CONSUMER DIRECT CARE NETWORK

SELF-DIRECTED ATTENDANT CARE

EMPLOYEE DATA FORM

Assistance with The Hiring Process: Any applicant who needs reasonable accommodation in any step of the hiring process should ask the Member or their Representative (employer) and/or Consumer Direct Care Network (CDCN).

Reset/clear all fields > Clear Form

Applicant Contact Information

Name: _____ _____ _____
First Middle Last

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

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

Phone #: Home (____) _____ Cell (____) _____

Email: _____

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

Emergency Contact: _____ _____ _____
Name Phone Relationship

How do you want to be contacted? ☐ Phone ☐ Email ☐ Mail

Member/Employer Information

Name of SDAC Member who will receive services: _____

Name of SCAC Member's Legal Representative (if exists): _____

Name of Employer or Record: _____

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

Lift 75 pounds	Kneel	Sit	Overhead reach
Push 75 pounds	Bend	Stand	Reach
Pull 50 pounds	Squat	Walk	Twist
Grasp, hold, or manipulate objects with hands			

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

Please explain any exceptions:

_____

_____

_____

Criminal History

Have you ever committed a felony? ☐ Yes ☐ No

Do you have a criminal record? ☐ Yes ☐ No If yes, explain:

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 Arizona Consumer Direct Personal Care, LLC doing business as Consumer Direct Care Network Arizona (CDCN).

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 my Member permission to contact schools, previous employers (unless otherwise indicated), references, and others, and hereby release my member 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 understand that I may begin working once I have received written authorization (Okay to Work Form) from CDCN. If applicable and requested, employment remains conditional until the results of the criminal background check have been received and approved.

Signature of Applicant: _____ **Date:** _____

CONSUMER DIRECT CARE NETWORK

SELF-DIRECTED ATTENDANT CARE

NEW EMPLOYEE CHECKLIST

Employee (ACW) Name	Member Name	Representative Name (if applicable)

Welcome to Consumer Direct Care Network (CDCN)!

Please complete all the forms and submit applicable photocopy attachments in the lists below. The employer should check each item as they are completed.

Mandatory Forms and Trainings – All New Employees:

1. ☐ Employee Data Form
2. ☐ New Employee Checklist (this form)
3. ☐ Employee-Employer Relationship Determination
4. ☐ Employee-Member Live-in Determination
5. ☐ I-9 Form - *Additional I-9 instructions are available on the CDCN Arizona website under the Forms tab*
6. ☐ W-4 Form
7. ☐ Pay Selection Form
8. ☐ Wage Memo
9. ☐ Employee Agreement
10. ☐ Employee Health Questionnaire
11. ☐ Driving Confirmation **OR** No Driving Confirmation (submit only one of these two forms)
12. ☐ Privacy Awareness Quiz & Confidentiality Agreement
13. ☐ Infection Control Quiz
14. ☐ Lifting and Moving Patients Quiz
15. ☐ Fraud Prevention Quiz
16. ☐ FEA Auth Request – T1023 or T1023UC (internal use only)

Photocopy Attachments:

1. ☐ Driver's License and Vehicle Insurance (<u>if</u> providing driving related services)
2. ☐ I-9 List A document (<u>if applicable</u>, do not attach List B or C documents)
3. ☐ Canceled Check or Bank Document (<u>if</u> selecting Direct Deposit pay option)
4. ☐ CPR and First Aid Certifications

We have reviewed and verified the above forms, quizzes and attachments for completeness. All forms are readable. I understand the Employee is not approved to begin work until all of the above materials are received and approved by CDCN and an "Okay to Work" approval form has been issued.

Signature:

_____ _____

Member/Representative Signature *Date*

CONSUMER DIRECT CARE NETWORK

EMPLOYEE-EMPLOYER RELATIONSHIP DETERMINATION

(Determine if employee is exempt from some payroll taxes)

Employee (Attendant) Name	Employer of Record Name	Member Name

Background: Employees providing domestic services may be exempt from some payroll taxes. This is based on the Employee's age and relationship to the Employer of Record (Employer). Consumer Direct Care Network (CDCN) will apply any exemptions based on the relationships identified below. **Incorrectly filling this form out may result in inaccurate tax withholdings.**

Note: If the Employee and Employer qualify for tax exemptions, they must be taken. Exemptions cannot be waived. If the Employee's earnings are exempt from these taxes, they may not qualify for related benefits. An example is unemployment insurance.

Employee-Employer Relationship

*Employee select **one** relationship below.*

☐ **I am the spouse of the Employer** (including Common Law marriage).
Exempt from FICA[1], FUTA[2], and SUTA[3].

