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

CONSUMER DIRECT CARE NETWORK

EMPLOYEE ENROLLMENT PACKET INSTRUCTIONS

Complete or Provide Photocopies of the Documents Listed Below

This employment packet contains all the required paperwork to become enrolled as the Member's employee in the Community First Choice/Personal Assistance Services program. Complete all the documents and trainings listed below and provide photocopies if needed. Use the checklists below to keep track of completed forms.

1. **Enrollment Forms.**
   - ☐ Employee Data Form – Employee provides contact information and answers all questions. *Ensure you have included a valid email address for CDCN to contact you.*
   - ☐ Equal Employment Opportunity Disclosure Form – Completed at Employee's discretion.
   - ☐ Form I-9 – Employee completes section 1. Member/PR completes section 2 and verifies identification provided by Employee. **See supplemental materials for I-9 instructions.**
   - ☐ Form W-4 – Employee completes to determine amount of federal taxes withheld from pay.
   - ☐ Form MW-4 – Employee completes to determine amount of state taxes withheld from pay.
   - ☐ Wage Memo – Issued by CDCN.
   - ☐ Pay Selection Form – Employee selects how pay will be issued. Direct deposit is recommended. **See supplemental materials for Pay Card information.**
   - ☐ Employee Agreement – Reviewed and signed by Employee and Member/PR.
   - ☐ Driving Confirmation <u>OR</u> No Driving Confirmation – <u>submit only one of these two forms</u>, depending on whether or not you will be providing driving related services as a part of your duties. **Attachments required with Driving Confirmation Form.**
   - ☐ Authorization/Declination of Hepatitis B Vaccination – Employee completes the form, choosing to decline or accept the Hepatitis B Vaccination at no charge.
   - ☐ New Employee Expected Weekly Hours – For internal use. Please complete only the top portion of the form.
2. **Photocopy Attachments.** <u>Provide if required, see explanations below</u>.
   - ☐ Voided check – Required if selecting direct deposit to a bank or credit union account.
   - ☐ Photocopy of driver's license - Required if you will be driving as part of your job.
   - ☐ Photocopy of vehicle insurance for vehicle used for driving-related services – Required if you will be driving as part of your job.
3. **Trainings.** Complete the trainings using the training materials provided.
   - ☐ Training Module Documentation – Review the associated training pamphlets and the Employee Handbook and complete the quizzes on Infection Control, Lifting and Moving Patients, and Reporting Work Place Injuries.
   - ☐ Privacy Awareness Quiz & Confidentiality Agreement – Review the Privacy Awareness Guide and take the quiz.
   - ☐ Exposure Control Plan Training Signature Page – Employee and Member/PR review the Exposure Control Plan. Both sign the signature page after the training is completed.

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

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

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

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

Supplemental Materials

Keep and refer to as needed:

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

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

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

Training Materials

Reference when completing the training quizzes in the enrollment packet:

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

This PDF document is optimized for use in Adobe Acrobat. Completion in a browser such as Chrome, Firefox, or Edge is not recommended.

CONSUMER DIRECT CARE NETWORK

Clear Form

EMPLOYEE DATA FORM

Member (Service Recipient) Name: _____

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

EMPLOYEE CONTACT INFORMATION

Name: _____ _____ _____
First Middle Last

Physical Address: _____
Street Apt/Unit # City State Zip

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

Phone Numbers: _____ _____
Home Cell

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

We may reach out to you via SMS/Text Messaging concerning your services with CDCN. Please note that CDCN will never request sensitive personal information, such as your Social Security Number, banking details, address, or date of birth through text messages. If you receive an SMS message from CDCN and would like to opt-out from future SMS messages, please respond to the initial message with "STOP".

Email Address*: _____ **A valid email address is required. CDCN will communicate with you regularly via email; your background check questionnaire will be sent to this address as well.*

Date of Birth: ____/____/____ Social Security Number: ____-____-____

Emergency Contact: _____ _____
Name Phone

Position: The position being applied for is Caregiver Relationship to member:_____

This Employee Application is for me to work as a: ☐ Primary Caregiver ☐ Back-Up Caregiver

PHYSICAL CAPACITY

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

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

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

Please explain any exceptions:

_____

_____

CRIMINAL BACKGROUND

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

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

_____

_____

CONSUMER DIRECT CARE NETWORK

EMPLOYEE DATA FORM

PROFESSIONAL STANDARDS AND LICENSING

Have you ever had a professional license, certificate, or driver's license in any state revoked, suspended, or had disciplinary action applied? ☐ Yes ☐ No

In the past three years, have you had moving violations or motor vehicle accidents? ☐ Yes ☐ No
If yes, please explain:

_____

_____

PREVIOUS EXPERIENCE WITH COMPANY

Have you previously worked for Consumer Direct Personal Care, LLC, Consumer Direct Management Solutions or Nightingale Nursing & Caregiving? ☐ Yes ☐ No

ALIASES OR PREVIOUSLY HELD NAMES

Please list any aliases or previously held names: _____

PLEASE READ CAREFULLY

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

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

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

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

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

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

_____	_____	_____
Applicant Printed Name	Applicant Signature	Date

Consumer Direct Care Network is an equal opportunity employer

CONSUMER DIRECT CARE NETWORK

EQUAL EMPLOYMENT OPPORTUNITY DISCLOSURE

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

The purpose of this questionnaire is to aid in complying with required governmental record keeping and/or reporting requirements. **This information <u>will not</u> 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 ☐ Undeclared

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

Decline Self Identification:

☐ I do not wish to self-identify.

