CONSUMER DIRECT CARE NETWORK

CAREGIVER EMPLOYMENT INFORMATION PACKET PART I

APPLICANTS: After being selected as a candidate for hire by a Client, you must complete, sign, and provide the following information to Consumer Direct Care Network Alaska (CDCN):

COMPLETE APPLICATION IN BLUE INK

Forms to return to Consumer Direct:

1. Caregiver Data Form
2. Equal Employment Opportunity Disclosure
3. I-9 Form (employee completes Section 1, include forms of ID from I9 lists)
4. W-4 Form
5. Pay Selection Form (include voided check for direct deposit)
6. Payroll Deduction Form
7. Driving Authorization & Auto Insurance Acknowledgement
8. Alaska Background Check Application
9. Release of Information Authorization for Background Check
10. Health Questionnaire
11. Hepatitis "B" Vaccination Waiver/Acceptance Form
12. Individual Provider Enrollment Application (HMS requirement)
13. Provider Enrollment Signature Page (Print Name, Sign and Date only)
14. W-9 (Conduent requirement)
15. New Hire Expectedly Weekly Hours

Trainings to return to Consumer Direct:

1. Training Modules
2. Certification Modules
3. Privacy Awareness Quiz and Confidentiality Agreement

Reference materials to keep: (Do not return these to Consumer Direct)

1. Infection Control pamphlet
2. Lifting and Moving pamphlet
3. Caregiver Training Guide: New Hire
4. Caregiver Handbook
5. Benefits Summary
6. Notice of Health Care Marketplace

You may not begin working as a Caregiver until the Employment Information Packets Part I & II have been completed, submitted and approved. In addition, you must pass a Criminal Background Check, provide certification of eligible CPR/First Aide training, complete enrollment in the Individual Provider Enrollment and receive an "OK to Work" from Consumer Direct.

Consumer Direct has the authority to terminate conditional employment based on any prohibited violations revealed on the background check.

Please see reverse of this form for appropriate Consumer Direct office locations to return completed enrollment packets.

CONSUMER DIRECT CARE NETWORK

CAREGIVER EMPLOYMENT INFORMATION PACKET PART I

Please send completed application to the appropriate address below:

Consumer Direct Care Network	Consumer Direct Care Network	Consumer Direct Care Network
405 E Fireweed Lane, Ste 100	126 Pioneer Ave, Ste 5	412 Frontage Road, Ste 40
Anchorage, AK 99503	**Homer, AK 99603**	**Kenai, AK 99611**

Consumer Direct Care Network	Consumer Direct Care Network
2417 Tongass Ave, Ste 207	131 E Swanson Ave, Ste 1
Ketchikan, AK 99901	**Wasilla, AK 99654**

Contact Information
Phone: 907-357-7962
Toll Free Phone: 888-900-7962
Toll Free Fax: 866-495-7963

CONSUMER DIRECT CARE NETWORK

CAREGIVER WAGE INFORMATION

SERVICE	STARTING WAGE
PERSONAL CARE	**$20.00 per hour**
CHORE	**$18.00 per hour**
HOURLY RESPITE	**$18.00 per hour**
DAILY RESPITE 12-24 HOURS DURING ONE CALENDAR DAY	**$230.00 per day**
HABILITATION DAY HABILITATION, IN-HOME SUPPORT, SUPPORTED LIVING	**$20.00 to $26.00 per hour***
TRAINING FOR TRAINING AUTHORIZED BY CDCN	**$10.85 per hour**
MILEAGE DAY HABILITATION ONLY	**$0.535 per mile**

*Habilitative services generally start at $20.00 per hour and increase annually to a maximum of $26.00 per hour, dependent on satisfactory work performance.

CONSUMER DIRECT CARE NETWORK

CAREGIVER DATA FORM

ASSISTANCE WITH THE HIRING PROCESS:

Any applicant who needs reasonable accommodation in any step of the hiring process should inform the client (managing employer) and/or Consumer Direct Care Network (CDCN).

