This packet is set up for single-sided paper printing.

CONSUMER DIRECT CARE NETWORK

Agency-Based CFC/PAS Caregiving

CAREGIVER ORIENTATION DATA SHEET

Name _____ Hire/OR Date _____

	Type	Date	Comments
KEY DATES	Drivers License	Exp.	State #
	Auto Liability Insurance	Exp.	
	OIG	OR date + 1 yr	Search conducted date
	Background	OR date + 5 yrs	Criminal check conducted date
	Professional License	Exp.	MT CNA #
	TB Update	OR date/TB + 1 yr	New hire OR date neg test date test'read' date

	In-Service Name	Date	Hrs	Exp. (1 year)	Score	Comments
TRAINING	PCA Class & Test #1		16			In-house class & test/certificate
	or					
	Interview & Test #2		0			Applicant test
	HIPAA/Boundary/Fraud Quizzes		.50			Orientation
	Hazardous Communication		.50			Orientation
	Fire Safety		.50			Orientation
	Safety		.50			Orientation
	Infection Control		.50			Orientation
	Lifting and Moving Patients		.50			Orientation
	PPE, Handbook, Policies, DressCode, Sexharass, Fraud		.50			Orientation: Verbal Discussions
	Duty Guides / Schedule / Timesheets		1.0			Orientation: Scheduler/Nurse Supervisor

CONSUMER DIRECT CARE NETWORK

Agency-Based CFC/PAS Caregiving

CAREGIVER ORIENTATION CHECKLIST

Name	Position	Date	Person Orienting

- _____ Sign In: In-Service Timesheet
- _____ Application Complete and Signed
- _____ Auto Insurance Copy
- _____ Drivers License
- _____ Equal Employment Opportunity Disclosure
- _____ I-9
- _____ W-4
- _____ MW-4
- _____ Pay Selection Form
- _____ Wage Memo
- _____ Position Description
- _____ Employee Availability Agreement
- _____ Statement of Understanding
- _____ Privacy Awareness Guide
- _____ Privacy Awareness Quiz/Confidentiality Agrmt
- _____ HIPAA Boundary Quiz
- _____ In-Service Booklet Quiz (x6)
- _____ Fraud Prevention Pamphlet
- _____ Payroll Calendar
- _____ Employee Handbook
- _____ Employee Handbook Acknowledgment
- _____ TB Test Received
- _____ Hepatitis B
- _____ PPE Kit & Discussion
- _____ PT Work Screen Received
- _____ Emergency Contact Info.
- _____ CNA Certificate
- _____ PCA Test & Training Verification
- _____ Absence Request Form
- _____ Name Badge
- _____ New Employee Expected Weekly Hours
- _____ Sign Out: In-Service Timesheet

Important Discussions

- _____ Sexual Harassment/Threats/Violence
- _____ Dress Code
- _____ Standard Precautions
- _____ Fraud
- _____ Timesheet Orientation
- _____ Other: _____

Background Checks

- _____ Reference Checks
- _____ OIG (On-Line)
- _____ CNA Certificate Verification (On-Line)
- _____ Criminal Background Check (On-Line)

Follow-up

- _____ CRM Data-Entry
- _____ In-Service Training Certificate made
- _____ TB Test Verification Signed by NNC
- _____ Payroll Paperwork Forwarded (I-9, W-4, Wage Memo, Pay Selection, App Front Page, DL)
- _____ ADP Work Opportunity Tax Credit form
- _____ PCA Training Verif. signed by Nurse Sup.
- _____ Create Personnel/Health File
- _____ In-Service/OR Timesheet to Payroll
- _____ Track Probation Period

Comments

_____

_____

CONSUMER DIRECT CARE NETWORK

Agency-Based CFC/PAS Caregiving

IN-SERVICE TIMESHEET

Employee Name _____ Employee ID _____ Position _____ Instructor/Self Study _____

☐ New Employee Orientation ☐ In-Service Credit ☐ Annual Review ☐ Mandatory Meeting

Twelve in-service credit hours are required annually. Self-study in-services must be completed when not working with a Community First Choice/Personal Assistant Services member.

TRAINING / SELF STUDY				OFFICE USE ONLY		
Date	Topic	Time In	Time Out	% Score	Credit Hours	VT Entry

OR

NEW EMPLOYEE ORIENTATION			
Date	Topic	Time In	Time Out
	Study/Quiz: HIPAA, Boundary Quiz, Fraud Quiz, Safety, Fire Safety, Infection Control, Lifting and Moving Patients Verbal Discussions: PPE kit, company policies/handbook review, sexual harassment, threats, fraud, dress code		
	Timesheets/duty guides/schedule		

Guidelines

- Annual requirement - CNA/PCA: 12 hours.
- Attach educational materials/source documentation.
- Complete Quiz if attached: 70% minimum score required for credit. Employee must sign and date.
- If time overlaps a scheduled shift, employee will receive credit only (no compensation).
- Minimum requirements: 1 service hour/month must be turned in or risk being removed from the schedule.
- Each completed self-study quiz equals ½ hour in-service credit.