Although I do not wish to self-identify my gender, ethnicity and/or race, I understand that my employer is <u>required</u> 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 05/31/2027

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

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

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

Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	Other Last Names Used (if any)

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number
/ /			

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

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

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

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

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

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

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

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

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

Additional Information

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS

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

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

Acceptable Receipts

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

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

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

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

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

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

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

2025

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.)

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (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 unless otherwise noted.

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2025 if you meet both of the following conditions: you had no federal income tax liability in 2024 **and** you expect to have no federal income tax liability in 2025. You had no federal income tax liability in 2024 if (1) your total tax on line 24 on your 2024 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 2025 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 17, 2026.

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

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

1. Are submitting this form after the beginning of the year;

2. Expect to work only part of the year;

3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;

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

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

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

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

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

Specific Instructions

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

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work. Submit a separate Form W-4 for each job.

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

Instead, if you (and your spouse) have a total of only two jobs, you may check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount 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 2025 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 2025 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:
- $30,000 if you're married filing jointly or a qualifying surviving spouse
- $22,500 if you're head of household
- $15,000 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	$700	$850	$910	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020
$10,000 - 19,999	0	700	1,700	1,910	2,110	2,220	2,220	2,220	2,220	2,220	2,220	3,220
$20,000 - 29,999	700	1,700	2,760	3,110	3,310	3,420	3,420	3,420	3,420	3,420	4,420	5,420
$30,000 - 39,999	850	1,910	3,110	3,460	3,660	3,770	3,770	3,770	3,770	4,770	5,770	6,770
$40,000 - 49,999	910	2,110	3,310	3,660	3,860	3,970	3,970	3,970	4,970	5,970	6,970	7,970
$50,000 - 59,999	1,020	2,220	3,420	3,770	3,970	4,080	4,080	5,080	6,080	7,080	8,080	9,080
$60,000 - 69,999	1,020	2,220	3,420	3,770	3,970	4,080	5,080	6,080	7,080	8,080	9,080	10,080
$70,000 - 79,999	1,020	2,220	3,420	3,770	3,970	5,080	6,080	7,080	8,080	9,080	10,080	11,080
$80,000 - 99,999	1,020	2,220	3,420	4,620	5,820	6,930	7,930	8,930	9,930	10,930	11,930	12,930
$100,000 - 149,999	1,870	4,070	6,270	7,620	8,820	9,930	10,930	11,930	12,930	14,010	15,210	16,410
$150,000 - 239,999	1,870	4,240	6,640	8,190	9,590	10,890	12,090	13,290	14,490	15,690	16,890	18,090
$240,000 - 259,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$260,000 - 279,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$280,000 - 299,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$300,000 - 319,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,170	19,170
$320,000 - 364,999	2,040	4,440	6,840	8,390	9,790	11,100	12,470	14,470	16,470	18,470	20,470	22,470
$365,000 - 524,999	2,790	6,290	9,790	12,440	14,940	17,350	19,650	21,950	24,250	26,550	28,850	31,150
$525,000 and over	3,140	6,840	10,540	13,390	16,090	18,700	21,200	23,700	26,200	28,700	31,200	33,700

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	$200	$850	$1,020	$1,020	$1,020	$1,370	$1,870	$1,870	$1,870	$1,870	$1,870	$2,040
$10,000 - 19,999	850	1,700	1,870	1,870	2,220	3,220	3,720	3,720	3,720	3,720	3,890	4,090
$20,000 - 29,999	1,020	1,870	2,040	2,390	3,390	4,390	4,890	4,890	4,890	5,060	5,260	5,460
$30,000 - 39,999	1,020	1,870	2,390	3,390	4,390	5,390	5,890	5,890	6,060	6,260	6,460	6,660
$40,000 - 59,999	1,220	3,070	4,240	5,240	6,240	7,240	7,880	8,080	8,280	8,480	8,680	8,880
$60,000 - 79,999	1,870	3,720	4,890	5,890	7,030	8,230	8,930	9,130	9,330	9,530	9,730	9,930
$80,000 - 99,999	1,870	3,720	5,030	6,230	7,430	8,630	9,330	9,530	9,730	9,930	10,130	10,580
$100,000 - 124,999	2,040	4,090	5,460	6,660	7,860	9,060	9,760	9,960	10,160	10,950	11,950	12,950
$125,000 - 149,999	2,040	4,090	5,460	6,660	7,860	9,060	9,950	10,950	11,950	12,950	13,950	14,950
$150,000 - 174,999	2,040	4,090	5,460	6,660	8,450	10,450	11,950	12,950	13,950	15,080	16,380	17,680
$175,000 - 199,999	2,040	4,290	6,450	8,450	10,450	12,450	13,950	15,230	16,530	17,830	19,130	20,430
$200,000 - 249,999	2,720	5,570	7,900	10,200	12,500	14,800	16,600	17,900	19,200	20,500	21,800	23,100
$250,000 - 399,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$400,000 - 449,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$450,000 and over	3,140	6,490	9,160	11,660	14,160	16,660	18,660	20,160	21,660	23,160	24,660	26,160