☐ **I am the parent of the Employer** (including adoptive and stepparent).
If parent checked, check any of the following that apply:
- ☐ I provide care for the Employer's child or stepchild that lives in the home.
- ☐ The Employer's child or stepchild is less than 18 years old or requires personal care of an adult for at least 4 straight weeks in 3 months.
- ☐ The Employer is a widow, widower, divorced or married and lives with a spouse, but the spouse has a physical or medical condition that prevents them from caring for the child at least 4 straight weeks in 3 months.

Exempt from FUTA and SUTA. Subject to FICA if all three boxes checked above; else FICA exempt.

☐ **I am the child of the Employer.**
If child checked, check one option below:
- ☐ I am 21 years of age or older. *Subject to FICA, FUTA, and SUTA.*
- ☐ I am less than 21 years old. *Exempt from FICA, FUTA, and SUTA.*

☐ **I am not related to the Employer or my relationship is not described above.**
Subject to FICA, FUTA, and SUTA.

Acknowledgement: The Employee and Employer agree the relationship selected above is accurate. If this information changes, the Employee must notify CDCN. If CDCN is not notified of changes, the Employee may have to pay back money that should have been withheld from pay.

Employee Signature	*Date*	*Employer of Record Signature*	*Date*

[1]FICA – Federal Insurance Contributions Act (Social Security and Medicare)
[2]FUTA – Federal Unemployment Tax Act
[3]SUTA – State Unemployment Tax

CONSUMER DIRECT CARE NETWORK

EMPLOYEE-MEMBER LIVE-IN DETERMINATION

(Determine if employee is exempt from overtime pay and income tax)

Employee (Attendant) Name	Employer of Record Name	Member Name

Domestic service workers may be exempt from overtime pay requirements if they live in the household where they are employed. Consumer Direct Care Network (CDCN) will apply exemptions based on your answers below.

Employee-Member Live-in Status

Employee answers below with Yes or No

☐ Yes ☐ No – **Do you live permanently in the same home as the above-named Member, or temporarily, but for extended periods of time (at least 120 hours per week or 5 consecutive days or nights per week)?**

If you answered YES:

- *Overtime hours worked are paid at the regular pay rate.*

If you answered NO:

- *Overtime hours worked are paid at 1.5 times regular pay rate.*

Acknowledgement: The Employee and Employer agree the declaration(s) above are accurate. Regardless of overtime status identified above, working over 40 hours per week requires prior approval. If living arrangements change, the Employee must notify CDCN.

Employee Signature	*Date*	*Employer of Record Signature*	*Date*

Instructions for Completing Form I-9 Section 1

(On or before employee's first day of work for pay)

Employee: Complete Section 1 of Form I-9 no later than your first day of work for pay. Print clearly. Sign and date when you are finished. Numbered explanations below are shown in the pictured example.

① Print your full legal name: Last, First and Middle Initial. Provide any other Last Names used, such as maiden name. Enter "N/A" if you have never had another name.

② Print your physical address. A PO Box is not allowed. Enter "N/A" if you have no apartment number.

③ Print your Date of Birth.

④ Print your Social Security Number.

⑤ Print your Email Address or print "N/A" if you choose to not provide it.

⑥ Print your Telephone Number or print "N/A" if you choose to not provide it.

⑦ Check one box that describes your citizenship or immigration status in the United States. Enter additional information if you check box 3 or 4.

⑧ Sign and ⑨ date the form. **No later than first day of work for pay.**

⑩ Submit Supplement A (*Preparer and/or Translator Certification*) if a preparer or translator assisted you.

Employer: Review Section 1. Ensure your employee has completed it properly.

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)
① Doe	Jane	Q	N/A

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code
② 123 Main St.	N/A	Anytown	AZ	12345

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number
③ 03/13/1964	④ 1 2 3 4 5 6 7 8 9	⑤ employee@email.com	⑥ 555-123-4567

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.): ⑦

- [X] 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)
⑧ Jane Doe	⑨ 09/15/2023

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.

Example

Note: Refer to Form I-9 Instructions for detailed information.

Instructions for Completing Form I-9 Section 2

(After employee has accepted job offer, but no later than 3 days after employee's first day of work)

Employee: Present original, unexpired documents to your employer to verify your identity and authorization to work in the United States. See LISTS OF ACCEPTABLE DOCUMENTS.

Employer: Examine and record the documents your employee provides. The employee must be present while you examine them. Numbered explanations below are shown in the pictured example.

① Examine each document. Print the details in the appropriate List column(s). Only accept unexpired, original documents (no photocopies). You may accept one document from List A **OR** one from List B and one from List C.

