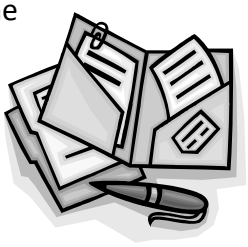
Please fill out the Data Form on page 3 prior to printing.
This packet is set up for double-sided paper printing.

CONSUMER DIRECT CARE NETWORK

EMPLOYEE ENROLLMENT PACKET INSTRUCTIONS

Complete or Provide Photo Copies of the Documents Listed Below

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



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

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

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

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

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

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

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

Supplemental Materials

Keep and refer to as needed:

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

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

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

Training Materials

Reference when completing the training quizzes in the enrollment packet:

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

Member (Service Recipient) Name: _____

CONSUMER DIRECT CARE NETWORK

Clear Form

EMPLOYEE DATA FORM

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 Work

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

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

Emergency Contact: _____ _____
Name Phone

Position: The position being applied for is Caregiver

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

PHYSICAL CAPACITY

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

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

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

Please explain any exceptions:

_____

_____

CRIMINAL BACKGROUND

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

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

_____

_____

CONSUMER DIRECT CARE NETWORK

EMPLOYEE DATA FORM

PROFESSIONAL STANDARDS AND LICENSING

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

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

_____

_____

PREVIOUS EXPERIENCE WITH COMPANY

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

ALIASES OR PREVIOUSLY HELD NAMES

Please list any aliases or previously held names: _____

PLEASE READ CAREFULLY

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

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

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

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

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

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

Applicant Printed Name	Applicant Signature	Date

Consumer Direct Care Network is an equal opportunity employer

CONSUMER DIRECT CARE NETWORK

EQUAL EMPLOYMENT OPPORTUNITY DISCLOSURE

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

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

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

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

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

-OR-

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

Decline Self Identification:

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

Employee Signature: _____ **Date**: _____

Staff Option:

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

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

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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	Other Last Names Used *(if any)*

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

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
/ /	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

03149

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear 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.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
		Managing Employer

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
		Consumer Direct Personal Care, LLC

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code
100 Consumer Direct Way, Suite 145	Missoula	MT	59808

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			**B.** Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

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 a nonimmigrant alien authorized to work for a specific employer because of his or her status: **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 alien's nonimmigrant status 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
		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				

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

Refer to the instructions for more information about acceptable receipts.

00540

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

2020

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 widow(er))
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **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 accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ► ☐

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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 Dependents

If your 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 and 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)

General Instructions

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.

Exemption from withholding. You may claim exemption from withholding for 2020 if you meet both of the following conditions: you had no federal income tax liability in 2019 **and** you expect to have no federal income tax liability in 2020. You had no federal income tax liability in 2019 if (1) your total tax on line 16 on your 2019 Form 1040 or 1040-SR is zero (or less than the sum of lines 18a, 18b, and 18c), 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 2020 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 1a, 1b, and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2021.

Your privacy. If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

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

1. Expect to work only part of the year;

2. Have dividend or capital gain income, or are subject to additional taxes, such as the additional Medicare tax;

3. Have self-employment income (see below); or

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

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

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

Specific Instructions

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

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

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

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

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

Step 3. Step 3 of Form W-4 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. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. 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 2020 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.

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 2020 itemized deductions (from Schedule A (Form 1040 or 1040-SR)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 10% of your income . . . . . **1** $

2 Enter:
- $24,800 if you're married filing jointly or qualifying widow(er)
- $18,650 if you're head of household
- $12,400 if you're single or married filing separately

. . . . . **2** $

3 If line 1 is greater than line 2, subtract line 2 from line 1. 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 Schedule 1 (Form 1040 or 1040-SR)). 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 possessions 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 Widow(er)