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	$450	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,870	$1,870	$1,870	$1,890
$10,000 - 19,999	450	1,450	2,000	2,200	2,220	2,220	2,220	3,180	4,070	4,070	4,090	4,290
$20,000 - 29,999	850	2,000	2,600	2,800	2,820	2,820	3,780	4,780	5,670	5,690	5,890	6,090
$30,000 - 39,999	1,000	2,200	2,800	3,000	3,020	3,980	4,980	5,980	6,890	7,090	7,290	7,490
$40,000 - 59,999	1,020	2,220	2,820	3,830	4,850	5,850	6,850	8,050	9,130	9,330	9,530	9,730
$60,000 - 79,999	1,020	3,030	4,630	5,830	6,850	8,050	9,250	10,450	11,530	11,730	11,930	12,130
$80,000 - 99,999	1,870	4,070	5,670	7,060	8,280	9,480	10,680	11,880	12,970	13,170	13,370	13,570
$100,000 - 124,999	1,950	4,350	6,150	7,550	8,770	9,970	11,170	12,370	13,450	13,650	14,650	15,650
$125,000 - 149,999	2,040	4,440	6,240	7,640	8,860	10,060	11,260	12,860	14,740	15,740	16,740	17,740
$150,000 - 174,999	2,040	4,440	6,240	7,640	8,860	10,860	12,860	14,860	16,740	17,740	18,940	20,240
$175,000 - 199,999	2,040	4,440	6,640	8,840	10,860	12,860	14,860	16,910	19,090	20,390	21,690	22,990
$200,000 - 249,999	2,720	5,920	8,520	10,960	13,280	15,580	17,880	20,180	22,360	23,660	24,960	26,260
$250,000 - 449,999	2,970	6,470	9,370	11,870	14,190	16,490	18,790	21,090	23,280	24,580	25,880	27,180
$450,000 and over	3,140	6,840	9,940	12,640	15,160	17,660	20,160	22,660	25,050	26,550	28,050	29,550

MONTANA DEPARTMENT OF REVENUE

Montana Employee's Withholding and Exemption Certificate

MW-4
V5 12/2024

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 surviving spouse (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 your wages each pay period. 3. _____
4. **Specified withholding.** Enter the amount you want to withhold from retirement distributions or unemployment compensation. 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. (See instructions) 4. _____
5. **Exemptions for Tax Year** 2025
   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 and checked the box on page 1, line 1b. 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 _____

Employee's Withholding and Exemption Certificate Instructions

Employee Instructions

What's New

Line 3 is now used only to designate additional amounts an employee would like withheld from their paycheck. Line 4 is used to designate a specific amount a taxpayer would like withheld from a payment or paycheck.

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.

You may also use the Form MW-4 to designate the amount you would like withheld from pension, annuity, and unemployment payments.

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 of withholding on your tax return, you may enter an additional amount on this line.

Line 4 – Specified withholding. Use this line to designate a specific amount you would like withheld from your paycheck or other payment. If you receive pensions or annuities, you may ask the payer to withhold a flat amount that you report on this line.

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

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. Do not complete lines 1 or 2. If you do not complete this line, your withholding will be calculated based on the standard calculations for your filing status.

CAUTION. If you are using this line to specify an amount of wage withholding you would like your employer to withhold, completing this line may reduce the amount of tax withheld from your wages. This could 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.

Thirty-Day Nonresident Worker Filing Exclusion. There is a filing exclusion for certain nonresident employees. Nonresidents who earned only wages for services performed in Montana for 30 days or less and worked in more than one state during the tax year do not have to file a tax return or pay tax to Montana on that income. The exclusion does not apply to nonresident employees who:

- work in Montana for more than 30 days
- work only in Montana
- are professional athletes
- are entertainers
- are persons that perform services for compensation on a per-event basis
- are construction workers
- are key employees (Key employees are employees that had an annual salary of more than $500,000 in the year preceding the current tax year.)
- are qualified production employees for the purposes of the MEDIA Credit.

If a nonresident employee does not meet the conditions above, then all income earned while working in the state is taxable to Montana and the employee must follow the general filing requirement. Additionally, this exclusion does not apply to nonresident employees who have other Montana source income. For example, a nonresident employee worked in Montana for 15 days. The nonresident also has a rental property located in Montana. This nonresident's wages and rental income are taxable to Montana.

Do not complete Form MW-4 if you meet the criteria for the filing exclusion.

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.

Thirty-Day Nonresident Wage Withholding Exclusion. Employers are not required to withhold on the wages of nonresident employees if the employee worked in Montana for less than 30 days and worked in more than one state. These employees do not need to complete a Form MW-4.

