CDS Attendant Application Packet

Open applications will be accepted without ID, however, when completing the second half of the application or a full application you must submit either 1 document from List A or a document from List B AND List C identified on the list of acceptable documents attached to the Form I-9. Documents presented must be original documents, no copies will be accepted.

Date: _____

Employer (Participant) Name (print): _____

Employee (Attendant) Name (print): _____

Are you related to the participant you are applying to work for?

- ☐ No
- ☐ Yes

If yes, how are you related?

- ☐ Parent
- ☐ Child
- ☐ Sibling
- ☐ Grandchild
- ☐ Cousin
- ☐ Other _____

Please note, you are not eligible to work as an attendant for your spouse or someone you are a legal guardian of.

Consumer Directed Services
Attendant Application

Personal Data

Name: _____

Address: _____
Street address City State Zip

Phone: (home) _____ (cell) _____ (message phone) _____

What is your primary mode of transportation?
☐ Personal Vehicle ☐ Public Transportation (i.e. bus) ☐ Other: _____

Some participants may have allergies, do you smoke? ☐ Yes ☐ No

Have you lived in Missouri for the last five (5) years? If not, what other states have you lived in?

_____

Do you have any criminal convictions, findings of guilt, pleas of guilty and or pleas of nolo contendere except minor traffic offenses? ☐ Yes ☐ No
If yes, describe offense and when it occurred:

_____

_____

Experience & Qualifications

Have you ever been an attendant for the CDS Program? ☐ Yes ☐ No

How did you learn about this position? _____

Have you ever worked with persons with disabilities? ☐ Yes ☐ No

Are you a Certified Nursing Assistant (CNA)? ☐ Yes ☐ No

Please check boxes you have experience in:

Personal Care
☐ Bathing
☐ Dressing/grooming
☐ Toileting
☐ Mobility/transfer
☐ Hoyer lift
☐ Assist with ambulation etc.)

Other plan of care tasks
☐ General housekeeping (vacuuming, dusting, etc.)
☐ Laundry
☐ Meal Preparation or assistance with eating
☐ Meal clean-up
☐ Shopping for someone
☐ Transporting participant for errands (groceries, bills,

What relevant experience do you have that is not mentioned above?

_____

_____

Employment History (most recent first)

Company Name: _____ **Phone:** _____
Address: _____
Dates of employment: (from) _____ (to) _____
Position: _____ **Duties:** _____
Reason for leaving: _____
Are you eligible for re-hire? ☐ Yes ☐ No
If no, explain why: _____

Company Name: _____ **Phone:** _____
Address: _____
Dates of employment: (from) _____ (to) _____
Position: _____ **Duties:** _____
Reason for leaving: _____
Are you eligible for re-hire? ☐ Yes ☐ No
If no, explain why: _____

Do you wish for your previous employers to be contacted? ☐ Yes ☐ No

References

Please list three personal references not related to you.

Name: _____ **Relationship:** _____
Address: _____ **Phone:** _____

Name: _____ **Relationship:** _____
Address: _____ **Phone:** _____

Name: _____ **Relationship:** _____
Address: _____ **Phone:** _____

- *I certify that the answers given herein are true and complete to the best of my knowledge.*
- *I understand that if I transport a participant in my car, I take on the assumption of liability.*
- *By signing this application, I give consent to a pre-employment criminal record check and a closed record check pursuant to section 610.210.RSMo.*

_____ _____
Applicant signature **Date**

Midland Empire Resources for Independent Living accepts job applications for attendant positions as a service to participants who may need an attendant. MERIL is not the employer or independent contractor for or with participants or attendants. Attendants are responsible for negotiating working relationships with individual participants, including discussion of responsibility for payment of taxes, etc.

Attendant Care Contract

A. **Participant/Employer's Name:** _____

B. **Attendant/Employee's Name:** _____

C. **Date of Contract:** _____

This Attendant Care Contract ("Contract") is made by the Center for Independent Living and the Attendant/Employee identified in line B. above [who will be employed by the Participant/Employer identified in line A. above] as of the Date of Contract specified in line C. above.

1. **Definitions and responsibilities.** In order to make this Contract more easily understood, certain terms are defined, and various responsibilities are described as follows:
   a. The term **"Participant/Employer"** means the individual identified in line A. above who requires attendant care services in his/her home. Hereafter, the Participant/Employer will be referred to as **"Participant."** Participant is the employer of the Attendant/Employee and as such is responsible for directing, managing, scheduling (within the parameters of authorized service hours), and supervising the Attendant/Employee. Participant is responsible for reviewing all timesheets connected with Attendant/Employee's hours of service for accuracy, and Participant is responsible for promptly forwarding the same to CIL. Participant, through the fiscal intermediary, will pay the Attendant/Employee for services authorized in Participant's Plan of Care and by this Contract. Participant will not pay Attendant/Employee for any services not authorized in Participant's Plan of Care and will make no supplemental payments to Attendant/Employee. Participant will not pay Attendant/Employee for hours in excess of those authorized in Participant's Plan of Care and in the documents furnished to Participant by CIL.