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	$220	$850	$900	$1,020	$1,020	$1,020	$1,020	$1,020	$1,210	$1,870	$1,870
$10,000 - 19,999	220	1,220	1,900	2,100	2,220	2,220	2,220	2,220	2,410	3,410	4,070	4,070
$20,000 - 29,999	850	1,900	2,730	2,930	3,050	3,050	3,050	3,240	4,240	5,240	5,900	5,900
$30,000 - 39,999	900	2,100	2,930	3,130	3,250	3,250	3,440	4,440	5,440	6,440	7,100	7,100
$40,000 - 49,999	1,020	2,220	3,050	3,250	3,370	3,570	4,570	5,570	6,570	7,570	8,220	8,220
$50,000 - 59,999	1,020	2,220	3,050	3,250	3,570	4,570	5,570	6,570	7,570	8,570	9,220	9,220
$60,000 - 69,999	1,020	2,220	3,050	3,440	4,570	5,570	6,570	7,570	8,570	9,570	10,220	10,220
$70,000 - 79,999	1,020	2,220	3,240	4,440	5,570	6,570	7,570	8,570	9,570	10,570	11,220	11,240
$80,000 - 99,999	1,060	3,260	5,090	6,290	7,420	8,420	9,420	10,420	11,420	12,420	13,260	13,460
$100,000 - 149,999	1,870	4,070	5,900	7,100	8,220	9,320	10,520	11,720	12,920	14,120	14,980	15,180
$150,000 - 239,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,190	16,050	16,250
$240,000 - 259,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,520	17,170	18,170
$260,000 - 279,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	13,120	15,120	17,120	18,770	19,770
$280,000 - 299,999	2,040	4,440	6,470	7,870	9,190	10,720	12,720	14,720	16,720	18,720	20,370	21,370
$300,000 - 319,999	2,040	4,440	6,470	8,200	10,320	12,320	14,320	16,320	18,320	20,320	21,970	22,970
$320,000 - 364,999	2,720	5,920	8,750	10,950	13,070	15,070	17,070	19,070	21,290	23,590	25,540	26,840
$365,000 - 524,999	2,970	6,470	9,600	12,100	14,530	16,830	19,130	21,430	23,730	26,030	27,980	29,280
$525,000 and over	3,140	6,840	10,170	12,870	15,500	18,000	20,500	23,000	25,500	28,000	30,150	31,650

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	$460	$940	$1,020	$1,020	$1,470	$1,870	$1,870	$1,870	$1,870	$2,040	$2,040	$2,040
$10,000 - 19,999	940	1,530	1,610	2,060	3,060	3,460	3,460	3,460	3,640	3,830	3,830	3,830
$20,000 - 29,999	1,020	1,610	2,130	3,130	4,130	4,540	4,540	4,720	4,920	5,110	5,110	5,110
$30,000 - 39,999	1,020	2,060	3,130	4,130	5,130	5,540	5,720	5,920	6,120	6,310	6,310	6,310
$40,000 - 59,999	1,870	3,460	4,540	5,540	6,690	7,290	7,490	7,690	7,890	8,080	8,080	8,080
$60,000 - 79,999	1,870	3,460	4,690	5,890	7,090	7,690	7,890	8,090	8,290	8,480	9,260	10,060
$80,000 - 99,999	2,020	3,810	5,090	6,290	7,490	8,090	8,290	8,490	9,470	10,460	11,260	12,060
$100,000 - 124,999	2,040	3,830	5,110	6,310	7,510	8,430	9,430	10,430	11,430	12,420	13,520	14,620
$125,000 - 149,999	2,040	3,830	5,110	7,030	9,030	10,430	11,430	12,580	13,880	15,170	16,270	17,370
$150,000 - 174,999	2,360	4,950	7,030	9,030	11,030	12,730	14,030	15,330	16,630	17,920	19,020	20,120
$175,000 - 199,999	2,720	5,310	7,540	9,840	12,140	13,840	15,140	16,440	17,740	19,030	20,130	21,230
$200,000 - 249,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
$250,000 - 399,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
$400,000 - 449,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,450	19,940	21,240	22,540
$450,000 and over	3,140	6,230	8,810	11,310	13,810	15,710	17,210	18,710	20,210	21,700	23,000	24,300