The exclusion does not apply to nonresident employees who:

- work in Montana for more than 30 days
- work only in Montana
- are professional athletes
- are entertainers
- are persons that perform services for compensation on a per-event basis
- are construction workers
- are key employees (Key employees are employees that had an annual salary of more than $500,000 in the year preceding the current tax year.)
- are qualified production employees for the purposes of the MEDIA Credit.

Additionally, nonresident employees with other types of Montana source income do not qualify for this exemption.

If an employee does not meet the conditions above, the employee must complete a Form MW-4 and the employer must begin withholding when the employee starts working in the state.

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 Separately											
		Lower Paying Job (Up to)									
Higher Paying Job		$9,999	$19,999	$29,999	$39,999	$49,999	$59,999	$69,999	$79,999	$89,999	$99,999
$0	$9,999	$235	$470	$517	$590	$590	$590	$590	$590	$590	$590
$10,000	$19,999	$470	$752	$872	$945	$945	$945	$945	$945	$945	$945
$20,000	$29,999	$517	$872	$992	$1,065	$1,065	$1,065	$1,065	$1,065	$1,065	$1,065
$30,000	$39,999	$590	$945	$1,065	$1,138	$1,138	$1,138	$1,138	$1,138	$1,138	$1,138
$40,000	$49,999	$590	$945	$1,065	$1,138	$1,138	$1,138	$1,138	$1,138	$1,138	$1,138
$50,000	$59,999	$590	$945	$1,065	$1,138	$1,138	$1,138	$1,138	$1,138	$1,138	$1,138
$60,000	$69,999	$590	$945	$1,065	$1,138	$1,138	$1,138	$1,138	$1,138	$1,138	$1,138
$70,000	$79,999	$590	$945	$1,065	$1,138	$1,138	$1,138	$1,138	$1,138	$1,138	$1,138
$80,000	$89,999	$590	$945	$1,065	$1,138	$1,138	$1,138	$1,138	$1,138	$1,138	$1,138
$90,000	$99,999	$590	$945	$1,065	$1,138	$1,138	$1,138	$1,138	$1,138	$1,138	$1,138
$100,000	$149,999	$590	$945	$1,065	$1,138	$1,138	$1,138	$1,138	$1,138	$1,138	$1,138
$150,000	$199,999	$590	$945	$1,065	$1,138	$1,138	$1,138	$1,138	$1,138	$1,138	$1,138
$200,000	$249,999	$590	$945	$1,065	$1,138	$1,138	$1,138	$1,138	$1,138	$1,138	$1,138
$250,000	$299,999	$590	$945	$1,065	$1,138	$1,138	$1,138	$1,138	$1,138	$1,138	$1,138
$300,000	$349,999	$590	$945	$1,065	$1,138	$1,138	$1,138	$1,138	$1,138	$1,138	$1,138
$350,000	$399,999	$590	$945	$1,065	$1,138	$1,138	$1,138	$1,138	$1,138	$1,138	$1,138
$400,000	$449,999	$590	$945	$1,065	$1,138	$1,138	$1,138	$1,138	$1,138	$1,138	$1,138
$450,000	$499,999	$590	$945	$1,065	$1,138	$1,138	$1,138	$1,138	$1,138	$1,138	$1,138

Married Filing Jointly or Qualifying Surviving Spouse											
		Lower Paying Job (Up to)									
Higher Paying Job		$9,999	$19,999	$29,999	$39,999	$49,999	$59,999	$69,999	$79,999	$89,999	$99,999
$0	$9,999	$0	$0	$470	$470	$470	$470	$564	$590	$590	$590
$10,000	$19,999	$0	$470	$940	$940	$940	$1,034	$1,154	$1,180	$1,180	$1,180
$20,000	$29,999	$470	$940	$1,410	$1,410	$1,504	$1,624	$1,744	$1,770	$1,770	$1,770
$30,000	$39,999	$470	$940	$1,410	$1,504	$1,624	$1,744	$1,864	$1,890	$1,890	$1,890
$40,000	$49,999	$470	$940	$1,504	$1,624	$1,744	$1,864	$1,984	$2,010	$2,010	$2,010
$50,000	$59,999	$470	$1,034	$1,624	$1,744	$1,864	$1,984	$2,104	$2,130	$2,130	$2,130
$60,000	$69,999	$564	$1,154	$1,744	$1,864	$1,984	$2,104	$2,224	$2,250	$2,250	$2,250
$70,000	$79,999	$590	$1,180	$1,770	$1,890	$2,010	$2,130	$2,250	$2,276	$2,276	$2,276
$80,000	$89,999	$590	$1,180	$1,770	$1,890	$2,010	$2,130	$2,250	$2,276	$2,276	$2,276
$90,000	$99,999	$590	$1,180	$1,770	$1,890	$2,010	$2,130	$2,250	$2,276	$2,276	$2,276
$100,000	$149,999	$590	$1,180	$1,770	$1,890	$2,010	$2,130	$2,250	$2,276	$2,276	$2,276
$150,000	$199,999	$590	$1,180	$1,770	$1,890	$2,010	$2,130	$2,250	$2,276	$2,276	$2,276
$200,000	$249,999	$590	$1,180	$1,770	$1,890	$2,010	$2,130	$2,250	$2,276	$2,276	$2,276
$250,000	$299,999	$590	$1,180	$1,770	$1,890	$2,010	$2,130	$2,250	$2,276	$2,276	$2,276
$300,000	$349,999	$590	$1,180	$1,770	$1,890	$2,010	$2,130	$2,250	$2,276	$2,276	$2,276
$350,000	$399,999	$590	$1,180	$1,770	$1,890	$2,010	$2,130	$2,250	$2,276	$2,276	$2,276
$400,000	$449,999	$590	$1,180	$1,770	$1,890	$2,010	$2,130	$2,250	$2,276	$2,276	$2,276
$450,000	$499,999	$590	$1,180	$1,770	$1,890	$2,010	$2,130	$2,250	$2,276	$2,276	$2,276