CLIENT NAME:

APPLICANT INFORMATION:

Name – First: _____ Middle: _____ Last: _____

Mailing Address: _____

_____

City State Zip

Email Address: _____

Phone - Mobile: _____ Home: _____

Mobile phone capabilities:

1. Do you have a smart phone with data available to clock in/out for EVV? ☐ Yes ☐ No
2. Do you consent to receiving text messages from CDCN? ☐ Yes ☐ No

Are you 18 or over? ☐ Yes ☐ No Date of Birth: _____ Social Security #: _____

Emergency Contact - Name: _____ Phone Number: _____

PHYSICAL CAPACITY:

Caregivers may be called upon to perform physically demanding work in the performance of their job duties. Physical capacity demands may include the ability to lift, push, pull, sit, stand, walk, kneel, bend, squat, reach, overhead reach, twist, and grasp, hold, or manipulate items with your hands.

A typical Caregiver position will have the following physical requirements:

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			

Please indicate whether you are able to perform the above physical tasks: ☐ Yes ☐ No

Comments/explanation: _____

_____

CRIMINAL BACKGROUND:

Have you ever been convicted of a crime or do you have criminal charges pending? ☐ Yes ☐ No

Have you ever had a child removed from your home by the Office of Children's Services? ☐ Yes ☐ No

If yes, please list each charge, conviction, or child removal event and describe the nature of each offense, how recently such offense was committed, any sentence imposed, and any rehabilitation completed. Offenses will not necessarily prevent employment but will be considered in-light of specific job requirements.

_____

_____

CONSUMER DIRECT CARE NETWORK

CAREGIVER DATA FORM

PROFESSIONAL STANDARDS & LICENSING:

Have you ever had a Professional License, Certificate, or Driver's License in any state revoked, suspended, or had disciplinary action applied? ☐ Yes ☐ No

In the past three (3) years, have you had any moving violations or motor vehicle accidents? ☐ Yes ☐ No

Please explain any "Yes" answer: _____

_____

PREVIOUS EXPERIENCE WITH COMPANY:

Have you previously worked for CDCN? ☐ Yes ☐ No

ALIASES OR PREVIOUSLY HELD NAMES:

Please list any aliases or previously held names: _____

***Please Read* Carefully**

Neither the acceptance of this application nor the subsequent entry into any type of employment relationship or agreement with Consumers for consideration of employment shall serve to create an actual or implied contract of employment.

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

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

The Fair Credit Reporting Act requires us to advise you, that from time to time, we may request from a consumer reporting agency an investigative consumer report including information on your background. 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 my employment is conditional until CDCN has received acceptable information on my Federal Criminal Background Check, all required application materials and forms, and CDCN has issued an Authorization to Begin Work in writing. CDCN has the authority to terminate the conditional employment based on any prohibited violations revealed on the background check.

I further understand that my employment with this Company shall be probationary for a period of up to 180 days, during which my relationship with the Company is terminable at will for any reason by either party.

Applicant Name (print): _____

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

This Company is an equal opportunity employer

01133

CONSUMER DIRECT CARE NETWORK

EQUAL EMPLOYMENT OPPORTUNITY DISCLOSURE

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

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

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

☐ Male ☐ Female

Race/Ethnic Identification:

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

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

-OR-

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

Decline Self Identification:

☐ I do not wish to self-identify.

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

Employee Signature: _____ **Date**: _____

Staff Option:

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

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

00540

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
Alaska Consumer Direct Personal Care	405 E. Fireweed Lane, Suite 100, Anchorage AK 99503

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*

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CONSUMER DIRECT CARE NETWORK

CAREGIVER DRIVING AUTHORIZATION & AUTO INSURANCE ACKNOWLEDGEMENT

_____
Print Caregiver Name

Instructions: Consumer Direct Care Network Alaska (CDCN) must ensure that caregivers who transport a client in a vehicle have a driver's license and the appropriate state-required insurance. Please read carefully below and check the box that best indicates your status regarding driving related services and whether you will or will not be driving the client as part of your caregiver responsibilities. Also provide your driver's license information if you will be providing driving services.