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	$830	$930	$1,020	$1,020	$1,020	$1,480	$1,870	$1,870	$1,930	$2,040	$2,040
$10,000 - 19,999	830	1,920	2,130	2,220	2,220	2,680	3,680	4,070	4,130	4,330	4,440	4,440
$20,000 - 29,999	930	2,130	2,350	2,430	2,900	3,900	4,900	5,340	5,540	5,740	5,850	5,850
$30,000 - 39,999	1,020	2,220	2,430	2,980	3,980	4,980	6,040	6,630	6,830	7,030	7,140	7,140
$40,000 - 59,999	1,020	2,530	3,750	4,830	5,860	7,060	8,260	8,850	9,050	9,250	9,360	9,360
$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,780	10,980	11,180	11,580	12,380
$80,000 - 99,999	1,900	4,300	5,710	7,000	8,200	9,400	10,600	11,180	11,670	12,670	13,580	14,380
$100,000 - 124,999	2,040	4,440	5,850	7,140	8,340	9,540	11,360	12,750	13,750	14,750	15,770	16,870
$125,000 - 149,999	2,040	4,440	5,850	7,360	9,360	11,360	13,360	14,750	16,010	17,310	18,520	19,620
$150,000 - 174,999	2,040	5,060	7,280	9,360	11,360	13,480	15,780	17,460	18,760	20,060	21,270	22,370
$175,000 - 199,999	2,720	5,920	8,130	10,480	12,780	15,080	17,380	19,070	20,370	21,670	22,880	23,980
$200,000 - 249,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
$250,000 - 349,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
$350,000 - 449,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,900	25,200
$450,000 and over	3,140	6,840	9,560	12,140	14,640	17,140	19,640	21,530	23,030	24,530	25,940	27,240

Montana Department of REVENUE

Montana Employee's Withholding Allowance and Exemption Certificate

MONTANA
MW-4

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

Current mailing address	City, state and ZIP code

Under penalty of false swearing, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature _____ **Date**_____
(This form is not valid unless you sign it.)

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

Section 1: Montana Allowances

A. Enter "1" for **yourself** A. _____

B. Enter "1" if you have only one job B. _____

C. Enter "1" for your **spouse** if you expect to file as **married filing jointly** on your Montana tax return. But, you may choose to enter "-0-" if you have a working spouse. (Entering "-0-" may help you avoid having too little tax withheld.) C. _____

D. Enter the number of **dependents** (other than your spouse or yourself) you will claim on your Montana tax return D. _____

E. Enter "1" if you will file as **head of household** on your Montana tax return E. _____

F. Enter "1" if you expect to report large itemized deductions (medical, child and dependent care, etc.) (Caution: An additional allowance could result in tax due when you file your return.) F. _____

G. Add lines A through F and enter the total here. **This is your total number of allowances**. (Note: This number may be different from the number of exemptions you claim on your Montana tax return.) G. _____

H. Additional amount, if any, you want withheld from each paycheck or pension and annuity payment. H. $_____

Section 2: Exemption from Montana Withholding for Tax Year 2020

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

☐ a. I am an enrolled member of a registered tribe, I live on the reservation of that tribe, AND I claim exemption from withholding on the wages derived from work performed on the reservation where I live. (*You must also complete Section 1.*)

☐ b. I am a member of the Reserve or National Guard, and I claim to be exempt from withholding on my compensation determined under USC Title 10. *(You must also complete Section 1.)*

☐ c. I am a resident of North Dakota, and claim exemption from withholding on my wages.

☐ d. I am a resident of another state living in Montana solely to be with my spouse, who is a resident of the same state and a member of the U.S. armed forces assigned to a military location in Montana, and I claim exemption from withholding on my wages.