Head of Household											
		Lower Paying Job (Up to)									
Higher Paying Job		$9,999	$19,999	$29,999	$39,999	$49,999	$59,999	$69,999	$79,999	$89,999	$99,999
$0	$9,999	$0	$352	$470	$470	$540	$590	$590	$590	$590	$590
$10,000	$19,999	$352	$822	$940	$1,010	$1,130	$1,180	$1,180	$1,180	$1,180	$1,180
$20,000	$29,999	$470	$940	$1,127	$1,247	$1,367	$1,417	$1,417	$1,417	$1,417	$1,417
$30,000	$39,999	$470	$1,010	$1,247	$1,367	$1,487	$1,537	$1,537	$1,537	$1,537	$1,537
$40,000	$49,999	$540	$1,130	$1,367	$1,487	$1,607	$1,657	$1,657	$1,657	$1,657	$1,657
$50,000	$59,999	$590	$1,180	$1,417	$1,537	$1,657	$1,708	$1,708	$1,708	$1,708	$1,708
$60,000	$69,999	$590	$1,180	$1,417	$1,537	$1,657	$1,708	$1,708	$1,708	$1,708	$1,708
$70,000	$79,999	$590	$1,180	$1,417	$1,537	$1,657	$1,708	$1,708	$1,708	$1,708	$1,708
$80,000	$89,999	$590	$1,180	$1,417	$1,537	$1,657	$1,708	$1,708	$1,708	$1,708	$1,708
$90,000	$99,999	$590	$1,180	$1,417	$1,537	$1,657	$1,708	$1,708	$1,708	$1,708	$1,708
$100,000	$149,999	$590	$1,180	$1,417	$1,537	$1,657	$1,708	$1,708	$1,708	$1,708	$1,708
$150,000	$199,999	$590	$1,180	$1,417	$1,537	$1,657	$1,708	$1,708	$1,708	$1,708	$1,708
$200,000	$249,999	$590	$1,180	$1,417	$1,537	$1,657	$1,708	$1,708	$1,708	$1,708	$1,708
$250,000	$299,999	$590	$1,180	$1,417	$1,537	$1,657	$1,708	$1,708	$1,708	$1,708	$1,708
$300,000	$349,999	$590	$1,180	$1,417	$1,537	$1,657	$1,708	$1,708	$1,708	$1,708	$1,708
$350,000	$399,999	$590	$1,180	$1,417	$1,537	$1,657	$1,708	$1,708	$1,708	$1,708	$1,708
$400,000	$449,999	$590	$1,180	$1,417	$1,537	$1,657	$1,708	$1,708	$1,708	$1,708	$1,708
$450,000	$499,999	$590	$1,180	$1,417	$1,537	$1,657	$1,708	$1,708	$1,708	$1,708	$1,708

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 PTO)
☐ $ 0.51 /mile CFC SHOP/CI Mileage/Medical Escort Mileage(MCDTRANSP) (CFCA0080)*
☐ $ 0.59 /mile Waiver Mileage (Mileage)*
☐ $ 0.60 / mile Private Pay Mileage (MILEAGEPVT)*
☐ $ 10.55 /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

CCH	Base Pay	DCW	Total Pay
0-2000.99	$18.00	$2.94	$20.94
2001-4000.99	$18.25	$2.94	$21.19
4001-6000.99	$18.50	$2.94	$21.44
6001-8000.99	$18.75	$2.94	$21.69
8001-10000.99	$19.00	$2.94	$21.94
10001-12000.99	$19.25	$2.94	$22.19
12001+	$19.50	$2.94	$22.44

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.

Revised 12/20/2024

12051

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*

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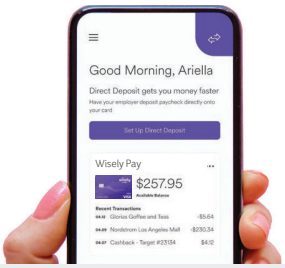

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[3] Amounts transferred to your savings envelope will no longer appear in your available balance. You can transfer money from your savings envelope back to your available balance at any time using the myWisely app or at mywisely.com.