Employee Signature _____ *Date* _____ *CDCN Representative Signature* _____ *Date* _____

Office use only _____ Quiz graded _____ Employee Signature _____ Supervisor signature _____ Certificate made _____ Fwd to Payroll

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)

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.

CAUTION

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

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

Step 4 (optional).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

. . . . . **2** $

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

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

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

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

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

Single or Married Filing Separately

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

Head of Household

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

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

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*

wisely® by ADP

Financial control: You've got it!

A Wisely® digital account[1] puts you in charge of your money.

Get paid early.[2]

Whether you need to pay a bill or get money for last-minute plans, Wisely could help you get paid up to 2 days early.[2]

Save and manage your money on your terms.

Track your balance and spending 24/7 and save[3] for the things that matter most to you.

Shop with confidence.

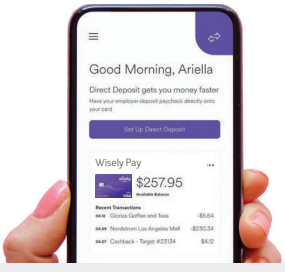
Pay online, in store, in app, or by phone everywhere Visa® debit cards are accepted or where Debit Mastercard® is accepted.

Skip ATM fees.

Get access to up to 90,000 surcharge-free ATMs nationwide.[4]

Get Wisely today!

Talk to your Payroll Department.



Manage your money, your way.
Afford yourself every advantage.™

[1] The Wisely card is a prepaid card. References to a digital account refer to the management and servicing of your prepaid card online digitally or through a mobile app. The Wisely card is not a credit card and does not build credit.

[2] You must log in to the myWisely app or mywisely.com to opt-in to early direct deposit. Early direct deposit of funds is not guaranteed and is subject to the timing of payor's payment instruction. Faster funding claim is based on a comparison of our policy of making funds available upon our receipt of payment instruction with the typical banking practice of posting funds at settlement. Please see full disclosures on mywisely.com or the myWisely app. If you have a Wisely Pay or Wisely Cash card (see back of your card), this feature requires an upgrade which may not be available to all cardholders. Please allow up to 3 weeks after your initial setup of direct deposit for your pay to start loading to your card.

[3] Amounts transferred to your savings envelope will no longer appear in your available balance. You can transfer money from your savings envelope back to your available balance at any time using the myWisely app or at mywisely.com.

[4] The number of fee-free ATM transactions may be limited. Please log in to the myWisely app or mywisely.com and see your cardholder agreement and list of all fees for more information.

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CONSUMER DIRECT CARE NETWORK

PCA WAGE MEMORANDUM

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

Position: Caregiver

Program: ☐ ABT ☐ AWC ☐ CORE EMPLOYEE

FOR OFFICE USE

Wage:

☐ $ _____ /hour (PCA,TRAINING, SHOWUP, VAPCA, VARESPITE, RESPITE, ABSOCSUP, SOCSUP, ABHMAKER, HOMEMAKER, ABRESPITE, CHILDCARE, CFCPAS, CFCSHOPCI, CFCMEDESC)
☐ $ 0.51 /mile CFC SHOP/CI Mileage/Medical Escort Mileage(MCDTRANSP) (CFCA0080)*
☐ $ 0.51 /mile Waiver Mileage (Mileage)*
☐ $ 0.60 / mile Private Pay Mileage (MILEAGEPVT)*
☐ $ 10.30 /hour Portal to Portal Travel Time
☐ $ 10.00 /day Weekday On Call (WDAYONCALL)*
☐ $ 20.00 /day Weekend On Call (WENDONCALL)*
☐ $ 20.00 /day Holiday On Call (HDAYONCALL)*

*Holiday Pay does not apply

Wage/Mileage Reimbursement

CCH	Base Pay	DCW	Total Pay
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**
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**

Holiday Pay: Caregivers will receive holiday pay at 1.5x's their rate of pay for hourly services for actual time worked on holidays as defined in the collective bargaining agreement between SEIU 775 and Consumer Direct Montana.