   b. The term **"Attendant/Employee"** means the individual identified in line B. above who, as a party to this Contract, agrees to provide attendant care services to Participant in Participant's home. Hereafter, the Attendant/Employee will be referred to as **"Attendant."** Attendant shall have and maintain the qualifications, credentials, certifications, licenses, and/or training ("qualifications") necessary to perform the attendant care services described and authorized in Participant's Plan of Care before rendering any attendant care services to Participant. Attendant is not entitled to be paid until and unless he/she has met/maintained all qualifications for rendering attendant care services. Attendant agrees that he/she will accept as payment in full for the services described and authorized in Participant's Plan of Care the payments he/she receives pursuant to this Contract. He/she will not seek additional or supplemental payments from Participant or others acting on behalf of Participant nor will he/she accept additional or supplemental payments from Participant or others acting on behalf of Participant.

c. The term **"attendant care services"** or **"attendant care"** means those services that Participant needs to have provided to him/her within his/her home in order to achieve independent living within the community. Attendant care services may include but are not limited to helping Participant with eating, dressing, meal preparation, toileting, bathing, grooming, transferring, and specific health maintenance tasks, as well as some incidental housekeeping tasks that ensure Participant's health and safety, like grocery shopping and laundry. The attendant care services that the Attendant will perform will be described and authorized in the Participant's Plan of Care. A copy of the pertinent parts of the Plan of Care will be provided to Attendant.

d. The term **"Center for Independent Living"** means the agency signing this Contract. Hereafter, the Center for Independent Living will be referred to as **"CIL."** It is recognized as a vendor of Consumer-Directed Services and enrolled as an Organized Health Care Delivery System with the Department of Social Services, Division of Medical Services. CIL is authorized to provide administrative support to Participant. CIL is authorized to enter into payroll service contracts with payroll service companies to provide fiscal intermediary services as set forth below.

e. The term **"fiscal intermediary"** means a payroll service company, under contract with CIL, retained to perform **"fiscal intermediary services"**—those services that an employer must generally perform in connection with paying his/her employee. These include calculating the amount that an employee is to be paid, writing payroll checks (or making direct deposits), withholding and paying state and federal income taxes to the appropriate authorities, withholding and paying Social Security (FICA) and Medicare payments and/or employer's portions as is required by law or regulation and paying them to the appropriate authorities, and making unemployment/workers compensation insurance payments, as well as withholding/paying those amounts as may be required by law or regulation from time-to-time. The fiscal intermediary will provide Attendant with a written summary of all
deductions and payments made. The fiscal intermediary will prepare and provide Participant and Attendant with end-of-year tax information and forms within the time prescribed by law, such as W-2's, so that Participant and Attendant may comply with all tax filing requirements. The fiscal intermediary will maintain copies of all records required by law or regulation for tax and other purposes, and these shall be the official records documenting the employer/employee (Participant/Attendant) relationship.

2. **Purpose and background information.** The purpose of this Contract is to allow Participant to interview, hire, direct, manage, schedule (within the parameters of authorized service hours), supervise, and discharge his/her Attendant. CIL is a vendor of Consumer-Directed Services and as such it is authorized by the Missouri Department of Health and Senior Services to provide administrative support for Consumer-Directed Services. CIL may contract with payroll service companies to act as fiscal intermediary. The fiscal intermediary will act as an agent for and provide payroll services for Participant, as explained herein.

Participant will employ Attendant to work in Participant's home, at the direction and under the supervision of Participant, to provide the attendant care services described and authorized in Participant's Plan of Care. Because of the work arrangement contemplated in this Contract, Attendant is an employee of Participant for purposes of the federal Fair Labor Standards Act, and not an independent contractor. It is, therefore,

necessary that Participant withhold and pay all income taxes required by law, as well as all other withholdings or payments that employers generally make in connection with employees in order to comply with applicable laws and regulations.

The fiscal intermediary will perform fiscal intermediary services as described above and prepare and write payroll checks to Attendant on behalf of Participant.

3. **Basis for payment.** Attendant agrees to perform the attendant care services described and authorized in Participant's Plan of Care at an initial rate of no less than $12.30/hour and no greater than $12.70/hour, which rate may be increased from time-to-time with or without notice to Attendant. Attendant will be paid only for those services described and authorized in Participant's Plan of Care, and no others. Medicaid will provide funds to the fiscal intermediary to pay Attendant for authorized attendant care services actually performed for Participant. Attendant is not permitted to work in excess of the number of hours authorized during a given month. If he/she does so, he/she will not be paid for those hours through this Contract. Attendant is not permitted to off-set excess hours in one month against scheduled hours in another month, even if this is agreeable to Participant. Attendant understands that he/she is not entitled to nor will he/she receive as part of his/her payment hereunder, or otherwise, any "fringe" benefits, such as health insurance, sick leave, paid personal days, paid vacations, paid holidays, and the like.

4. **Method of payment.** CIL will provide Participant with documents authorizing payment for the services described and authorized in Participant's Plan of Care. The documents will set forth: a) the maximum number of hours to be worked during a specific time period; b) the rate of compensation in effect for the services; and, c) the applicable time period for performance of the attendant care services. CIL will also provide Attendant with access to an EVV system to record the services performed by Attendant and the time spent in service. Participant must monitor use of EVV system for accuracy. The completed EVV documentation is the basis for payment to Employee.

