck	☐	☐	J	Knee	☐	☐
D	Elbow	☐	☐	K	Ankle	☐	☐
E	Wrist	☐	☐	L	Foot	☐	☐
F	Hand	☐	☐	M	Leg	☐	☐
G	Finger	☐	☐	N	Other	☐	☐

CDCN does not discriminate in hiring, promotion, or other terms and conditions of employment. In addition, CDCN does not discriminate against persons who have, in good faith, filed a claim for or received benefits according to State Workers' Compensation Laws. Requests for Accommodations which allow employees to perform the essential functions need to be requested in writing and will be provided if they do not cause an undue hardship.

Please explain any "Yes" answers from page 1 and 2 in detail below and note the associated number or letter. Also, include the dates of injuries & surgeries. Use additional pages, if necessary:

I affirm that I have answered the above questions to the best of my knowledge. My answers are true and complete. I understand that knowingly providing false information is cause for dismissal and may result in denial of workers' compensation benefits.

Employee Signature: _____ Date: _____/_____/_____

Office Use Only

Reviewed by: [_____] Date _____/_____/_____ Date sent to Risk Mgr: _____/_____/_____

State Office/Location: _____ Risk Mgr Review: [_____] Date _____/_____/_____

05095

CONSUMER DIRECT CARE NETWORK

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*

CONSUMER DIRECT CARE NETWORK

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*

CONSUMER DIRECT CARE NETWORK

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*

CONSUMER DIRECT CARE NETWORK

TRAINING MODULE DOCUMENTATION

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*

00041

PRIVACY AWARENESS QUIZ AND CONFIDENTIALITY AGREEMENT

Employee Name: _____
(please print)

Office Use Only
Score: _____ (min. 80%)

Reference Material: Consumer Direct Care Network (CDCN) *Privacy Awareness Guide – Caregivers.*

1. What does "HIPAA" stand for?
    a. Health Insurance Portability and Accountability Act
    b. Healthcare Industry Privacy and Accountability Act
    c. Health Insurance Privacy and Administration Act
    d. None of the above

2. Which example is considered an unauthorized disclosure?
    a. Bringing a third party to a service recipient's home.
    b. Speaking to a service recipient about their condition.
    c. Mentioning a caregiver's name to another person.
    d. Talking to a CDCN Representative about working with the service recipient.

3. CDCN employees must adhere to privacy laws in their individual state, as well as HIPAA federal regulations.
    a. True
    b. False

4. Which of the following are considered PII/PHI? (select all that apply)
    a. Full Address
    b. Medical history
    c. Doctor's Office Location
    d. First and Last Name
    e. Social Security Number
    f. Mother's Maiden Name
    g. Name of City of Residence
    h. Medical Diagnosis
    i. Medication History

5. In which situation(s) are CDCN employees required to comply with HIPAA privacy standards?
    a. At home with employee's family.
    b. In a service recipient's house.
    c. To another caregiver who works for a different service recipient.
    d. All of the above.

6. What should you do if you're concerned about a possible unauthorized disclosure of PII/PHI?
    a. Keep quiet and see if anything bad happens before reporting it.
    b. Call the police.
    c. Notify your Service Coordinator.
    d. All of the above.

7. Which of the following could possibly cause an unauthorized HIPAA disclosure?
    a. Talking to CDCN about a service recipient.
    b. Leaving paperwork out that contains PHI where others can view it.
    c. Shredding any paper documents with service recipient information.
    d. Talking to a service recipient about their condition and care.

8. Penalties for unauthorized disclosure can be applied to CDCN and the employee.
    a. True
    b. False

9. Only employees taking care of service recipients with medication need to worry about HIPAA.
    a. True
    b. False

Confidentiality Agreement: By signing below, I acknowledge that the disclosure of confidential information obtained through my employment with the Member (service recipient) and CDCN is **Prohibited!** Furthermore, I understand that any information concerning the Member's diagnosis, personal care services, and their personal details are 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. I acknowledge that confidentiality is an important part of the job, and that failure to follow confidentiality requirement is cause for termination.

_____ _____

Employee Signature *Date*

CONSUMER DIRECT CARE NETWORK

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: _____

CONSUMER DIRECT CARE NETWORK

EXPECTED WEEKLY HOURS - NEW HIRE

CAREGIVER/NURSE
(Non-FEA)

Employee Name: _____

Entity: CDMT

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.

Always Designing for People™

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