Paid Time Off (PTO) **Non-cores**: Beginning by August 21st, 2024, employees will accrue PTO at a rate of 1 hour for every thirty (30) hours worked. PTO hours shall cap at one hundred and sixty (160) hours. PTO shall not be counted toward a caregiver's workweek. The sum of hours worked, training hours and/or PTO hours shall not exceed twenty-four (24) hours for one day.

Paid Time Off (PTO) **Cores**: Employees will accrue PTO at a rate of ten (10) days per calendar year. PTO hours shall cap at one hundred and sixty (160) hours. PTO shall not be counted toward a caregiver's workweek. The sum of hours worked, training hours and/or PTO hours shall not exceed twenty-four (24) hours for one day.

11871

Paid Sick Time **Cores**: After the first year of employment, there will be accrual of three (3) paid sick days annually, bankable to a maximum of 15 days. Paid sick time is "use it or lose it"; accumulated sick days are not paid out upon separation from the Core PCA position or upon termination of employment.

Bereavement Pay (BP) **Cores**: After completion of their 6-month probationary period, a Core PCA is entitled to up to three (3) BP days in the event of a death of a family member.

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

Agency-Based CFC/PAS Caregiving

PCA/CNA Position Description

General Information

Position Title:	Personal Care Attendant (PCA)/Certified Nurse's Aide (CNA)
Specific Location:	Visits in clients' home, office
Classification:	Non-exempt
Designation:	Part Time to Full Time
Reports to:	Nurse Supervisor

Working Conditions/Environment

Primarily works out of a local office. Local area travel will be required; required to provide his or her own transportation with valid driver's license and proof of insurance. Must have a telephone and email account for communicating with CDCN staff.

Position Summary

The PCA/CNA is a trained worker who provides in-home personal care and activities incidental to personal care for Agency clients while under the supervision of a nurse. The PCA/CNA provides direct client care and social support to homebound clients of all ages. Direct personal care consists of those tasks related to the individual's physical care such as bathing, grooming, dressing, feeding, and elimination. The PCA/CNA is trained to assist with the client's physical activity involving changing position in bed, ambulation, transfers, routine exercises, and the routine care of prosthetic and orthopedic devices. They will also be responsible for those household chores incidental to meeting the client's personal care needs. A nurse establishes and supervises the PCA/CNA plan of care.

Employment Standards

Minimum Skills, Education, Experience Required:

1. Completion of an approved program for PCA/CNA with notification of passage of agency exam.
2. Sympathetic attitude toward care of the sick, elderly and disabled.
3. Ability to read, write, and carry out directions.
4. Excellent documentation skills.
5. Maturity and ability to deal effectively with the demands of the job.
6. Preferably, experience in home health care, but not limited entirely to that experience.
7. Completion of any required competency testing.
8. Current continuing education of 12 hours per year.
9. Completion of self-declaration for knowledge/skills/competency checklist.
10. Evidence of past negative TB test.

Other

1. Complete employment process.
2. Provide references.
3. Comply with OSHA requirements.
4. Adhere to professional/industry standards of practice/care.
5. Uphold professional/industry ethics.

6. Must have current driver's license and automobile insurance.
7. Must have reliable transportation.

ESSENTIAL FUNCTIONS

Responsibilities

1. Observes client's general condition on each visit.
2. Delivers personal care, i.e. grooming needs and other assigned tasks.
3. Assists with ambulation and transfers.
4. Assists with range of motion exercises when appropriate instruction has been given and nurse supervisor has established a plan of care.
5. Assists client with self-administered medications as ordered by the physician and after receiving instruction from the nurse supervisor.
6. Assists client with homemaking tasks (meal preparation, laundry, linen change, dishes, cleaning client area), which are incidental to the necessity for home care and essential to the client's care at home.
7. Reports immediately to the nurse supervisor any changes in the client's care at home.
8. Completes appropriate client visit documentation.
9. Attends scheduled staff meetings.
10. Reviews and provides input regarding job description at least annually or upon performance appraisal.
11. Consumer Direct Care Network (CDCN) reserves the right to change the job description without notice or input from employees.
12. Other duties as assigned.

Critical Time Periods

1. Arrives at client's residence within 15 minutes of scheduled time.
2. All time sheets, charting, and other documentation must be turned in as required by CDCN policy.
3. Call office for messages and changes in schedule as soon as possible upon notice of change.
4. Participates in monthly in-services.

CONTINUING EDUCATION REQUIREMENTS

The PCA/CNA is expected to participate in appropriate continuing education as may be requested and/or required by this position. In addition, the PCA/CNA is expected to accept personal responsibility for educational activities to enhance job related skills and abilities.

I have read and understand the job description for PCA/CNA.