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CONSUMER DIRECT CARE NETWORK

PAY SELECTION FORM

Employee Name: _____ Date of Birth: ____/____/_____

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

Please check one pay option below.

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

☐ **Direct Deposit to a Wisely Pay Card Account.** I authorize CDCN to issue me a Wisely Pay card. The card will be tied to my identification on file. CDCN will make payroll deposits to my card account. I will receive the card in 7 to 10 business days after initial processing.

☐ **Direct Deposit to an Existing Checking, Savings or Pay Card Account.** I authorize CDCN to initiate payroll deposits to my bank or financial institution.

The Name of my bank is: _____

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

AN ATTACHMENT IS REQUIRED.

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

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

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

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

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

_____ _____

Employee Signature *Date*

CONSUMER DIRECT CARE NETWORK

EMPLOYEE AGREEMENT

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

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

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

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

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

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

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

4. **Training**
   I have received the following training and agree to understand the information covered. I will complete and submit the following quizzes or signature page to CDCN:
   - Infection Control, Guidelines for Healthcare Workers (quiz)
   - Lifting and Moving Patients (quiz)
   - Privacy Awareness Guide (quiz)
   - Exposure Control (signature page)

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

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

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

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

I understand CDCN is not responsible to pay me if:

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

7. Automatic (Direct) Deposit

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

8. Effective Date

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

9. Caregiver Responsibilities

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

10. Non-Emergent Care

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

11. Member Relationship

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

12. Inactive Status

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

_____	_____	_____	_____
Employee Signature	*Date*	*Member/PR Signature*	*Date*

CONSUMER DIRECT CARE NETWORK

DRIVING CONFIRMATION

_____ _____

Print Employee's Name Print Member's Name

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

Driving-related services include the following:

- Community Integration
- Medical Escort
- Socialization
- Shopping

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

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

Attachments Required

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

Employee's Driver's License.

State: _____ Number: _____ Expiration Date: _____

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

Expiration Date: _____ Vehicle owner: _____

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

_____ _____ _____ _____

Employee Signature *Date* *Member/PR Signature* *Date*

CONSUMER DIRECT CARE NETWORK

NO DRIVING CONFIRMATION

Print Employee's Name _____ Print Member's Name _____

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

Driving-related services include the following:

- Community Integration
- Medical Escort
- Socialization
- Shopping

Acknowledgement

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

Employee Signature _____ *Date* _____ *Member/PR Signature* _____ *Date* _____

CONSUMER DIRECT CARE NETWORK

AUTHORIZATION/DECLINATION HEPATITIS B VACCINATION

Employee Name: _____
(please print)

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

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

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

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

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

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

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

THIS AUTHORIZATION IS NOT VALID UNLESS SIGNED

_____	_____	_____
Name of CDCN Representative	Signature	Date of Issue

This authorization expires on: _____

HEPATITIS B DECLINATION

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

I choose to: ☐ be vaccinated ☐ decline vaccination

_____ _____
Employee Signature *Date*

CONSUMER DIRECT CARE NETWORK

TRAINING MODULE DOCUMENTATION

Employee Name	Member Name

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

INFECTION CONTROL

[Reference material: Krames #11386]

Score: _____ (minimum 80%)

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

Continued on the other side.

LIFTING AND MOVING PATIENTS

[Reference material: Krames #11356]

Score: _____ (minimum 80%)

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

REPORTING A WORKPLACE INJURY

[Reference material: Employee Handbook]

Score: _____ (minimum 80%)

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

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

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

_____ _____ _____ _____

Employee Signature *Date* *Member/PR Signature* *Date*

00041

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

EXPOSURE CONTROL PLAN TRAINING SIGNATURE PAGE

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

Member Section:

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

Member/PR Printed Name: _____

Member/PR Signature: _____ Date: _____

Employee Section:

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

Employee Printed Name: _____

Employee Signature: _____ Date: _____

CONSUMER DIRECT CARE NETWORK

EXPECTED WEEKLY HOURS - NEW HIRE

CAREGIVER/NURSE
(Non-FEA)

Employee Name: _____

Entity: CDMT

Email Address: _____

-- Office Use Only --

Hire Date: _____

Anticipated Weekly Hours:

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

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

Comments:

CDCN Representative Name: _____

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

Employees marked "variable" will not be offered benefits upon hire.

Always Designing for People™

Work Opportunity Tax Credits - Consumer Direct Care Network

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

Applicant Instructions

- Open https://tcs.adp.com/consumerdirectcare or scan the QR code below.
  ***Note: If using a shared screening device, ensure the device does not have an autofill/auto complete function enabled*

- Please answer each question to complete the voluntary screening.

- Eligible applicants will be asked to **Electronically Sign and click Submit** to complete the screening.

- Ineligible applicants will be asked to click **Submit** to finish the screening. You will not be asked to electronically sign.