I will or will not be providing driving related services as indicated below:

☐ **I will NOT be providing driving related services to the client I work for.**
The client I work for IS NOT AUTHORIZED to receive driving related services under their Plan of Care or Service Level Authorization OR I do not have automobile insurance or a current driver's license and therefore cannot provide such service. I acknowledge that I will not drive the client in a personal vehicle.

☐ **I WILL be providing driving related services to the client I work for.**
The client I work for IS AUTHORIZED to receive driving related services under their Plan of Care or Service Level Authorization. I understand and acknowledge that if my personal vehicle is used to transport the client, I must have automobile liability insurance that will cover the client in the event of an accident. Additionally, I acknowledge that I am not authorized to drive the client (whether in my car or theirs) if my driver's license is revoked or lost.

Driver's License Information (drivers only)

Name of State: _____ License #: _____ Exp. Date: _____

Name of State: _____ License #: _____ Exp. Date: _____

By signing below, I agree to comply with the above requirements, and will contact the Consumer Direct office if there is a change in my driving status.

_____ _____ _____ _____
Caregiver Signature Date CDCN Signature Date

00540

CONSUMER DIRECT CARE NETWORK

PAYROLL DEDUCTION FORM

I, _____ , authorize Alaska Consumer Direct Personal Care, LLC doing business as Consumer Direct Care Network Alaska (CDCN) to automatically process a onetime deduction from my biweekly pay to cover the State of Alaska Background Check Unit processing fees.

I understand the deduction will occur on my first paycheck, and if my net pay is inadequate to deduct the full amount, any subsequent paychecks will be adjusted to recover any difference of the fees still owed.

By signing below, I agree to the terms outlined above.

_____ _____

Caregiver Signature Date

Please do not write below this line. For CDCN office use only:

Processing fees to be deducted: (check all that apply)

- ☐ $40.00: Application processing fee
- ☐ $48.25: Fingerprint processing fee
- ☐ $88.25: Application and fingerprint processing fee
- ☐ $00.00: No fees are due at this time

_____ _____

CDCN Signature Date

00540

Department of Health and Social Services

DIVISION OF HEALTH CARE SERVICES
Background Check Program

4601Business Park Blvd., Bldg K
Anchorage, Alaska 99503-7167
Main: 907.334.4475
Fax: 907.269.3488

Alaska Background Check Application

Asterisks mark required fields. Applications will not be processed without complete information.

Personal Information

Full Legal Name: _____ / / _____
*Last *First M.I. Date of Birth (mm/dd/yyyy)

Permanent/ Physical Address:
_____ _____
*Physical Street Address *Apartment/Unit #
_____ _____ _____
*City *State *ZIP Code

Mailing Address (if different than Permanent/ Physical Address):
_____ _____
*Mailing Address *Apartment/Unit #
_____ _____ _____
*City *State *ZIP Code

Primary Phone: ( ) _____ Secondary Phone: ( ) _____

*Applicant's Email Address: _____

*SSN (or ITN) : _____
☐ This is an ITN

Demographic Information

*Race: (Asian, Black, White Native American, or Unknown) _____
*Gender: (Male, Female, Unknown, Other) _____
*Eye Color: (Black, Blue, Brown, Hazel, Green, Grey, Unknown) _____
*Hair Color: (Black Blonde, Brown, Grey, Sandy or Light Brown, Red, White, Unknown) _____
*Height: _____ **FT** _____ **IN**
*Weight: _____ **Lbs.**
*Place of Birth (Country/State): _____
US Citizen(Y/N): _____

Alias

Aliases/Prior Names (includes all names by which a person is currently known as, or has previously gone by, including nick names): Please attach additional pages as necessary

First Name: _____ Middle Name: _____
Last Name: _____ SSN/ITN: This is an ITN☐ _____
Date of Birth: (mm/dd/yyyy) _____

First Name: _____ Middle Name: _____
Last Name: _____ SSN/ITN: This is an ITN☐ _____
Date of Birth: (mm/dd/yyyy) _____

Background Check Application for: First Name: _____ Last Name: _____ DOB: _____

Prior Address History

Prior Addresses in the last 10 years: Please list the state(s) in which you have lived outside of Alaska for the last 10 years. This includes those states in which you have lived for schooling or training even if you remained an Alaska resident during that time. If you have lived in Alaska for the entirety of the last 10 years, you do not need to complete this section. Please attach additional pages as needed.