   Payroll will be processed bi-weekly. Any payroll errors may delay Attendant receiving payment for services.

   It is imperative that Participant and Attendant accurately record and report services and hours. Falsification or misrepresentation on any EVV record constitutes fraud. Payments made on behalf of Participant as a result of inaccurate records will be recouped from Attendant and/or Participant. Any incidents of apparent fraud may be reported to Medicaid and/or other appropriate authorities.

5. **Conditions and understandings of Contract.** The quality, appropriateness, and timeliness of the attendant care services rendered and reimbursed through this Contract are subject to evaluation, through inspection or other means, by CIL. In addition, for so long as Medicaid funds are used, in whole or in part, to pay Attendant, the Missouri Department of Social Services and the U.S. Department of Health and Human Services, and/or its/their designee(s), have the right to evaluate, through inspection or other means, the attendant care services rendered and reimbursed hereunder.

   Attendant understands and agrees that he/she is not an employee of CIL. Attendant will not represent to anyone that he/she is an employee of CIL.

Attendant understands and agrees that he/she is not an employee of the State of Missouri or any department, unit, agency, or subdivision thereof. Attendant will not represent to anyone that he/she is an employee of the State of Missouri or any department, unit, agency, or subdivision thereof.

Attendant understands and agrees that pursuant to this Contract, he/she is employed solely by Participant.

Attendant understands and agrees that this Contract is non-exclusive. Participant may enter into one or more other Attendant Care Contracts with other attendants. Participant may terminate this Contract with Attendant and such termination will have no effect on other non-terminated contracts which will remain in full force and effect.

Similarly, Attendant may enter into one or more Attendant Care Contracts with other participants. Termination of one or more of such other Attendant Care Contract(s) with other participant(s) does not automatically terminate this Contract.

Attendant understands and agrees that this Contract does not guarantee him/her any specific number of hours of work or any hours at all.

Attendant understands and agrees that he/she may not act as Participant's personal representative in matters regarding medical treatment, financial, and/or budgetary decision making, unless Attendant is Participant's agent under power of attorney, conservator, or representative payee, and is acting within the scope of his/her legal authority.

6. **Liability for work-related injury/illness.** Attendant understands and agrees that Attendant and/or Participant is/are solely responsible for any injuries or illness Attendant sustains while providing attendant care services and/or acting within the scope of his/her employment, and that neither CIL nor the State of Missouri has any liability for such injuries or illness.

7. **Direction and supervision of participant.** Attendant understands and agrees that he/she will perform the attendant care services specified in Participant's Plan of Care in Participant's home under the direction and supervision of Participant, in a manner reasonably satisfactory to Participant, on such dates and at such times as agreed upon by Attendant and Participant; however, the service time shall not exceed the number of hours authorized for service.

8. **Termination for cause.** Attendant understands and agrees that Participant may establish reasonable standards for employment and performance and may discharge Attendant for violation of the same. Attendant understands that Participant may discharge Attendant for cause with or without prior notice to Attendant. Participant's discharge of Attendant for cause is a termination of this Contract for cause.

9. **Termination by Attendant.** Attendant may terminate this Contract, with or without cause, upon 30-days written notice to Participant and CIL of his/her intention to terminate.

10. **Contract term.** If this Contract has not been previously terminated, it shall terminate one year from the Date of Contract specified in line C. above, or it shall be renewed as set forth herein. On or before the end of the Contract term, CIL will review this Attendant Care Contract. If CIL determines that Attendant is employed by Participant

at the end of the Contract term and the terms of this Contract are met, then this Contract shall automatically renew for a consecutive one-year term unless Participant has informed CIL that he/she no longer wishes to employ Attendant or Attendant has informed CIL that he/she no longer wishes to work for Participant. This Contract may be renewed for successive consecutive one-year terms if the terms of this Contract are met, Attendant continues to be employed by Participant, and neither Participant nor Attendant have told CIL that he/she wishes to discontinue the employment relationship. If, at the time of review, CIL determines that Attendant is no longer employed by Participant, this Contract shall terminate. Notwithstanding the foregoing sentence, if at the time of review, CIL determines that Attendant is not presently working for Participant but is likely to be re-employed in the immediate future, then CIL, in its sole discretion, may renew this Contract for a one-year term commencing with the date of re-employment. It may be renewed again for successive consecutive one-year terms upon the conditions set forth in this paragraph and in this Contract.

11. **Confidentiality.** Attendant understands that Participant is entitled to have his/her personal and health care information treated with confidentiality. Attendant agrees to protect and maintain Participant's confidentiality. Under no circumstances will Attendant discuss or disclose Participant's personal or health care information without legal authorization to do so. Participant's right to confidential treatment of personal and health care information survives the termination of this Contract.

12. **Non-discrimination.** The parties to this Contract agree that they and each of them will refrain from discrimination on the basis of race, religion, nationality, sex, age, familial status, color, handicap, or any other basis not permitted by law.