Employee Name	*Employee Signature*	*Date*
CDCN Representative Name	*CDCN Representative Signature*	*Date*

09189

CONSUMER DIRECT CARE NETWORK

Agency-Based CFC/PAS Caregiving

APPLICANT/EMPLOYEE AVAILABILITY AGREEMENT

Employee Name: _____ Date: _____

Please specify the hours for each day that you are willing to work as well as the maximum hours per day that you would be willing to work.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time							
End Time							
Max Hours/Day							

Hours/Week Desired: _____

Minimum Hours/Week Willing to Work: _____

Maximum Hours/Week Willing to Work: _____

Date Availability Starts: _____

Comments:

Vacation/absence request forms are required 30-days in advance for approval. Request for schedule changes will take up to three weeks, with no guarantee. It is the employee's responsibility to confirm the request for change can occur.

Signature: _____ Date: _____

CONSUMER DIRECT CARE NETWORK

Agency-Based CFC/PAS Caregiving

STATEMENT OF UNDERSTANDING

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

1. **Employer**
   I am an employee of Consumer Direct Personal Care, LLC, doing business as Consumer Direct Care Network Montana Caregiving (CDCN). I am not an employee of the insurer/contractor, Medicaid, worker's compensation, the hospital, case management, or the Community First Choice Member.

   I understand CDCN restricts a Member from hiring me directly.

   I understand that this Statement of Understanding is not an employment contract.

2. **Caregiver Handbook**
   I have reviewed and understand the policies in the CDCN Caregiver Handbook. If I have questions, I will ask CDCN.

3. **Scheduled Shifts**
   Definite hours are not guaranteed. Service requests and service hours are defined by the Member's needs. Scheduled shifts are assigned accordingly by CDCN. I agree to meet commitments and the scheduled hours I accept.

   - Call-offs are only allowed for extreme emergencies. Frequent call-offs can result in disciplinary action, up to and including termination. Call-offs are defined as providing at least two-hour notice before being absent for an assigned shift.
   - No-call/no-shows will result in disciplinary action, up to and including termination. No-call/no-shows are defined as failing to show-up for an assigned shift without providing at least two-hour notice.

   I agree to work assigned shifts every other weekend. If I am unable to work my scheduled weekend, I understand I will be expected to work my weekend off.

   The Member does not have to use my services. At any time, they may request to discontinue my services without reason. This does not mean I am terminated from CDCN unless required for disciplinary reasons.

4. **Schedule Change & Time-Off Request**
   I understand a schedule change request and removal from a Member's home may take up to three (3) weeks. My request for change must be in writing. I understand I must continue working my current schedule for up to three (3) weeks or until CDCN finds replacement staff.

   Time-off requests must be submitted a month ahead of time. Failure to provide one-month notice may result in denial of the request.

5. **Overtime**
   NO overtime is allowed unless approved by CDCN. If working overtime is needed, I must get it authorized from CDCN before working the extra hours. I agree to monitor hours worked and anticipate overtime work.

6. Payment

Paychecks are issued every other Friday. In order to be paid correctly, timesheets are collected for each member. The start and end of each shift must be clearly charted on the timesheet. Timesheets must be signed by the Member and myself.

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 (a 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.

CDCN will deduct state and federal taxes from my paychecks. I will receive the benefits of Worker's Compensation coverage, employer Social Security contribution, and Federal/State Unemployment Insurance.

7. Certifications and Licenses

I must maintain certain licenses/certifications. CDCN will verify my:

- Current automobile liability insurance
- TB Screening
- Understanding of Standard Precautions

8. Transporting Members

Transportation is only allowed if authorized in the Member's Service Plan. For Member transport I acknowledge there must be adequate automobile liability insurance in place to cover injuries or vehicle damage, if there's an accident. This is true whether it is my own personal vehicle or the Member's vehicle. Also, I may not drive the Member if I do not have a valid driver's license. I must notify CDCN if my driving status changes.

9. Workplace Monitoring

I will not expect privacy when working in a Member's home or at the CDCN office. I acknowledge these locations may be under periodic surveillance or video-monitored by law enforcement, Members or their families, or CDCN.

10. Non-Emergent Care

I understand my role as a Personal Care Attendant is to assist the Member with Activities of Daily Living (ADLs) and provide nonmedical care. Under CDCN guidelines, I understand I will not perform any invasive and/or medical treatments. These treatments require a licensed professional to administer and/or provide (such as: suctioning, bowel care, insertion/removal of urinary catheter, complex wound care, medication box fills, etc.). I understand violating this condition can result in immediate termination of employment.