State: _____ Year(s) From: _____ **to** _____

State: _____ Year(s) From: _____ **to** _____

State: _____ Year(s) From: _____ **to** _____

Pre-Employment Information

Pre-Employment Information: Only complete this information if you are applying directly with a licensed and/or certified entity. The entity should provide you this information. If the entity does not provide this information to you, leave this section blank.

Provider Name: Alaska Consumer Direct Personal Care dba Consumer Direct Care Network Alaska

State Program under which the individual will work, such as Assisted Living, PCA, Hospital, Hospice, etc.: PCA

Position Title: Caregiver

Position Type: Employee
(Employee/Independent Contractor/Volunteer/Other)

Instructions

1. You should only submit this form to the Background Check Program (BCP) if you have not already applied on-line or through a licensed and/or certified entity. You may apply on line at: https://nabcs.dhss.ak.local/bcpapplicant. Hard copy applications will only be processed in the order in which they are received and will not be processed until a full and complete application is received, including all applicable fees and fingerprint cards.
2. Hard copy applications submitted to the BCP will not be connected to any other application or to any specific provider type within the system and require fingerprint cards and all applicable fees. **Please note fees are non-refundable.**
3. Hard copy applications submitted to the BCP must be complete within 30 days from the date the application was received. All fees and fingerprint cards must be **received by** the BCP within the 30 day timeframe. Applications found incomplete after 30 days are automatically closed. If you still require a background check, you will be required to submit a new application including all fees and fingerprints.
4. Payments may be made by check, credit card or money order. Cash payments may only be made in person at 4601 Business Park Blvd., Bldg. K, Anchorage, AK 99503. All payments must be for the exact amount. If you wish to pay by credit card, you must contact the Background Check Program at (907) 334-4475 to make a payment over the phone. Fees for fingerprint based background checks are $76.50 and are **not refundable.**
5. Please ensure you provide a valid email address. The email address will be used to communicate with you regarding your application status, including information regarding determinations or needed information.
6. If an eligible determination is made, you must associate with a licensed and/or certified entity within 100 days of the determination. Unassociated applications will be closed after 100 days without further notice and will immediately render a background check invalid. If you continue to need a valid criminal history check, you will be required to submit a new application including all fees and fingerprints.
7. A complete application includes this application form, non-refundable payment in the amount of $76.50, and one set of fingerprints. Complete applications should be mailed to: State of Alaska, Background Check Program, 4601 Business Park Blvd., Bldg. K, Anchorage, AK 99503.

I, _____, authorize and consent to any person provided a copy or facsimile of this Release of Information Authorization for Background Check by an authorized representative of the Department of Health & Social Services, to disclose any information regarding me in relation to civil court information, criminal justice, juvenile justice, protective service and licensing records. I understand any person providing information or records in accordance with this authorization is released from any and all claims or liability for compliance. I understand that this information may otherwise be confidential and that I am waiving that confidentiality and any claim I may have with regard to release of these records. I understand information obtained through this Release of Information Authorization for Background Check will be held in confidence in accordance with DHSS guidelines.

I, _____, authorize and consent to the department marking my name in the Alaska Public Safety Information Network (APSIN) under 7 AAC 10.915(e).

Applicant Signature _____ Date _____

Department of Health & Social Services
Background Check Program

RELEASE OF INFORMATION AUTHORIZATION FOR BACKGROUND CHECK

This form must be signed by the applicant for a background check and must be maintained in the individual's personnel file. If requested by the department, the form must be provided within 24 hours.