Employer name	Employer EIN	Employer MT withholding account ID

Employer address	City, state and ZIP code

Employee Instructions

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

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

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

Should I complete Form MW-4?

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

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

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

Section 1: Montana Allowances

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

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

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

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

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

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

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

Section 2: Exemption from Montana Withholding

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

a. You are an enrolled member of an American Indian tribe living and working on the reservation of which you are an enrolled member. You must also complete Section 1 because your exemption may not cover all the wages you earned in Montana.

b. You are a member of the Montana National Guard and are receiving pay or for active duty in the U.S. military under USC Title 10 orders. You must also complete Section 1 because your exemption only applies to your pay derived from your USC Title 10 orders.

c. Your wages are exempt from withholding because you are a resident of North Dakota. This exemption is available for residents of North Dakota because of the reciprocity agreement in place between North Dakota and Montana.

d. You are the spouse of a military member assigned to duty in Montana, you and your spouse are domiciled in another state (the same state as one another) and you are present in Montana solely to be with your spouse.

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

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

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

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

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

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

Employer instructions are on the next page.

Employer Instructions

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

Should my employee complete Form MW-4?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Invalid Forms MW-4

The following situations make the Form MW-4 invalid:

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

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

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

Questions?

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

CONSUMER DIRECT CARE NETWORK

Self-Directed CFC/PAS Caregiving

PCA WAGE MEMORANDUM

Employee Name (please print)	Effective Date

Position: Personal Care Attendant (PCA)

Wage Information:

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

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

_____ _____

Employee Signature *Date*

_____ _____

CDCN Representative Signature *Date*

CONSUMER DIRECT CARE NETWORK

PAY SELECTION FORM

Employee Name: _____

(please print)

Consumer Direct Care Network (CDCN) recommends every employee select direct deposit, either to a prepaid debit card issued through US Bank or to another account you specify. Direct deposits avoid all possible delays associated with delivery of mail - and that helps you access your pay on pay day. Your pay stub (summary of your pay) will be sent by first class mail to your address on file. First class mail terms and limitations apply.

CDCN offers the following pay options. Please select one option below.

☐ **US Bank Focus Card Direct Deposit** – I authorize CDCN to issue me a US Bank Focus Card using my Social Security Number and other identification on file and to initiate payroll deposits to my card account. You should receive your debit card in approximately two weeks.

☐ **Bank or Credit Union Direct Deposit** – I authorize CDCN to initiate payroll deposits to

(name of bank or financial institution): _____

Account Type (check one): ☐ Checking ☐ Savings

For Checking Accounts:

Attach (tape) a voided check here

Do not attach a deposit slip.

For Savings Accounts: provide a document from your bank with exact numbers to process direct deposits to your account. If the document is larger than a standard-sized check, please provide a separate document. Do not attach a deposit slip because it does not have all the necessary numbers.

I authorize CDCN to process my selected method of pay as indicated above. In the event that funds are deposited mistakenly to my account, I authorize CDCN to debit my account to correct the error. It is my responsibility to confirm that each deposit has occurred and to pay any fees caused by overdrafts on my account. Deposits will be made on each payday unless I notify my employer, in writing, of my request to stop direct deposits. I understand that CDCN reserves the right to refuse any direct deposit request, that all direct deposits are made through an Automated Clearing House (ACH), and that the processing is subject to ACH terms and limitations, as well as those of my financial institution. **I understand that I may still receive a paper check while my selected method of pay is being set up**.

_____ _____

Signature *Date*

CONSUMER DIRECT CARE NETWORK

EMPLOYEE AGREEMENT

I (Employee's name) _____ **agree to and acknowledge the following:**

1. _____ (Member or Personal Representative's name), hereinafter referred to as Member/PR, has elected to hire me for the position of Caregiver to perform personal care services for the Member in accordance with Medicaid's self-directed programs.