If accepting a List B document, it must bear a photograph.

If accepting a List A document, provide a photocopy to Consumer Direct.

② Print the date of the employee's first day of work.

③ Print your last name, first name and title. Title is "Employer."

④ Sign and ⑤ date the form. **Must be completed and signed within 3 days of employee's first day of work.**

⑥ Print your first and last name.

⑦ Print physical address where services are provided (the Member's home).

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		①	Driver's License		Social Security Card
Issuing Authority			State of Residence		SSA
Document Number (if any)			0123456789abcde		123-45-6789
Expiration Date (if any)			08/17/2027		N/A
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

Example

Do not check. You must physically examine documents.

☐ 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): ② 09/15/2023

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)
③ Smith, Ronald Employer	④ Ronald Smith	⑤ 09/15/2023

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
⑥ Ronald Smith	⑦ 500 Fictional Street, Anytown AZ 85018

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

Note: Refer to Form I-9 Instructions for detailed information.

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		

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.

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

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

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

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

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

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

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

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

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

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

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

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

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

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2024

Step 1: Enter Personal Information

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

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

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

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

Step 3: Claim Dependent and Other Credits

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

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

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

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

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

02227

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

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

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

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

1. Expect to work only part of the year;

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

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

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

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

Specific Instructions

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

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

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

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

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

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

Step 4 (optional).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

. . . . . **2** $

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

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

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

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

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

Single or Married Filing Separately

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

Head of Household

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

CONSUMER DIRECT CARE NETWORK

PAY SELECTION FORM

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

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

Please check one pay option below.

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

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

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

The Name of my bank is: _____

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

AN ATTACHMENT IS REQUIRED.

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

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

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

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

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

_____ _____

Employee Signature *Date*

CONSUMER DIRECT CARE NETWORK

SELF-DIRECTED ATTENDANT CARE

WAGE MEMO

Employee (ACW) Name	Employer of Record Name	Member Name	Member CDCN ID #

Members who self-direct their Personal Care Services are the managing employer. Along with their other duties and privileges, they set their Attendant Care Worker's wage rate.

A member must set an ACW's wage consistent with employment law and may consider such factors as experience, training, how well they do the job, willingness to work at night or odd hours, or how long the attendant has worked for the member. If a member has a question about setting wages, they may contact Consumer Direct Care Network (CDCN).

To ensure compliance with employment law CDCN offers members an ACW wage range based on state or municipality minimum wage and Medicaid reimbursement rates.

Completed by Member/Representative	
Regular Wage: (complete only one line)	☐ $_____ /hour (**outside Flagstaff**; min $14.35/hour, max $17.00/hour) ☐ $ 17.40 /hour (**Flagstaff only;** member must reside within zip code 86001, 86004, or 86005)
Training Wage: (complete only one line)	☐ $_____ /hour (**outside Flagstaff**; min $14.35/hour, max $17.00/hour) ☐ $ 17.40 /hour (**Flagstaff only;** member must reside within zip code 86001, 86004, or 86005)

_____ _____ _____ _____

ACW Signature *Date* *Member/Employer Signature* *Date*

Office Use Only - Completed by Consumer Direct			
Service Code:	☐ S5125 U2	☐ S5125 U2 U4	☐ S5125 U2 U5
	☐ S5125 U6	☐ S5125 U6 U4	☐ S5125 U6 U5
Training Service Code:	☐ S5110	☐ S5115	
Sick Time Service Code:	SICK2		
MCO:	☐ Banner UFC	☐ Mercy Care	☐ United
Effective Date:	_____		

CONSUMER DIRECT CARE NETWORK

SELF-DIRECTED ATTENDANT CARE

EMPLOYEE AGREEMENT

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

_____ has elected to hire me for the position of Attendant
(Member or Personal Representative (PR) Print Name)

Care Worker (ACW). I will perform attendant care services for the Member according to Arizona's Self-Directed Attendant Care (SDAC) program. I understand Arizona Consumer Direct Personal Care, LLC doing business as Consumer Direct Care Network Arizona (CDCN) is the Fiscal and Employer Agency. CDCN assists the Member/PR with employer related tasks. CDCN IS NOT my employer. The Member/PR is my employer.

1. **Enrollment**
   I have received the New Employee Packet with mandatory forms and trainings. I will complete and submit all documents and quizzes to CDCN. If I have questions, I'll ask CDCN.