I,_____, authorize and consent to any person provided a copy or facsimile of this Release of Information Authorization for Background Check by an authorized representative of the Department of Health & Social Services, to disclose any information regarding me in relation to civil court information, criminal justice, juvenile justice, protective service and licensing records. I understand any person providing information or records in accordance with this authorization is released from any and all claims or liability for compliance. I understand that this information may otherwise be confidential and that I am waiving that confidentiality and any claim I may have with regard to release of these records. I understand information obtained through this Release of Information Authorization for Background Check will be held in confidence in accordance with DHSS guidelines.

I,_____, authorize and consent to the department marking my name in the Alaska Public Safety Information Network (APSIN) under 7 AAC 10.915(e).

I,_____, understand that upon submission of my fingerprints will be used to check the criminal history records of Alaska and of the Federal Bureau of Investigations (FBI).

I,_____, understand that procedures for obtaining a change, correction, or updating of an FBI criminal history record are set forth at Title 28, Code of Federal Regulations (CFR), Section 16.34.

This form must be signed; if the individual is 16-17 years of age, a parent signature must also be included.

_____	_____
Printed Name of Applicant (must be legible)	Date
_____	_____
Signature of Applicant	Applicant's SSN
_____	_____
Parent Printed Name, if applicable (must be legible)	Parent Signature.

00540

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

HEPATITIS B VACCINATION WAIVER/ACCEPTANCE FORM

_____
Caregiver Name (printed)

Instruction to Caregiver: Below, please choose either to waive or receive the Hepatitis B vaccination by marking the box which describes your choice and sign and date where indicated. If you choose to receive the Hepatitis B vaccination, Consumer Direct will return the form to you with a signed authorization so that you may complete the vaccination at one of the medical facilities listed on the back of this form.

HEPATITIS B VACCINATION DECLINATION/ACCEPTANCE

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. I understand that if I decline the Hepatitis B vaccination at this time, I may continue to be at risk of acquiring Hepatitis B, a serious disease. In the future, if I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

☐ **I choose to waive (decline) the Hepatitis B vaccination**

☐ **I choose to receive the Hepatitis B vaccination**

_____
Caregiver Signature *Date*

MEDICAL CENTER/CLINIC PERSONNEL

The above-named caregiver is authorized to receive or complete the Hepatitis B vaccination series.

THIS AUTHORIZATION IS NOT VALID UNLESS SIGNED BY CONSUMER DIRECT

Consumer Direct Authorization Approval by: _____
Printed Name Signature Date of Issue

This Authorization expires on: _____/_____/_____
Please do not honor this authorization if presented after the expiration date.

Please bill to: Consumer Direct Care Network Alaska, 100 Consumer Direct Way, Suite 375, Missoula, MT 59808 Phone (406) 532-1900

CONSUMER DIRECT CARE NETWORK

HEPATITIS B VACCINATION WAIVER/ACCEPTANCE FORM

Medical Centers and Clinics that Administer the Hepatitis B Vaccination

Anchorage

First Care Medical Center
1301 Huffman Rd., Suite 100
Anchorage, AK 99504
(907) 345-1199

Homer

Kachemak Bay Medical Clinic
4201 Bartlett Street
Homer, AK 99603
(907) 235-7000

Kenai

Redoubt Medical Clinic
11472 Kenai Spur Hwy, Suite 2
Kenai, AK 99611
(907) 283-6030

Kodiak

North Pacific Medical Center
104 Center Ave. Suite 100
Kodiak, AK 99615
(907) 486-4183

Individual Provider Enrollment Application
Enrollment through Alaska Department of Health and Human Services

About this form: All caregivers must be enrolled as an individual provider through the state portal. By completing this form you certify Consumer Direct Care Network as the provider's designee. A designee is a person the provider assigns the responsibility for the purposes of the provider's enrollment in the Alaska Medical Assistance Programs.

Identifying Information – Part 1

Please Print Clearly

Date: _____

Last Name: First Name: MI: Suffix:

Gender: **M / F** Country of Birth: State of Birth: DOB:

Social Security Number: - - E-Mail Address:

Previous Enrollment: (Please Circle Answers)

Are you or have you been previously enrolled as a Medicaid provider in another state? **Yes** **No**
If yes, what states?