2. I have received a copy of the Consumer Direct Care Network Montana Caregiving (CDCN) Caregiver Handbook. The Handbook provides guidelines on the policies, procedures, and programs affecting my employment with this organization. I understand that CDCN can, at its sole discretion, supersede, modify, revoke, suspend, terminate or deviate from the guidelines, policies, procedures, benefits and information in this handbook as circumstances or situations warrant, in whole or in part, at any time, with or without notice.

   Furthermore, I understand that this Handbook is neither a contract of employment nor a legal document, and nothing in the Handbook creates an express or implied contract of employment. I understand that I should consult the Member/PR or CDCN if I have any questions that are not answered by the Handbook.

   I accept responsibility for familiarizing myself with the information in the Handbook, seeking clarification of its terms or guidance where necessary, and complying with the policies and procedures contained therein.

3. I understand that CDCN is not financially responsible for payment of services in situations where:
   - The Member becomes ineligible for Medicaid
   - The Member/PR allows me to work overtime (hours in excess of 40 per week)
   - The Member/PR allows me to work time outside the approved Profile

4. I have received the following training modules, and am responsible for understanding the information covered in each module, and completing and submitting to CDCN the associated training quizzes or signature page:
   - Infection Control, Guidelines for Healthcare Workers (quiz)
   - Lifting and Moving Patients (quiz)
   - HIPAA Training Guide (quiz)
   - Exposure Control (signature page)

5. I have received a blank Status Change Form and am responsible for notifying CDCN within ten (10) days of any change in name, addresses, telephone number, or any pending criminal charges not previously disclosed by criminal justice information or since my hire date.

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

7. Verification of current automobile liability insurance is required prior to my accepting any transportation assignments. Verification must be filed with CDCN and updated as required.

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

9. **Effective Date**
   Employment will be effective upon completion of the CDCN Employee Enrollment Packet and approval by a CDCN representative. You and the Member/PR will be notified of your start date by the Okay to Work Form.

10. **My Responsibilities as a caregiver include:**
    - Program compliance
    - Documents and Record Keeping
    - Confidentiality
    - Status Change Notification
    - Refusal of Prohibited Payments
    - Disclosure to Law Enforcement Officers

11. **Non-Emergent Care**
    Services provided under this program are not designed to be an emergency or acute medical service plan. I understand that any potentially risky health situation should be reported to the Member's attending physician or to local emergency services, such as 911, as appropriate.

12. **Wage Information and Acknowledgment**
    - I understand I will be paid at an hourly rate, identified in a wage memo, for approved services I provide to the Member.
    - I have received a current 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 anticipate and resolve potential overtime situations.
    - Anytime there is misrepresentation on the timesheet, CDCN has the right to withhold future payments.

13. **Automatic (Direct) Deposit**
    CDCN wants all employees to be paid in a timely and consistent manner. CDCN offers two direct deposit pay options, either to a bank account specified by you, or a debit card through a US Bank Focus Pay Card. CDCN considers these to be the most regular and efficient method of pay delivery. Pay stubs (a summary of your pay) are sent by first class mail to your address on file. I understand that if I choose to receive checks that delivery is dependent upon federal holidays, other U.S. mail disruptions and payroll corrections.

14. I understand if I do not work for a CDCN Member for 6 months I will become inactive. In order to work any scheduled shifts I must re-apply through the Member and receive a new Okay to Work Form.

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

CONSUMER DIRECT CARE NETWORK

EMPLOYEE HEALTH QUESTIONNAIRE

Employee Name: _____
(please print)

Background: At this point in the employment process, you have been conditionally hired by a Consumer/Member/ Representative/Individual ("Employer") as an Employee. Your position involves delivering services for the Employer. Your duties will vary according to the needs and authorized services of the Employer, but will require you to perform tasks of a physical nature, which have physical demand requirements. The purpose of this Health Questionnaire is to obtain information about your ability to safely perform the authorized tasks. The information provided on this Questionnaire will be used to help manage your employment in a safe manner. Your responses are considered *Confidential*.