13. **Miscellaneous provisions.** This Contract shall be interpreted in accordance with and governed by the laws of the State of Missouri. The place of contract is the county where CIL has its principal offices.

    The invalidity or unenforceability of any portion or provision of this Contract shall not effect, impair, or render unenforceable any other portion or provision. It is intended that each provision herein that is invalid or unenforceable as written be valid and enforceable to the fullest extent possible.

    Under no circumstances may Attendant assign his/her obligations, duties, or rights pursuant to or connected with this Contract to any other person or entity.

    All understandings, agreements, offers, representations, and/or writings made by the parties to this Contract prior to the Date of Contract specified in line C. above are hereby merged in this Contract and are of no force and effect unless specifically set forth in this Contract.

    The captions in this Contract are for convenience only and are not to be construed as substantive parts of this Contract.

    This Contract may not be modified except by a writing signed and dated by both parties except 1) the Contract may be renewed pursuant to paragraph 10 above without an additional writing and 2) Attendant's compensation for services may be increased from time-to-time as authorized by law or regulation without notice or a writing signed by both parties.

At the time of termination of this Contract, whether for cause, end of term, or otherwise, Attendant agrees to promptly deliver to CIL any and all records, materials, directives, memos, or other documents that pertain to this Contract, Participant, or CIL, including but not limited to all originals and/or copies of Participant's Plan of Care (in whole or in part), confidential Participant information, medical care directions and/or physician/medical care instructions, medical records, health care information, behavioral plans, CIL training materials, completed or incomplete timesheets, and the like, except that Attendant may retain Attendant's payroll records and tax information.

At the time of termination of this Contract, whether for cause, end of term, or otherwise, Attendant agrees to promptly provide Participant with current timesheet information so that the last payroll for Attendant may be completed.

By signing below, you acknowledge you have read this contract, you accept it, and agree to its terms.

Center for Independent Living staff:

Staff Signature: _____

Staff Name (print) & Title: _____

Attendant:

Attendant Signature: _____

Attendant Name (print): _____

END OF DOCUMENT

Missouri Department of Health and Senior Services
P.O. Box 570, Jefferson City, MO 65102-0570 Phone: 573-751-6400 FAX: 573-751-6010
RELAY MISSOURI for Hearing and Speech Impaired 1-800-735-2966 VOICE 1-800-735-2466
Julia M. Eckstein
Director

VM-06-10

November 9, 2005

MEMORANDUM FOR VENDORS OF CONSUMER DIRECTED SERVICES

From: Brenda F. Campbell, Interim Director BFC
Division of Senior and Disability Services

Subject: Sex Offender Registry

The division asks vendors under contract with the Department of Health and Senior Services for consumer-directed services to urge attendants to check the Missouri Sex Offender Registry to determine whether any of an attendant's consumers are on the registry. This enables attendants to make informed decisions with regard to contact with consumers. The registry may be accessed at:

http://www.mshp.dps.mo.gov/MSHPWeb/PatrolDivisions/CRID/SOR/SORPage.html

Vendors should notify DHSS if they receive any reports by attendants of any inappropriate contact by consumers.

Questions may be submitted to the in-home services contracts e-mail address at: ihscontracts@dhss.mo.gov.

BFC/MW

Distribution List: 4

Human Rights Checklist

This checklist is to be **INITIALED and SIGNED** by each attendant that a participant hires, acknowledging they fully understand the Personal Care Attendant Program and their responsibilities to their employer.

___ The participant of this Personal Care Attendant Program is the employer of each attendant they hire.

___ Any conflict the attendant may have with the participant (the attendant's employer), should be discussed immediately with them, unless it is an abusive situation, then the attendant should discuss the conflict with the CDS Specialist.

___ The participant is the expert in matters of how he or she chooses to live his or her life. The attendant should not tell the participant how to live, but the attendant will not be expected to do things that violate his or her human rights or value structure. If discussion between the attendant and the participant does not solve the problem, the attendant should not take the job with this participant.

___ The participant depends on attendants in order to lead a normal life. The attendant will give a minimum of two hours notice if he/she is not able to work on a certain day or it will be necessary to be late. If the employer has more than one attendant, the attendants should exchange phone numbers and indicate a willingness to switch shifts (with the employer's approval) in case of need. If something happens on the way to work, call right away.

___ The attendant should give the participant at least two weeks' notice before terminating employment. It is the participant's responsibility to inform MERIL when an attendant has quit their job or has given notice to quit.

___ Open communication is required of both parties at all times.

___ The attendant should try to develop a sense of initiative and willingness. For example, to clean behind furniture or to be able to do what needs to be done without necessarily being told each time. This should be discussed with your employer.

___ This is a consumer-directed program. The attendant should not attempt to "take over," violating the employer's desires, methods or lifestyle.

___ Discussion between the participant and the attendant should be made before the attendant implements a new idea.

___ The participant participates in the evaluation process for the program and is given a Plan of Care. The attendant is to follow the Plan of Care. If the participant needs changes made to the Plan of Care, he or she should contact MERIL so a re-evaluation may be scheduled.

___ MERIL must be notified immediately should a participant be hospitalized. The attendant will not be paid for time the participant is in the hospital.