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

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

IVR CODE: 410849

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2025 Payroll Calendar

CONSUMER DIRECT CARE NETWORK

Symbol Key: Time Due | Pay Day | Postal and Bank Holiday

JANUARY

Sun	Mon	Tue	Wed	Thu	Fri	Sat
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

FEBRUARY

Sun	Mon	Tue	Wed	Thu	Fri	Sat
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	

MARCH

Sun	Mon	Tue	Wed	Thu	Fri	Sat
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

APRIL

Sun	Mon	Tue	Wed	Thu	Fri	Sat
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

MAY

Sun	Mon	Tue	Wed	Thu	Fri	Sat
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

JUNE

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

JULY

Sun	Mon	Tue	Wed	Thu	Fri	Sat
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

AUGUST

Sun	Mon	Tue	Wed	Thu	Fri	Sat
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

SEPTEMBER

Sun	Mon	Tue	Wed	Thu	Fri	Sat
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

OCTOBER

Sun	Mon	Tue	Wed	Thu	Fri	Sat
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

NOVEMBER

Sun	Mon	Tue	Wed	Thu	Fri	Sat
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

DECEMBER

Sun	Mon	Tue	Wed	Thu	Fri	Sat
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

2025 Bank & Post Office Holidays

*Consumer Direct Care Network office closures

*__New Year's Day__ - Wednesday, January 1

*__Martin Luther King, Jr. Day__ - Monday, January 20

Presidents Day - Monday, February 17

*__Memorial Day__ - Monday, May 26

*__Juneteenth__ - Thursday, June 19

*__Independence Day__ - Friday, July 4

*__Labor Day__ - Monday, September 1

Columbus Day - Monday, October 13

*__Veterans Day__ - Tuesday, November 11

*__Thanksgiving Day__ - Thursday, November 27

*__Christmas Day__ - Thursday, December 25

CONSUMER DIRECT CARE NETWORK

Work weeks are Sunday through Saturday. Time must be submitted by MONDAY at MIDNIGHT. Late time or time with mistakes may result in late pay. Thank you!

Pay Period - Week 1 Sunday through Saturday	**Pay Period - Week 2** Sunday through Saturday	**Pay Date** Friday
12/15/2024 to 12/21/2024	12/22/2024 to 12/28/2024	1/10/2025
12/29/2024 to 1/4/2025	1/5/2025 to 1/11/2025	1/24/2025
1/12/2025 to 1/18/2025	1/19/2025 to 1/25/2025	2/7/2025
1/26/2025 to 2/1/2025	2/2/2025 to 2/8/2025	2/21/2025
2/9/2025 to 2/15/2025	2/16/2025 to 2/22/2025	3/7/2025
2/23/2025 to 3/1/2025	3/2/2025 to 3/8/2025	3/21/2025
3/9/2025 to 3/15/2025	3/16/2025 to 3/22/2025	4/4/2025
3/23/2025 to 3/29/2025	3/30/2025 to 4/5/2025	4/18/2025
4/6/2025 to 4/12/2025	4/13/2025 to 4/19/2025	5/2/2025
4/20/2025 to 4/26/2025	4/27/2025 to 5/3/2025	5/16/2025
5/4/2025 to 5/10/2025	5/11/2025 to 5/17/2025	5/30/2025
5/18/2025 to 5/24/2025	5/25/2025 to 5/31/2025	6/13/2025
6/1/2025 to 6/7/2025	6/8/2025 to 6/14/2025	6/27/2025
6/15/2025 to 6/21/2025	6/22/2025 to 6/28/2025	7/11/2025
6/29/2025 to 7/5/2025	7/6/2025 to 7/12/2025	7/25/2025
7/13/2025 to 7/19/2025	7/20/2025 to 7/26/2025	8/8/2025
7/27/2025 to 8/2/2025	8/3/2025 to 8/9/2025	8/22/2025
8/10/2025 to 8/16/2025	8/17/2025 to 8/23/2025	9/5/2025
8/24/2025 to 8/30/2025	8/31/2025 to 9/6/2025	9/19/2025
9/7/2025 to 9/13/2025	9/14/2025 to 9/20/2025	10/3/2025
9/21/2025 to 9/27/2025	9/28/2025 to 10/4/2025	10/17/2025
10/5/2025 to 10/11/2025	10/12/2025 to 10/18/2025	10/31/2025
10/19/2025 to 10/25/2025	10/26/2025 to 11/1/2025	11/14/2025
11/2/2025 to 11/8/2025	11/9/2025 to 11/15/2025	11/26/2025*
11/16/2025 to 11/22/2025	11/23/2025 to 11/29/2025	12/12/2025
11/30/2025 to 12/6/2025	12/7/2025 to 12/13/2025	12/24/2025*
12/14/2025 to 12/20/2025	12/21/2025 to 12/27/2025	1/9/2026

Consumer Direct Care Network Montana
100 Consumer Direct Way, Suite 120
Missoula, MT 59808-5037

Phone: 866-438-8591
Fax: 855-486-7246
Email: InfoCDMT@ConsumerDirectCare.com
Web: www.ConsumerDirectMT.com

WELCOME TO SEIU 775!