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

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

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

CONSUMER DIRECT CARE NETWORK

EMPLOYEE HEALTH QUESTIONNAIRE

Employee Name: _____
(please print)

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

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

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

_____

_____

_____

_____

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_____

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_____

_____

_____

_____

I hereby certify that I have answered the above questions to the best of my knowledge, and that my answers are true and complete. I understand that misrepresentation or omission of facts is cause for dismissal and may result in denial of workers' compensation benefits.

Employee Signature: _____ Date: _____/_____/_____

Office Use Only

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

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

05095

CONSUMER DIRECT CARE NETWORK

DRIVING CONFIRMATION

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

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

Driving-related services include the following:

- Community Integration
- Medical Escort
- Socialization
- Shopping

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

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

Attachments Required

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

- **Employee's Driver's License.**

  State: _____ Number: _____ Expiration Date: _____

- **Proof of Auto Insurance** (for vehicle used for driving-related services).

  Expiration Date: _____ Vehicle owner: _____

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

_____ _____ _____ _____

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

CONSUMER DIRECT CARE NETWORK

NO DRIVING CONFIRMATION

Print Employee's Name

Print Member's Name

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

Driving-related services include the following:

- Community Integration
- Medical Escort
- Socialization
- Shopping

Acknowledgement

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

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

CONSUMER DIRECT CARE NETWORK

Caregiving

AUTHORIZATION/DECLINATION HEPATITIS B VACCINATION

Employee Name: _____
(please print)

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

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

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

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

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

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

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

THIS AUTHORIZATION IS NOT VALID UNLESS SIGNED

Name of CDCN Representative	Signature	Date of Issue

This authorization expires on: _____

HEPATITIS B DECLINATION

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

I choose to: ☐ be vaccinated ☐ decline vaccination

_____ _____
Employee Signature *Date*

CONSUMER DIRECT CARE NETWORK

TRAINING MODULE DOCUMENTATION

Employee Name	Member Name

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

INFECTION CONTROL

[Reference material: Krames #11386]

Score: _____
(minimum 80%)

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

Continued on the other side.

LIFTING AND MOVING PATIENTS

[Reference material: Krames #11356]

Score: _____ (minimum 80%)

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

REPORTING A WORKPLACE INJURY

[Reference material: Employee Handbook]

Score: _____ (minimum 80%)

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

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

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

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

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CONSUMER DIRECT CARE NETWORK

HIPAA QUIZ & CONFIDENTIALITY AGREEMENT

Employee Name	Member Name	Score (minimum 80%)

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

1. HIPAA stands for:
    a. Health Insurance Protection and Accuracy
    b. Health Insurance Portability and Accountability Act
    c. Help Insurance company Profits - Always Applicable

2. PHI stands for: P_____ H_____ I_____

3. Under HIPAA, patients are generally not allowed to see their medical information:
    a. True b. False

4. If a patient requests information from their medical record, you should:
    a. Run to Kinko's, make a copy, & give it to the patient
    b. Answer that the information is not available, sorry
    c. Refer the request to a Program Manager or Privacy Officer

5. HIPAA law includes penalties for non-compliance of (mark all that apply):
    a. $100 civil penalty up to a maximum of $25,000 per year for each standard violated
    b. A criminal penalty for knowingly disclosing PHI up to a maximum of $250,000
    c. Revocation of your driving license

6. If you get a question from a patient about how their PHI is used and disclosed, you should:
    a. Inform them that a sign has been posted on the door
    b. Say everything is written in invisible ink to protect the information
    c. Refer the patient to a Program Manager or Privacy Officer

7. Patients will not be told of their rights under HIPAA, but rather have to look up information on a government web site:
    a. True b. False

8. The HIPAA Privacy Rule (the law) took effect on: _____

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

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

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.