   Mandatory trainings include:
   - CPR
   - First Aid
   - Privacy Awareness (HIPAA)
   - Infection Control
   - Lifting and Moving Patients
   - Fraud Prevention
   - Work Injury Hotline (review only)
   - Additional trainings authorized by Case Management or administered by my employer, the Member/PR

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

3. **I will maintain:**
   - A copy of First Aid/CPR Training Certificate. I understand this cannot be completed online. It must be certified through a hands-on, in-person course.
   - Infection Control training requirements.

4. **Payment**
   - CDCN issues payment on a biweekly schedule. Pay stubs (summary of pay) and W-2s are sent by first class mail to my address on file or electronically.
   - There are two direct deposit pay options. I can specify a bank account or choose a pay card. If I change my direct deposit option, I must submit a new Pay Selection Form.
   - All compensation is subject to applicable tax withholding.

- CDCN will file all required amended payroll tax returns in instances where there have been over-collected Social Security and Medicare taxes from employees' compensation. I will receive refunds of over-collected taxes directly from CDCN if earnings are less than the IRS threshold published in Circular E for the current tax year. Refunds will be paid in January immediately following year-end. I agree to not file a claim for refund of over-collected Medicare or Social Security taxes with the IRS.
- I must use an approved Electronic Visit Verification method to record each shift worked. The Member/PR must approve each shift worked. **All corrections and approvals must be done within 10 days of the date of service or my pay may be affected.**
- CDCN is not responsible to pay me if:
    - The Member becomes ineligible for Medicaid.
    - The Member/PR allows me to work overtime (more than 40 hours per week) without prior written approval from CDCN.
    - The Member/PR allows me to perform unauthorized tasks or work more hours than what is approved.

5. Effective Date

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

6. My ACW Responsibilities include:

- Provide services according to the Member's authorized tasks and hours.
- Program compliance (follow all SDAC program guidelines).
- Use an approved Electronic Visit Verification method to record each shift worked.
- Confidentiality of Member information.
- Status Change Notification (as necessary).
- Refusal of gifts and other forms of payments for services.
- Report to appropriate authorities if concerned about abuse, neglect or exploitation (Case Manager, Arizona Adult or Child Protective Services: 877-767-2385).

7. Non-Emergent Care

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

8. Relationship to Member

By program rules, I cannot be the Member's legal guardian, spouse or parent (if the Member is under 18 years old).

My relationship to the Member is: _____.

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

CONSUMER DIRECT CARE NETWORK

EMPLOYEE HEALTH QUESTIONNAIRE

Employee Name: _____
(please print)

Background: You have been conditionally hired to provide services for the service recipient in accordance with their authorized plan of care. You may be required to perform physical tasks. The purpose of this Health Questionnaire is to assess your ability to safely perform the authorized tasks. The information provided on this Questionnaire will be used to help manage your employment in a safe manner. Your responses are considered *Confidential*.

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

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

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

CONSUMER DIRECT CARE NETWORK

EMPLOYEE HEALTH QUESTIONNAIRE

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

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

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

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

Employee Signature: _____ Date: _____/_____/_____

Office Use Only

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

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

05095

CONSUMER DIRECT CARE NETWORK

SELF-DIRECTED ATTENDANT CARE

DRIVING CONFIRMATION

Employee (ACW) Name	Member Name

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

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

1. Support Services must be approved by the Case Manager and/or authorized on the member's individualized Care Plan.
2. The vehicle used for driving-related services must always have current, valid automobile insurance.
3. The ACW's driver's license and proof of insurance for the vehicle driven must be on file with Consumer Direct Care Network (CDCN). If these are not provided and updated when necessary, the ACW cannot claim driving services.

Driving is only authorized for Support Services that are on the member's care plan. The ACW will not be paid for driving services other than what has been approved by the Case Manager prior to providing services. Additionally, this program does not pay for driving-related expenses such as mileage or gas.

Attachments Required

Please attach a photocopy of the following documents:

ACW's Driver's License

State: _____ Number: _____ Expiration Date: _____

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

Expiration Date: _____ Vehicle owner: _____

Acknowledgement

By signing below, I agree to comply with the above requirements, and will contact CDCN if there is a change in automobile insurance or driver's license status.

_____ _____ _____ _____

ACW Signature *Date* *Member/Representative Signature* *Date*

CONSUMER DIRECT CARE NETWORK

SELF-DIRECTED ATTENDANT CARE

NO DRIVING CONFIRMATION

Employee (ACW) Name	Member Name

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

Acknowledgement

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

ACW Signature *Date* *Member/Representative Signature* *Date*

CONSUMER DIRECT CARE NETWORK

PRIVACY AWARENESS QUIZ AND CONFIDENTIALITY AGREEMENT

Employee Name: _____
(please print)

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

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

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

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

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

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

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

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

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

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

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

Confidentiality Agreement: By signing below, I acknowledge that the disclosure of confidential information obtained through my employment with the Member (service recipient) is **Prohibited!** Furthermore, I understand that any information concerning the Member's diagnosis, personal care services, and their personal details are considered to be strictly confidential. When a Member's history or condition is reviewed, it must be done in private where only those persons involved with the care of the Member are present. I acknowledge that confidentiality is an important part of the job, and that failure to follow confidentiality requirement is cause for termination.