___ Before beginning employment, the attendant must have received training on proper procedure for time sheets and have been informed of what circumstances constitute Medicaid Fraud.

___ I understand that the CDS program is for participants with disabilities and as an employee of a participant I understand information about my employer is confidential and should not be shared with others.

___ I understand if I become aware of abuse or neglect of the participant, I work for I am responsible to report this to MERIL or DHSS. I understand how to make this report.

Attendant Signature: _____ **Date:** _____

Last Revision Date: 12/20/2023

Personal Care Attendant
Health and Safety

General Information regarding universal precautions & infection control

Good hand washing and other general infection control techniques should be exercised when handling body fluids to prevent infection with non-blood borne pathogens.

Dos of Universal Precautions

- **DO** wash your hands with soap, running water, and friction prior to patient contact, immediately following client contact, between clients, and after removing gloves. Wash hands immediately after contact with blood or any body fluids to which Universal Precautions apply.
- **DO** wear gloves when coming in contact with blood, body fluids containing visible blood, and other body fluids to which Universal Precautions apply.
- **DO** protect yourself from potentially infected material by wearing gloves if you have any minor cuts, scratches, or dermatitis of the hands.
- **DO** clean all blood and body fluids spills promptly. Use detergent and water followed by a disinfecting solution consisting of 1 part household bleach to 10 parts water.
- **DO** treat all linen and clothing soiled with blood or body fluids (to which Universal Precautions apply) as infected.
- **DO** wear gloves when removing such linen or clothing.
- **DO** place the soiled articles into a plastic bag and later wash the articles in hot water (160 degrees Fahrenheit) with detergent for 25 minutes.

Don’ts of Universal Precautions

- **DO NOT** reuse gloves!

What body fluids do universal precautions apply to?

- Universal Precautions apply to all blood and other body fluids containing visible blood. Universal Precautions also apply to: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid, amniotic fluid, and mucous membranes.

What body fluids do Universal Precautions not apply to?

- Universal Precautions do not apply to feces, nasal secretions, sputum, sweat, tears, urine, and vomitus, unless they contain visible blood. Universal Precautions also do not apply to human breast milk although HIV and HBV have been isolated in breast milk. Gloves may be worn in situations where exposures to breast milk might be frequent (ie: breast milk banking).

Each consumer on the CDS Program is responsible for providing materials for infection control and universal precautions.

Attendant Signature: _____ **Date:** _____

Attendant Name: _____

Last Revision Date: 12/20/2023

Personal Care Attendant
Background Checks

I, the undersigned, understand in order to work as a personal care attendant for a participant of the CDS Program must register with the Family Care Safety Registry as described in Missouri Statute 210.900RSMo.

I understand background checks, which include any discrepancies, could be cause for me to file a "Good Cause Waiver" and forward the positive results to MERIL, before employment as a personal care attendant can begin.

☐ **I currently have NO discrepancies on my background** including listings with the Missouri Highway Patrol, Missouri Department of Social Services, Missouri Department of Health and Senior Services, Missouri Department of Mental Health.

☐ **I currently HAVE one or more discrepancies on my background.**

☐ I have received and completed a Good Cause Waiver Application.
☐ I have NOT received and completed a Good Cause Waiver Application.

_____

Applicant Name (print)

_____

Applicant Signature

_____

Date

Last Revision Date: 12/20/2023

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
FAMILY CARE SAFETY REGISTRY

WORKER REGISTRATION

FCSR USE ONLY

Register online at www.health.mo.gov/safety/fcsr OR mail this form, copy of Social Security card, and payment to **Missouri Dept. of Health and Senior Services, Fee Receipts, PO Box 570, Jefferson City, MO 65102**. Register only once!

REGISTRATION TYPE (Check all that apply. Complete column on right only if Long Term Care/Personal Care selected from left.)

- ☐ Adoptive Parent
  Agency Name: _____
- ☐ Child Care
- ☐ Missouri Foster Parent/Family Member of Foster Parent
  Children's Division County Office: _____
- ☐ Hospital
- ☑ Long Term Care/Personal Care (Please choose subcategory at right ▸.)
- ☐ Mental Health/Psychiatric Hospital
- ☐ Voluntary *(Select voluntary if no other registration type applies.)*

A one-time registration fee of **$15.00** applies to all categories except Missouri Foster Parents, who must list the Missouri Children's Division county office.

Have you or an immediate family member ever served in the U.S. Armed Forces? ☐ Yes ☐ No
If Yes, would you like information about military-related services in Missouri? ☐ Yes ☐ No

Long Term Care / Personal Care Subcategories
(Complete if LTC/PC selected at left.)

- ☐ Adult Day Care
- ☐ Assisted Living Facility
- ☐ Hospice
- ☐ Hospital LTAC/Swing Bed
- ☐ Mental Health – Residential Facility/ICF
- ☐ Nursing Facility/Skilled Nursing
- ☐ Personal Care – Home Health
- ☐ Personal Care – In-Home Services
- ☑ Personal Care – Consumer Directed Services/Center for Independent Living
- ☐ Personal Care – HCY/PDW/DDD/Other

SOCIAL SECURITY NUMBER (Mail copy of card with form.)