SEIU 775
The Caregivers Union

1. Join Our Movement

Yes! I want to join with other long-term care workers for a stronger voice for quality care, living wages and good benefits and become a member of SEIU 775 ("Union"). I request and voluntarily accept membership in SEIU 775. This means I will receive the benefits and abide by the obligations of membership set forth in the Constitution and Bylaws of both SEIU 775 and the Service Employees International Union ("SEIU"). I authorize SEIU 775 to act as my representative in collective bargaining over wages, hours, benefits and other terms and conditions of employment with my current employer(s) and any subsequent employer(s) within the Union's jurisdiction, and their successor(s), and as my exclusive representative, where authorized by law. I know that membership in the Union is voluntary and is not a condition of employment, and that I can decline to join without reprisal. I acknowledge that failure to pay my dues on a timely basis may affect my membership standing in the Union, as set forth in the SEIU 775 Constitution and Bylaws.

FIRST NAME / LAST NAME | EMPLOYER

HOME ADDRESS | CITY | STATE / ZIP

CELL PHONE (Please see * below) | ALTERNATE PHONE (Please see * below)

EMAIL ADDRESS | BIRTHDATE MM/DD/YY

SOCIAL SECURITY # (LAST 4 DIGITS) | HIRE DATE MM/DD/YY

*By providing my phone number, I understand SEIU 775, SEIU and affiliates may use automated calling technologies and/or text message me on my cell phone on a periodic basis. SEIU 775, SEIU and affiliates will never charge for text message alerts. Carrier message and data rates may apply to such alerts. Text STOP to 787753 to stop receiving messages or HELP to 787753 for more information.

SIGNATURE | DATE

2. Maintain Our Strength

In exchange for obtaining the rights and privileges of union membership, and special benefits through exclusive access to the SEIU 775 Membership Plus Benefits Program, I request and voluntarily authorize my employer(s) to deduct from my wages an amount equal to all Union dues and other fees or assessments as shall be certified by SEIU 775 under its Constitution and Bylaws and to remit those amounts to SEIU 775. This authorization shall remain in effect unless I revoke it by sending written notice to SEIU 775, with my valid signature, of my desire to revoke this authorization during the periods not less than 15 days and not more than 45 days before either (1) the annual anniversary date of this agreement, or (2) the date of termination of the applicable collective bargaining agreement between my employer and the Union. This authorization shall be automatically renewed from year to year unless I revoke it during a window period, even if I have resigned my membership. SEIU 775 is authorized to use this authorization with my current employer(s), and any subsequent employer(s) and their successor(s), and with any other employer(s) in the event I change employers or obtain additional employment. This authorization is voluntary and is not a condition of my employment, and I can decline to agree to it without reprisal. I understand that all members benefit from everyone's commitments because they help build a strong union that is able to plan for the future.

Contributions or gifts to SEIU 775 are not tax deductible as charitable contributions.

SIGNATURE | DATE

3. Hold Politicians Accountable

Yes! I want to hold politicians accountable to working families and I know we can only do that if we stand together. I hereby authorize my employer(s) to withhold the indicated amount per month to forward to SEIU 775 ("Union") as a contribution to SEIU Committee on Political Education ("COPE"). If I do not choose one of the amounts below, or write in a different amount, I agree to a $10.00 per month deduction. My signature shows that I agree with this term and the terms below.

This authorization is made voluntarily based on my specific understanding that: (1) I am not required to sign this form or make voluntary contributions to COPE as a condition of my employment or membership in the union; (2) I may refuse to contribute without reprisal; (3) under law, only union members and executive/ administrative staff who are U.S. Citizens or lawful permanent residents are eligible to contribute to COPE; (4) the contribution amounts on this form are merely suggestions, and I may contribute more or less by this or other means without fear or disadvantage from SEIU or my employer(s); (5) COPE uses the money it receives for purposes including but not limited to making contributions to and expenditures on behalf of candidates for federal offices. This authorization shall remain in effect until revoked by me in writing to SEIU 775 via U.S. mail.

Contributions or gifts to SEIU COPE are not tax deductible as charitable contributions.

☐ **$10** ☐ **$15** ☐ **$20**

SIGNATURE | DATE

Optional Demographic Information

Language Preference
(select all that apply)

- ☐ Arabic
- ☐ Amharic
- ☐ Cantonese
- ☐ English
- ☐ Korean
- ☐ Mandarin
- ☐ Russian
- ☐ Spanish
- ☐ Vietnamese
- ☐ Other: _____

Race/Ethnicity (select all that apply)

- ☐ Asian or Asian American
- ☐ Black or African American
- ☐ Indigenous American or Alaska Native
- ☐ Latina/Latino/Latinx/Latine
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Prefer not to answer

Gender Identity

- ☐ Female
- ☐ Male
- ☐ Non-binary

Registered Voter

- ☐ Yes
- ☐ No

☐ I want to volunteer my time to MY UNION!

FOR OFFICE USE ONLY:

☐ BT ☐ CE ☐ MCOI
☐ NEO ☐ IPO
☐ Other: _____
☐ Name: _____

V7 Card
Field

SEIU 775