_____ _____

Employee Signature *Date*

EMPLOYEE HANDBOOK ACKNOWLEDGEMENT

I acknowledge that I have received a copy of Consumer Direct Personal Care, LLC doing business as Consumer Direct Care Network Montana Caregiving (CDCN) Employee Handbook and Appendix. I understand that I am responsible for familiarizing myself with the contents of the Handbook and Appendix. I also understand that failure to follow the policies and procedures contained in the Handbook and Appendix may result in disciplinary measures up to and including dismissal.

Handbook version/revision date: _____

_____	_____	_____
Employee Name	*Employee Signature*	*Date*

CONSUMER DIRECT CARE NETWORK

Agency-Based CFC/PAS Caregiving

EMPLOYEE EMERGENCY CONTACT INFORMATION

Employee Name

EMERGENCY CONTACT #1

Contact Name

Home/Work Phone

Relation

Cell Phone

EMERGENCY CONTACT #2

Contact Name

Home/Work Phone

Relation

Cell Phone

Employee Signature

Date

CONSUMER DIRECT CARE NETWORK

Agency-Based CFC/PAS Caregiving

INITIAL TRAINING RECORD

Employee Name _____ Date _____

1. The above-named employee has completed the initial training OR meets the minimum competency requirements (check one):

   ☐ - Completed the 16-hour PCA Class (attach certificate/documentation)

   ☐ - Provided proof of successful training through another personal assistance services agency (attach copy of training certificate).

   ☐ - Provided documentation of a minimal of one year experience as a trained personal assistant in a community based program such as a licensed developmental disabilities group home or licensed assisted living facility (attach documentation).

   ☐ - Provided a copy of a CNA certificate that is current or less than two years expired (attach certificate).

2. Employee demonstrates competency for this agency by completing and passing the Agency Program Competency Test as follows:

   ☐ 100% - 90% ☐ 89% - 80% ☐ Failed

3. Employee understands they must complete 12 hours of in-service trainings every year within their anniversary hire date. Consumer Direct Care Network will mail 3 hours of trainings quarterly to the employee's mailing address on file.

   Hire Date: _____ Anniversary Date: _____

_____ _____

Employee Signature *Date*

This form was approved by the Nurse Supervisor before direct placement in the field.

_____ _____

Nurse Supervisor Signature *Date*

CONSUMER DIRECT CARE NETWORK

Agency-Based CFC/PAS Caregiving

TB TEST VERIFICATION

_____

Employee Name

EMPLOYEE

Have you had a prior TB skin test? ☐ Yes ☐ No

Have you ever had a positive TB skin test? ☐ Yes ☐ No

*If yes, chest X-ray results are required

Proof of prior negative test result is required and must be provided immediately. If not available, testing is necessary and must be completed promptly – see authorization below.

_____ _____

Employee Signature *Date*

HEALTH DEPARTMENT – PPD SKIN TEST

Date Given: _____ Date Read: _____

Result: _____ mm Pos. / Neg.

Read By: _____

Signature: _____

AUTHORIZATION

☐ The above-named employee is authorized to be given a PPD skin test at the expense of Consumer Direct Care Network Montana Caregiving (CDCN), 100 Consumer Direct Way, Suite 145, Missoula, MT 59808.

_____ _____

CDCN Representative Signature *Date*

☐ The above-named employee has provided a negative PPD skin test.

_____ _____

CDCN Representative 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

Agency-Based CFC/PAS Caregiving

TIME OFF/VACATION REQUEST FORM

All Leave Requests Must Be Submitted 30 Days In Advance

Employee Name: _____ Today's Date: _____

Skill Code (please circle one): PCA | CNA | LPN | RN | Other: _____

City: _____

Vacation/Absence Beginning Date: _____ Time: _____

Return to Work on Date: _____ Time: _____

Comments: _____

_____

_____ _____

Employee Signature *Date*

Office Use Only

☐ Reviewed by Scheduler: _____ _____

Initials Date

Comments: _____

_____

☐ Approved ☐ NOT Approved

Regional Coordinator/Nurse Supervisor: _____ _____

Initials Date

Comments: _____

_____

☐ Soneto Updated: _____ _____

Initials Date

09196

Rev. 05/08/2018

CONSUMER DIRECT CARE NETWORK

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

Agency-Based CFC/PAS Caregiving

BOUNDARY HIPPA QUIZ

True (T) or False (F)

T F 1. It is OK for me to give out my phone number to a client & their family in case of emergency.

T F 2. It is OK for me to talk on my cell phone in a client's home.

T F 3. If I know my client is friends with another client, it is OK to discuss their current medical status with each client.

T F 4. It is OK for me to have colorful personal conversations regarding relationships with my clients if they are the ones that started the conversation.