— —

PERSONAL INFORMATION (Provide all names you have used, starting with most recent. Include legal names and nicknames.)

LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX (JR., SR., II, III)

BIRTH NAME (LIST FULL NAME)	PRIOR NAMES USED (IF APPLICABLE, LIST FIRST AND LAST NAMES.)	DATE OF BIRTH (MM-DD-YYYY)	GENDER
			☐ M ☐ F

CONTACT INFORMATION

MAILING ADDRESS (ENTER YOUR STREET ADDRESS OR POST OFFICE BOX. THIS ADDRESS MUST BE DIFFERENT FROM EMPLOYER ADDRESS.)

CITY	STATE	ZIP CODE	COUNTY

TELEPHONE	EMAIL ADDRESS (REQUIRED)	COUNTRY (COMPLETE ONLY IF OUTSIDE U.S.)

EMPLOYER ASSOCIATED WITH THIS REGISTRATION (Complete either left or right column, not both.)

☐ My current/potential child care, long term care or mental health care employer is:

EMPLOYER NAME

EMPLOYER ADDRESS

EMPLOYER CITY	STATE	ZIP

EMPLOYER TELEPHONE	EMPLOYER CONTACT NAME	EMPLOYER CONTACT TITLE

☐ No Employer, because I am a(n):

- ☐ Adoptive Parent
- ☐ Foster Parent/Family Member
- ☐ Home Child Care Provider
- ☐ Private Pay/Private Duty
- ☐ Student
- ☐ Volunteer
- ☐ Other (Explain:_____)

REGISTRATION AGREEMENT

The information provided is complete and accurate to the best of my knowledge. I understand it is unlawful to withhold or falsify information required on this form. I grant my permission for the Missouri Department of Health and Senior Services (DHSS) to obtain any and all background information authorized by law to process this request. Furthermore, I authorize the DHSS to release the fact that I am a registrant in the Family Care Safety Registry (FCSR) and any related background information to the requester of the FCSR for employment purposes only, as provided in §210.921, subsection 1, subdivisions (1) and (2), RSMo. For purposes of the FCSR, "employment purposes" includes direct employer/employee relationships, prospective employer/employee relationships, and screening and interviewing of persons or facilities by those persons contemplating the placement of an individual in a child care, elder care or personal care setting. I understand that if I dispute the information contained in the FCSR I have the right to appeal the accuracy of the transfer of information to the FCSR within thirty (30) days of receiving the results of the background screening.

NOTICE: The FCSR may choose to deposit the check enclosed electronically as an ACH debit entry to my designated bank account. I understand that my signature below authorizes my financial institution to deduct this payment from my account. In the event that DHSS or its subcontractor is unable to secure funds from my account or I provide insufficient or inaccurate information regarding my account, my obligation to the DHSS will remain unpaid and further collection action may be taken by the DHSS or its subcontractor, including, but not limited to, returned check fees.

SIGNATURE OF APPLICANT	DATE OF SIGNATURE (MUST BE WITHIN SIX MONTHS OF SUBMISSION.)

WHAT IS THE FAMILY CARE SAFETY REGISTRY?

The Family Care Safety Registry (FCSR), administered by the Missouri Department of Health and Senior Services (DHSS), provides families and employers with a method to obtain background screening information. The Registry, through various state agencies, offers several resources to screen child care, long term care and mental health workers:

- State criminal history and sex offender registry records maintained by the Missouri State Highway Patrol
- Child abuse/neglect records maintained by the Missouri Department of Social Services
- The Employee Disqualification List maintained by the Missouri Department of Health and Senior Services
- The Employee Disqualification Registry maintained by the Missouri Department of Mental Health
- Child care facility licensing records maintained by the Missouri Department of Elementary and Secondary Education
- Foster parent records maintained by the Missouri Department of Social Services

WHO HAS TO REGISTER?

Any person hired on or after January 1, 2001, as a child care worker or elder care worker, hired on or after January 1, 2002, as a personal care worker, or hired on or after January 1, 2009, as a mental health worker, as provided in §210.906, RSMo, is required to make application for registration in the Family Care Safety Registry within fifteen (15) days of the beginning of employment. **Such person who fails to submit a completed registration form to the DHSS without good cause, as determined by the department, is guilty of a class B misdemeanor**. Employees and volunteers from non-state and/or federally regulated entities are NOT REQUIRED to register with the FCSR.

HOW DO I COMPLETE THE REGISTRATION FORM?

Registration Type – Check at least one box from the left column for type of registration that best describes your worker category. If no other type applies, select "Voluntary." (A "voluntary registrant" is a person who is not mandated to register with the Family Care Safety Registry pursuant to §210.900 et seq., RSMo.) If you checked Long Term Care / Personal Care, please also make one or more selections from the column on the right for subcategory.

Social Security Number – You must provide your Social Security number pursuant to 19CSR 30-80.030(1). This identifying information, including Social Security number, will be used for internal identification purposes and to conduct background screenings for the resource information listed in paragraph one above.