_____ _____

Employee Signature *Date*

CONSUMER DIRECT CARE NETWORK

SELF-DIRECTED ATTENDANT CARE

INFECTION CONTROL QUIZ

Employee (ACW) Name	Member Name	Score (minimum 80%)

Instructions: Review the Infection Control Guidelines for Healthcare Workers training pamphlet. Discuss with your employer (Member or their Representative) and ask questions as necessary to ensure you fully understand the information presented. Complete the training quiz below and return it with the enrollment materials.

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**

ACW Signature *Date* *Member/Representative Signature* *Date*

CONSUMER DIRECT CARE NETWORK

SELF-DIRECTED ATTENDANT CARE

LIFTING AND MOVING PATIENTS QUIZ

Employee (ACW) Name	Member Name	Score (minimum 80%)

Instructions: Review the Lifting and Moving Patients training pamphlet. Discuss with your employer (Member or their Representative) and ask questions as necessary to ensure you fully understand the information presented. Complete the training quiz below and return it with the enrollment materials.

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**

ACW Signature *Date* *Member/Representative Signature* *Date*

CONSUMER DIRECT CARE NETWORK

ACW/DCW FRAUD PREVENTION QUIZ

TEST YOURSELF

True or False

Score _____

1. If a member is out of town, it is considered fraud for his worker to submit a work shift for payment as if services were provided like normal – even if the member says it's okay. **T F**

2. If a member is hospitalized for a few days and her worker stops by to visit, brings her mail and magazines, stops by her house and feeds her dog and waters plants, it is okay for the worker to submit a work shift for payment. **T F**

3. It is considered Medicaid Fraud for a member to give their worker their online credentials or password to allow the worker to adjust work shifts or do visit maintenance. **T F**

4. Fraud is easy to detect and it is easy to prosecute those who commit fraud. **T F**

5. If a member is approved only for meal preparation for 1 hour a day, it is okay for a worker to cook for ½ hour and vacuum for another ½ hour in order to get in the correct amount of time. **T F**

6. Medicaid Fraud is a serious offense that can result in prosecution, loss of job, loss of Medicaid benefits, fines, and jail time. **T F**

7. Reporting Medicaid Fraud is mandatory. You must report Medicaid Fraud to Consumer Direct, the state, or the Federal Medicaid Fraud unit. **T F**

8. With Electronic Visit Verification (EVV), the member must confirm and approve each work shift when their worker is clocking out. **T F**

9. It is okay for a worker to encourage a member to request additional services so they can work more hours and increase their pay. **T F**

10. The first time you commit fraud, Consumer Direct will not report your actions to the state or federal government. **T F**

ACW/DCW Name	ACW/DCW Signature	Date
Member Name	Member/Representative Signature	Date
CDCN Service Coordinator Name Coordinator Name	Coordinator Signature	Date

Work Opportunity Tax Credits - Consumer Direct Care Network

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

Applicant Instructions

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

- Please answer each question to complete the voluntary screening.

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

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

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

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

IVR CODE: 410849

CONSUMER DIRECT CARE NETWORK ARIZONA

SDAC Authorization Request

To:	Case Manager Name	**Fax:**	
Co.:	MCO Name - Banner, Mercy Care, UHC	**Date:**	
Ref:		**Pages:**	1
From:	CDCN Service Coordinator Name		

Message:

Member's Name:		**AHCCCS ID #:**		
Service	**Code**	**Units**	**Start**	**End**
FEA Services				
Member Initiation	T2040/UA	1	SOS Date	EOM Date
FEA Services Ongoing	T2040/UB	Monthly	2nd Month Date	
Caregiver Initiation w/ Background	T1023/UC			
Caregiver Initiation w/o Background	T1023	1 Unit per CG	SOS Date	
Attendant Care Services				
Attendant Care, non-family	S5125/U2		SOS Date	
Attendant Care, Family non-home	S5125/U2, U4			
Attendant Care, Family in-home	S5125/U2, U5			
Attendant Care, nurse delegated	S5125/U2, U6			
Training Services				
Member Training	S5108			
Caregiver Training, Member Relative	S5115			
Caregiver Training, Non-Relative	S5110			

10012