Were you previously enrolled in the Alaska medical assistance program? **Yes** **No**
If yes, please list your previous Alaska medical assistance provider number: _____

Tribal Provider: Are you a federal employee assigned to a tribal hospital, tribal clinic, or any other type of travel healthcare facility or program?

Yes **No**

Hospital Based Provider: Are you a federal employee assigned to a tribal hospital, tribal clinic, or any other type of travel healthcare facility or program?

Yes **No**

Ownership:

Have you ever had ownership in any organization that has billed, or is currently billing Medicare or Alaska Medical Assistance or other state Title XIX services?

Yes **No**

Have you ever managed or directed any organization that is billed, or is currently billing Medicare or Alaska Medical Assistance or other state Title XIX services?

Yes **No**

Do you have an ownership interest of 5% or greater in a subcontractor for your business or practice? (yes or no) (A subcontractor is an individual, agency, or organization to which applicant/provider has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients.)

Yes **No**

Do any of the members of your immediate family (spouse, parent, child, sibling) have ownership of 5% or greater in a subcontractor to your business or practice?

Yes **No**

Exclusions and Sanctions: (Please Circle Answer)

Has any person who has ownership of, or a controlling interest in, the provider's practice or business entity, or who his agent, managing employee, contract employee, subcontractor, or employee of the provider's practice or business entity, ever been convicted of a criminal offense related to Alaska's Medical Assistance programs, the Medicaid program in another state or territory, the Medicare Program, or any other federally funded health or social service program?

Yes **No**

Have you or any member of your immediate family ever been convicted, assessed, debarred, or excluded from the Medicaid, Medicare, or Title Capital XVIII, Title XIX, Title XX, Social Security program or any other federal program due to fraud, obstruction of an investigation, or controlled substance violation?

Yes **No**

Do you, under any name or business identity, have any outstanding overpayments with any state or federal program?

Yes **No**

Have you ever pled guilty, no contest or been sentenced for any felony crime and/or had a criminal fine or restitution order assessed or do you have of felony charge pending under Federal or State Law?

Yes **No**

Have you or any of your employees, contract employees, or any person or entity with ownership of your business, ever been sanctioned by the office of Inspector General (OIG), Medicare, Medicaid, or the Social Security Act, including a state Medicaid program?

Yes **No**

Have you or any of your employees, contact employees, or any person or entity with ownership of your business, ever been denied malpractice insurance or ever voluntarily or involuntarily agree to any limitations, restrictions, or conditions to your license, certification, or permit including any formal or informal Professional Board of Disciplinary Action(s)?

Yes **No**

Have you or any of your employees, contract employees, or any person or entity with ownership of your business, ever had any Program Exclusions from any federal funded programs? (yes or no)

Yes **No**

Have you or any of your employees, contract employees, or any person or entity was ownership of your business, been involved in any civil litigation whereby a judgment or settlement was entered into, or Civil Monetary Penalty(s) was paid?

Yes **No**

Do you or any of your employees, contract employees, or any person or entity with ownership of your business have any Judgment(s) or Pending actions under the False Claims Act?

Yes **No**

Affiliations – Part 2:

Have you been affiliated with any other Personal Care Agency? (Yes or No)_____

If yes, company name? _____ Effective Date: _____

Location – Part 3:

Physical Address: (cannot be a PO Box)

City: State: Zip:

Mailing Address: (if different from physical)

City: State: Zip:

Certifications & Licensures:

If you hold any current licensures or certifications; such as, certified in First Aid and CPR, please provide a copy of the licenses and/or certifications with this application.

ENTER YOUR APPLICATION TRACKING NUMBER: _____

Alaska Medical Assistance Program

Alaska Department of Health

PERSONAL CARE ASSISTANT (PCA) PROVIDER ENROLLMENT AGREEMENT

The purpose of this form is to obtain a personal care assistant (PCA) provider's information and agreement to abide by mandated federal and state law and/or regulations, relative to 1) Internal Revenue Service requirements and 2) Medicaid program (also known as the Alaska Medical Assistant Program) requirements. A provider may choose to submit IRS Form W-9 as an addendum to this Agreement, however the W-9 may not be provided to the Alaska Department of Health (the Department) in lieu of executing, dating, and providing the original of **this** form to the Department. Failure to return this dated and fully executed Agreement may exclude a provider from participation in the State of Alaska Medicaid program.