Personal Information – List your current Last Name, First Name, Middle Name, and any suffix associated with your last name. List any other names by which you may have been known, including maiden names, past married names, and nicknames (attach additional sheets if needed). For identification purposes, list your gender and date of birth.

Contact Information – List your address, city, state, ZIP code, and county. Include your telephone number and email address. We will use this information to notify you of registration results and any background screenings conducted. Email notifications will be encrypted for improved security. To reduce postage costs, the Registry may contact you to request a personal email address if one is not provided.

Employer Associated with this Registration - If you are currently employed by or are seeking employment with a child care or long term care provider, please list the facility name, address, telephone number, and contact person. If registration is not for employment purposes, make a selection from column on right. The employer entered in this section will not receive a copy of the registration notification. Employers eligible to use the Registry for caregiver screenings must make a separate request for your background information.

Registration Agreement – Sign and date the registration form. Your signature will authorize the Family Care Safety Registry to conduct the background screening outlined in §210.903.2, RSMo and to provide the information to requesters for employment purposes, as provided in §210.921.1, RSMo.

WHERE DO I SEND MY REGISTRATION FORM?

Send your completed registration form and photocopy of Social Security card and required fee to the **Missouri Department of Health and Senior Services, ATTN: Fee Receipts, P.O. Box 570, Jefferson City, MO 65102.** If you have questions, please call the Registry using the toll-free telephone number, **866-422-6872**.

WHEN WILL I KNOW THE RESULTS OF MY BACKGROUND SCREENING?

After the background screening has been completed, you will be notified in writing of the results that will be recorded in the Family Care Safety Registry. You will also be notified in writing each time background screening information is provided. The notification will contain the name and address of the person who made the request and the background information disclosed. The person making the request will be informed that information will be released for employment purposes only, pursuant to §210.921.1, RSMo. Any person using Registry information for any other purpose is guilty of a class B misdemeanor. In addition, state agencies can request information for licensure or regulatory purposes. Prior to disclosing information, the Registry obtains the name and address of the requester, and determines that the request is for employment or regulatory purposes. To ensure you receive these notifications, it will be important for you to notify the Family Care Safety Registry when you have a change in your contact information. Notify the Family Care Safety Registry of changes in personal or contact information using the toll-free telephone number, 866-422-6872, by email to fcsr@health.mo.gov, or by mail to FCSR, PO Box 570, Jefferson City, MO 65102.

WHAT IF I DON'T AGREE WITH THE RESULTS OF MY BACKGROUND SCREENING?

As provided in §210.912, RSMo, you have the right to appeal the information transferred to the Family Care Safety Registry. Your right to appeal is limited to the accuracy of the transfer of information from the state agency that maintains the background information and does not include a right to appeal the accuracy of the substance of the information transferred. An appeal must be filed in writing to the Office of the Director, Missouri Department of Health and Senior Services, P.O. Box 570, Jefferson City, MO, 65102, within 30 days of receiving the results of the background screening determination. An administrative appeal shall be set within 30 days of the filing of the appeal and a decision shall be made within 60 days. This right to appeal is in addition to any other appeal rights granted by state law.

WHAT INFORMATION WILL BE DISCLOSED BY THE FAMILY CARE SAFETY REGISTRY?

Disclosure of background information on a person registered in the Family Care Safety Registry will be limited. If the person is registered, the Registry worker will disclose whether the person's name is listed in any of the background checks pursuant to §210.903, subsection 2, RSMo, and if so, which one(s). Specific information will be disclosed by the Registry pursuant to §210.921, subsection 1, subdivision (2).

MERIL CDS Payroll - Attendant Direct Deposit Form

MANDATORY - PLEASE COMPLETE FOR DIRECT DEPOSIT

Banking Information

I would like my wages/salary deposited to the bank account attached.

NEW / ADD

Bank Name: _____ ☐ Checking ☐ Savings

CANCEL

Bank Name: _____ ☐ Checking ☐ Savings

IMPORTANT NOTICE: We CANNOT deposit into an account that is in the participant/employer's name. This includes shared accounts.

Employee Information (please print)

Employee Name: _____

Social Security Number: _____

Employer (Participant) Name: _____

I hereby authorize my **employer**, (listed above and hereinafter **COMPANY**), to deposit any amounts owed me by initiating credit entries to my account at the financial institution (hereinafter **BANK**) indicated above. Further, I authorize **BANK** to accept and to credit any credit entries indicated by **COMPANY** to my account. In the event that **COMPANY** deposits funds erroneously into my account, I authorize **COMPANY** to debit my account for an amount not to exceed the original amount of the erroneous credit. For my convenience, I request that MERIL directly deposit my wages/salary earned from my employer, into my bank account. I understand that deposit of my earnings into my account by MERIL may be an advance of funds on behalf of my employer, which is subject to the successful collection of these funds by MERIL from my employer's bank. If, within 30 days of MERIL making the deposit into my account, my employer does not make available to MERIL the funds that were advanced to make the deposit into my account, I authorize MERIL to charge my account to recover said advance. I agree to hold MERIL harmless from loss and to indemnify it, limited to the amount of deposit. This authorization is to remain in full force and effect until **COMPANY** and **BANK** have received written notice from me of its termination in such time and in such manner as to afford **COMPANY** and **BANK** a reasonable opportunity to act on it.