T F 5. Gossiping about clients and other caregivers is NOT something I can be written up for and possibly terminated over.

T F 6. I can tell my clients all about my family and my exciting weekend plans.

T F 7. It is OK if I want to take a client to a movie with my family when I am not working.

T F 8. I can accept gifts from my clients and give them gifts in return.

T F 9. While on a scheduled visit, I can have a beer with my client if they offer it to me.

T F 10. It is OK for me to remove items from a client's home for safekeeping if they fear family members will take them.

T F 11. It is OK for me to bring my children and pets with me to a client's home, as long as my client approves.

T F 12. There is no problem with posting a copy of my weekly schedule at each client's home.

T F 13. It is OK for me to arrange a schedule change with another caregiver and not tell the office about it.

T F 14. It is OK to send my time cards in a paper-clipped pile into the office with a girlfriend that is going to town so I can save some postage.

T F 15. It is appropriate to have a friend drop me off at a client's home and pick me up after the visit as long as I am on time.

T F 16. As long as I text message, it is OK for me to be chatting with my friends while I am at a client's home.

T F 17. It is professional of me to scold another caregiver in front of a client if they haven't done something the way I would have.

T F 18. If I don't complete my timesheets at each visit, I can complete them by using my schedule and transferring the information over.

T F 19. I can be fined up to $250,000 for releasing private client information and for violating HIPAA laws.

T F 20. When a client asks me to do something that is not on my duty guide, I can use the phrase "I would love to do that for you, but I need you to call the office and get that authorized by the program manager first."

T F 21. When there is a signature stamp, I do not have to ask for approval or permission to stamp my timesheets on the last day of the week that I take care of my client.

Employee Name	*Employee Signature*	*Date*

CONSUMER DIRECT CARE NETWORK

Agency-Based CFC/PAS Caregiving

FRAUD PREVENTION QUIZ

True (T) or False (F)

T F 1. If you commit fraud intentionally, you will be prosecuted by the State.

T F 2. It's okay to take a break during your shift and not subtract the break time when you write down your time.

T F 3. Marking tasks completed when you did not do them is considered fraud.

T F 4. Mary calls telling you she forgot to mark a task she completed that day and asks you to please mark it for her. You can change her time sheet for her since she gave permission if you document the correction with "per instruction by [name]," the date and your initials.

T F 5. If you are aware of a fellow employee committing fraud, you must report the suspected fraud to your employer.

T F 6. As a Consumer Direct employee, you read and signed the Employee Handbook, which includes the company's Standard of Conduct, Corporate Compliance and a fraud component.

T F 7. When you sign your time sheet, you are signing an "acknowledgement and anti-fraud statement" every time.

T F 8. RNs and LPNs do not have to pass an Office of Inspector General (OIG) and criminal background check since they are already licensed.

T F 9. "Padding" a time sheet is recording a false in and out time when you've actually shown up late and/or left early.

T F 10. It is considered fraud if you do not provide the expected quality of care/services for your patient/service recipient.

_____	_____	_____
Employee Name	*Employee Signature*	*Date*

CONSUMER DIRECT CARE NETWORK

Agency-Based CFC/PAS Caregiving

SAFETY QUIZ

True (T) or False (F)

T F 1. Healthcare workers face fewer hazards in the home than in institutions.

T F 2. When working in a patient's home, you have more control over the environment than in an institution.

T F 3. Slips, trips and falls can be avoided if you slow down, watch where you are going, and wear sensible shoes.

T F 4. As a healthcare worker in the home, you can have as much strain on your back as a construction worker.

T F 5. Back injuries can be avoided only by using good posture and staying physically fit.

T F 6. If a cord heats up during use, just unplug it for about five minutes to let it cool off – and then it will be ready to use again.

T F 7. If the home you work in is older and does not have three-holed outlets, just bend the third prong on your plug to make it fit the older outlet.

T F 8. Always order medical equipment from a Durable Medical Equipment supply company that is approved by JCAHO.

T F 9. If a fire starts in the home, you should rescue the patient first and then call 911.

T F 10. In a fire, flames are far more deadly than heat or smoke.

T F 11. Always dispose of medical waste by following your agency's policy.

T F 12. Blood or body fluids can be infectious even before the patient shows signs or symptoms of illness.

T F 13. Soiled laundry is not considered hazardous medical waste.

T F 14. If you take your gloves off very carefully after handling medical waste, you don't really need to wash your hands.

T F 15. There is very little you can do to protect yourself in a dangerous neighborhood.

T F 16. Morning is the safest time to make visits in neighborhoods that may be dangerous.