Instructions: Review Section 1, Personal Care Assistant Information and sign Section 2, the Personal Care Assistant Agreement.

An original signature is required on this signature page. Photocopied, stamped, or electronically generated signatures are not acceptable. Mail all signed signature pages together with any required documentation to HMS at the address provided on the following page.

Section 1: PERSONAL CARE ASSISTANT (PCA) INFORMATION

Provider Type:

Provider's Last Name: First Name: MI: Suffix:

Section 2: PERSONAL CARE ASSISTANT (PCA) AGREEMENT

By my signature below, as the PCA provider named herein, I affirm that:

1. The number I have entered on this form is my correct social security number.
2. I have met and will continuously comply with the responsibilities, qualifications, education, and training requirements in 7 AAC § 125.090, 7 AAC § 125.120 and 7 AAC § 125.160.
3. I will abide by all applicable Alaska and federal laws, regulations, rules, written policies, and billing manual instructions related to the Alaska Medicaid program.
4. I will submit, within 35 days of the date upon a request sent by the U.S. Secretary or the Alaska Medicaid agency, full and complete information regarding:
   a. The ownership of, or other financial interest in, any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request (42 C.F.R. § 455.105);
   b. Any significant business transactions between the provider and any wholly-owned supplier, or between the provider and any subcontractor, during the five-year period ending on the date of request (42 C.F.R. § 455.105).
5. I have read and understand 42 U.S.C. § 1320a-7 "Exclusions of certain individuals and entities for participation in Medicare and State health care programs" and will comply with 42 U.S.C. § 1320c-5 "Obligations of Health Care Practitioners and Providers of Health Care Services; Sanctions and Penalties; Hearing and Review".
6. I will maintain the confidentiality, privacy, and security of Alaska Medicaid recipient information as I have access as a PCA provider and comply with all applicable Health Insurance Portability and Accountability Act of 1996 (HIPAA) federal and state laws, regulations, policies, and rules (codified principally at 42 U.S.C. § 1320d - 1320d-6 and 45 C.F.R. § 160, § 162, and § 164).
7. I will inform the Department in writing within 30 days of a change in ANY information contained in this Alaska Medicaid PCA Provider Enrollment Agreement.
8. I will update my Alaska Medicaid PCA provider enrollment information every five years or as requested by the Department.
9. I will maintain written clinical and other records as required by state and federal laws and regulations, necessary to demonstrate the nature and extent of the medical necessity, support, care, and services for which I provide service. I agree to fully disclose any and all records reflecting the extent of services or items furnished to recipients under Alaska's Medicaid program. Upon request, records and information will be made available to the Department or its authorized representatives, including the federal grantor agency (US Department of Health and Human Services), the Comptroller General of the United States, the Alaska Medicaid Provider Fraud Control Unit, or any authorized representatives of these agencies.
10. I have read and understand the penalties for medical assistance fraud contained at AS § 47.05.210.
11. I am a citizen or national of the United States, an alien lawfully admitted for permanent residence, or an alien authorized by the U.S. Citizenship and Immigration Services ("USCIS") to work in the United States.
12. I authorize the Department to verify all information submitted as part of the Alaska Medicaid provider enrollment and enrollment update process.

			-			-				

Legal Name of PCA (please print or type)

Social Security Number

Signature of PCA (use blue ink)

Date

SUBMISSION INFORMATION

Return this original signed form along with any additional required documentation to the address below.

Alaska Medicaid Fiscal Agent
Attn.: Provider Enrollment
P.O. Box 240808
Anchorage, Alaska 99524-0808

If you have questions, please contact Provider Enrollment at 907.644.5993 or 888.944.6877 (toll-free in Alaska).

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–		–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and

4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting,* later, for further information.