Employee Signature _____ **Date** _____

PLEASE ATTACH VOIDED CHECK OR DOCUMENTATION FROM YOUR BANK

Attach only a voided check or documentation that includes the following: bank name, name of account holder, type of account, account number, and bank routing number.

Unfortunately, we are UNABLE to accept direct deposit tickets or handwritten account information.

PLEASE DO NOT STAPLE

Last Revision Date: 12/15/2023

Form
MO W-4

MISSOURI DEPARTMENT OF REVENUE

Employee's Withholding Certificate

This certificate is for income tax withholding and child support enforcement purposes only. Type or print.

Employee

Full Name		Social Security Number
Home Address (Number and Street or Rural Route)	**City or Town**	**State** / **ZIP Code**

1. Filing Status: Check the appropriate filling status below.
   - ❒ Single or Married Spouse Works or Married Filing Separate
   - ❒ Married (Spouse does not work)
   - ❒ Head of Household

2. Additional withholding: If you expect to have a balance due (as a result of interest income, dividends, income from a part-time job, etc.) on your tax return, you may request your employer to withhold an additional amount of tax from each pay period. To calculate the amount needed, divide the amount of the expected tax by the number of pay periods in a year. Enter the additional amount to be withheld each pay period on line 2. 2

3. Reduced withholding: If you expect to receive a refund (as a result of itemized deductions, modifications or tax credits) on your tax return, you may direct your employer to only withhold the amount indicated on line 3. Your employer will not use the standard calculations for withholding. If you designate an amount that is too low, it could result in you being under withheld. 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 instead of the standard calculation. If no amount is indicated on line 3, the standard calculations will be used. 3

4. Exempt Status: Select the appropriate reason you are claiming an exemption from withholding below and indicate EXEMPT on line 4. 4

   - ❒ I am exempt because I had a right to a refund of all Missouri income tax withheld last year and expect to have no tax liability this year. A new MO W-4 must be completed annually if you wish to continue the exemption.
   - ❒ I am exempt because I meet the conditions set forth under the Servicemember Civil Relief Act, as amended by the Military Spouses Residency Relief Act and have no Missouri tax liability.
   - ❒ I am exempt because my income is earned as a member of any active duty component of the Armed Forces of the United States and I am eligible for the military income deduction.

Signature

Under penalties of perjury, I certify that the information provided on this form is true and accurate.

Employee's Signature (Form is not valid unless you sign it)	Date (MM/DD/YYYY)
	__ __ / __ __ / __ __ __ __

Employer

Employer's Name	Employer's Address	
City	**State**	**ZIP Code**
Date Services for Pay First Performed by Employee (MM/DD/YYYY)	**Federal Employer I.D. Number**	**Missouri Tax Identification Number**
__ __ / __ __ / __ __ __ __		

Notice to Employer:
Within 20 days of hiring a new employee, a copy of the Employee's Withholding Certificate (Form MO W-4) must be submitted by one of the following methods:

- **Email**: withholding@dor.mo.gov
- **Fax:** 877-573-6172
- **Mail to**: Missouri Department of Revenue
  P.O. BOX 3340
  Jefferson City, MO 65105-3340

Please visit **dss.mo.gov/child-support/employers/new-hire-reporting.htm** for additional information regarding new hire reporting.

Notice to Employee:
Return completed form to your Employer. Consider completing a new Form MO W-4 each year and when your personal or financial situation changes. Visit our online withholding calculator **mytax.mo.gov/rptp/portal/home/withholding-calculator.**

Items to Remember:

- Employees must complete a new form if their filing status changes or to adjust the amount of withholding.
- If you are claiming an "Exempt" status due to the Military Spouses Residency Relief Act you must provide one of the following to your employer: Leave and Earnings Statement of the non-resident military servicemember, Form W-2 issued to the nonresident military servicemember, a military identification card, or specific military orders received by the servicemember. You must also provide verification of residency such as a copy of your state income tax return filed in your state of residence, a property tax receipt from the state of residence, a current drivers license, vehicle registration or voter ID card. For additional assistance in regard to Military, visit the department's website **dor.mo.gov/military/.**
- Additional information can be found at **mo.gov/business/withhold/**.

Mail to: Taxation Division
P.O. Box 3340
Jefferson City, MO 65105-3340
Phone: (573) 522-0967
Fax: 877-573-6172

Ever served on active duty in the United States Armed Forces?
If yes, visit **dor.mo.gov/military/** to see the services and benefits we offer to all eligible military individuals. A list of all state agency resources and benefits can be found at **veteranbenefits.mo.gov/state-benefits/**.

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2024

Step 1: Enter Personal Information

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

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

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

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

Step 3: Claim Dependent and Other Credits

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

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

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

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

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

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

1. Expect to work only part of the year;

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

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

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

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

Specific Instructions

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

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

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

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

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

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

Step 4 (optional).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

. . . . . **2** $

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

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

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

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

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

Single or Married Filing Separately

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

Head of Household

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

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 07/31/2026

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Additional Information

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

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

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

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

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

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.