T F 17. AS you approach your car always use a flashlight to check underneath the car and in the back seat before opening the door.

T F 18. IF you find yourself in a potentially dangerous situation, always look like you know what you are doing.

T F 19. Never try to break up domestic arguments since they can be extremely volatile.

T F 20. When it comes to personal safety, always trust your instincts.

Employee Name _____ *Employee Signature* _____ *Date* _____

True (T) or False (F)

T F 1. More than 400,000 fires take place in the home each year.

T F 2. The four elements needed to make fire are oxygen, fuel, heat and the resulting chemical reaction.

T F 3. Cooking accidents are the leading cause of fire-related injuries for older Americans.

T F 4. The kitchen is the most common setting for electrical fires in the home.

T F 5. When performing a home safety check, be sure the address is clearly marked and visible.

T F 6. Space heaters pose less of a fire risk if they have three feet of clearance around them.

T F 7. Dry and aging construction materials pose the major fire hazard to older homes.

T F 8. Kerosene heaters can be run on gasoline as long as the room has plenty of ventilation.

T F 9. There should be at least one smoke detector on each level of your patient's house.

T F 10. It's a good idea to keep a portable fire extinguisher in the kitchen.

T F 11. For best results, aim the fire extinguisher's nozzle directly into the biggest part of the flame.

T F 12. Every family should have a written fire escape plan that shows two ways out of the home.

T F 13. Most fire deaths in the home occur between 2 am and 6 am.

T F 14. Breathing in small amounts of smoke and toxic gases during a fire can make you drowsy and disoriented so that it becomes difficult to get to safety.

T F 15. In case of fire, confine the blaze first; then sound the alarm and rescue the patient from danger.

T F 16. When you evacuate a patient, it is more important to walk quickly through a burning room than to take time to crawl beneath the smoke and heat.

T F 17. The leading cause of fire deaths is careless smoking.

T F 18. Workplace fires are most often electrical.

T F 19. In the office, sound the alarm only when you're sure there is an actual fire.

T F 20. Sine fire is fast, what you do in the first three minutes is very critical to the protection of lives and property.

Employee Name _____ *Employee Signature* _____ *Date* _____

True (T) or False (F)

T F 1. You can tell by looking whether 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 bloodborne pathogen.

T F 6. Used sharps should be places in a leakproof, 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 they land on.

T F 13. If you have a sharps exposure, you can reduce your chances infection by seeking medical attention right away.

Employee Name _____ *Employee Signature* _____ *Date* _____

True (T) or False (F)

T F 1. When lifting, you should flatten the curves in 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 coworkers 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 back fitness.

Employee Name	*Employee Signature*	*Date*

Multiple Choice

1. Ultraviolet radiation is an example of a:
    a. Pyrophoric hazard
    b. Physical hazard
    c. Health hazard
    d. Simple asphyxiant

2. Reproductive and organ toxicity are consequences of which type of hazard?
    a. Physical hazard
    b. Aspiration hazard
    c. Health hazard
    d. Pyrophoric hazard

3. Which of the following is an example of an asphyxiant hazard?
    a. Coal and carbon dust
    b. Silane
    c. Elevated levels of nitrogen in a confined space
    d. Carcinogen benzene

4. What is a combustible dust?
    a. Coal and carbon particles
    b. Sulfuric acid and carcinogen benzene
    c. Nitrogen and oxygen
    d. Mineral and organic acids

5. A pyrophoric hazard is a gas that will:
    a. Cause deprivation of oxygen
    b. Cause skin corrosion or irritation
    c. Ignite in the air at or below 130 degrees Fahrenheit
    d. Emit a flammable substance when in contact with water

6. The purpose of the product identifier is to:
    a. Alert the reader quickly to severity of the chemical's hazard
    b. Describe the nature of hazards of the product
    c. Identify what is in the container
    d. Explain how to handle chemical safely

7. Each pictogram has a symbol on a:
    a. Red background with a white border
    b. White background with a red border
    c. White background with a black border
    d. Orange background with a black border

8. The gas cylinder pictogram applies to chemicals that are:
    a. Oxidizers
    b. Explosive and self-reactive
    c. Skin and respiratory tract irritants
    d. Gases under pressure

9. Safety Data Sheets communicate what information?
    a. A proper PPE maintenance and storage
    b. The hazards of chemicals you work with
    c. Safety evacuation procedures
    d. Ergonomic safety

10. The chemical's characteristics would be covered in which of the following sections?
    a. Stability and Reactivity
    b. Toxicological Information
    c. Handling and Storage
    d. Physical and Chemical Properties

Employee 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.

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

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[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact

_____

_____.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name		4. Employer Identification Number (EIN)
5. Employer address		6. Employer phone number
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above)	12. Email address	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☐ Some employees. Eligible employees are:
- With respect to dependents:
  - ☐ We do offer coverage. Eligible dependents are:
  - ☐ We do not offer coverage.

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

CONSUMER DIRECT CARE NETWORK

2024 Benefits Summary
MT Caregivers

Benefit	Eligibility Requirements	Enrollment	Important Details
Health Insurance	30+ Hours per week	First of the month following 30 days of employment	Comprehensive health plan with a $1,500 deductible. Plan offers co-pays for office visits and prescriptions. Max out-of-pocket $3,000.
Dental Insurance Plan	30+ Hours per week and enrolled in company health insurance	First of the month following 30 days of employment	FREE preventative care (cleanings). Additional services subject to $50 deductible and $1,000 maximum benefit per year.
Telemedicine by 98point6	30+ Hours per week and enrolled in company health insurance	First of the month following 30 days of employment	App allows you to text directly with a doctor about non-emergency medical issues. Doctors are available 24/7 by text messaging and can prescribe some medications. Prescription and lab fees are at your own expense.
Health Care Flexible Spending Account (FSA)	30+ Hours per week	First of the month following 30 days of employment	Employees can defer up to $3,200 per calendar year in pre-tax dollars to use for eligible medical expenses. Unused funds exceeding $640 are forfeited at the end of the year; unused funds of $640 or less are rolled over to the following year's FSA.
Dependent Care Flexible Spending Account (FSA)	10+ Hours per week	First of the month following 30 days of employment	Employees can defer up to $5,000 per calendar year in pre-tax dollars to use for daycare or disabled adult dependent care expenses. Unused funds are forfeited at the end of the year.
Vision Insurance	10+ Hours per week	First of the month following 30 days of employment	Plan participants receive a free annual eye exam with in-network providers, and can choose between new lenses or frames with $20 copay OR free contacts (within allowance). Additional discounts available.
Voluntary Dental Insurance	10+ Hours per week	First month following 30 days of employment	FREE preventative care (cleanings). Additional services subject to $50 deductible and $1,000 maximum benefit per year.
Basic Life/AD&D Insurance	10+ Hours per week	**Automatic:** First of the month following 30 days of employment	In the event of an employee's death, this **company paid** plan pays their beneficiary a benefit equal to $10,000. Life and AD&D Benefits reduce to 65% at age 65 and to 45% at age 80.
Voluntary Supplemental Life Insurance	10+ Hours per week	First of the month following 30 days of employment	Employees can elect amounts in $10,000 increments, up to the lesser of $300,000 or 5 times your annual earnings. Verification may be required in certain circumstances. Life Benefits reduce to 65% at age 65 and to 45% at age 80.
Unum Supplemental Insurances	10+ Hours per week	First of the month following 30 days of employment	Coverages Available: Critical Illness, Accident and Hospital Insurance
Employee Assistance Program (EAP)	No hours requirement	**Automatic:** All employees and eligible family members	The EAP offers free and confidential counseling and assistance resolving situations that may inpact your personal or professional life. Employees are given 3 counseling sessions per issue.
401(k) Retirement Plan	No hours requirement Must be age 18 or older	First of the month following 90 days of employment	Employees can defer pre-tax dollars into the company's 401(k) plan.
Pet Insurance	No hours requirement	No waiting period	MetLife Pet Insurance offers assistance to pay for your pet's medical care, including check-ups, testing, surgery, and hospitalization. Contact MetLife at www.metlife.com/getpetquote or 800-438-6388.

For additional assistance, please contact Health Advocate at answers@healthadvocate.com or by calling 866-695-8622.

CONSUMER DIRECT CARE NETWORK

Employee Badge Information

Date of Request: _____

Employee First Name: _____

Employee Last Name: _____

Department: _____

Action Requested:

- ☐ New Badge
- ☐ De-Activate Badge
- ☐ Change Access (See "Areas of Access" Below)

Areas of Access (Please check all that apply):

- ☐ ID Badge Only (No Access)
- ☐ General Access (Stairs, Elevator, Bike Room, North Door, Employee Deck)
- ☐ Special Access:
  - ☐ Executive Office ☐ Human Resources ☐ Mailroom ☐ Payroll
- ☐ Service Access:
  - ☐ Behavioral Health ☐ CDMT ☐ Home Health ☐ Hospice

Notes: _____

_____

Supervisor: _____
(Name and Department)

Supervisor Signature: _____

Facilities to Complete

Badge Issue/Change Date: _____ Badge #: _____

Facilities Staff Name: _____

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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