Note: If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States.

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items.

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 24% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the instructions for Part II for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code,* later, and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships,* earlier.

What is FATCA Reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code,* later, and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account (other than an account maintained by a foreign financial institution (FFI)), list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9. If you are providing Form W-9 to an FFI to document a joint account, each holder of the account that is a U.S. person must provide a Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note: ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C corporation, or S corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box on line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box on line 3.

IF the entity/person on line 1 is a(n) . . .	THEN check the box for . . .
• Corporation	Corporation
• Individual • Sole proprietorship, or • Single-member limited liability company (LLC) owned by an individual and disregarded for U.S. federal tax purposes.	Individual/sole proprietor or single-member LLC
• LLC treated as a partnership for U.S. federal tax purposes, • LLC that has filed Form 8832 or 2553 to be taxed as a corporation, or • LLC that is disregarded as an entity separate from its owner but the owner is another LLC that is not disregarded for U.S. federal tax purposes.	Limited liability company and enter the appropriate tax classification. (P= Partnership; C= C corporation; or S= S corporation)
• Partnership	Partnership
• Trust/estate	Trust/estate

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space on line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)

2—The United States or any of its agencies or instrumentalities

3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

4—A foreign government or any of its political subdivisions, agencies, or instrumentalities

5—A corporation

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession

7—A futures commission merchant registered with the Commodity Futures Trading Commission

8—A real estate investment trust

9—An entity registered at all times during the tax year under the Investment Company Act of 1940

10—A common trust fund operated by a bank under section 584(a)

11—A financial institution

12—A middleman known in the investment community as a nominee or custodian

13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 5[2]
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)

J—A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note: You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns. If this address differs from the one the requester already has on file, write NEW at the top. If a new address is provided, there is still a chance the old address will be used until the payor changes your address in their records.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN.

If you are a single-member LLC that is disregarded as an entity separate from its owner, enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note: See *What Name and Number To Give the Requester,* later, for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at *www.SSA.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/Businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. Go to *www.irs.gov/Forms* to view, download, or print Form W-7 and/or Form SS-4. Or, you can go to *www.irs.gov/OrderForms* to place an order and have Form W-7 and/or SS-4 mailed to you within 10 business days.

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, 4, or 5 below indicates otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code,* earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), ABLE accounts (under section 529A), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account) other than an account maintained by an FFI	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Two or more U.S. persons (joint account maintained by an FFI)	Each holder of the account
4. Custodial account of a minor (Uniform Gift to Minors Act)	The minor[2]
5. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee[1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner[1]
6. Sole proprietorship or disregarded entity owned by an individual	The owner[3]
7. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
8. Disregarded entity not owned by an individual	The owner
9. A valid trust, estate, or pension trust	Legal entity[4]
10. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
11. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
12. Partnership or multi-member LLC	The partnership
13. A broker or registered nominee	The broker or nominee
14. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
15. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships,* earlier.

***Note:** The grantor also must provide a Form W-9 to trustee of trust.

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records From Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Pub. 5027, Identity Theft Information for Taxpayers.

Victims of identity theft who are experiencing economic harm or a systemic problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov.* You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at *spam@uce.gov* or report them at *www.ftc.gov/complaint.* You can contact the FTC at *www.ftc.gov/idtheft* or 877-IDTHEFT (877-438-4338). If you have been the victim of identity theft, see *www.IdentityTheft.gov* and Pub. 5027.

Visit *www.irs.gov/IdentityTheft* to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

CONSUMER DIRECT CARE NETWORK

EXPECTED WEEKLY HOURS - NEW HIRE

CAREGIVER/NURSE
(Non-FEA)

Employee Name: _____

Entity: CDAK

Email Address: _____

-- Office Use Only --

Hire Date: _____

Anticipated Weekly Hours:

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

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

Comments:

CDCN Representative Name: _____

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

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

00540

CONSUMER DIRECT CARE NETWORK

CAREGIVER TRAINING MODULES

_____

Print Caregiver Name

INSTRUCTIONS: Review the training materials provided to you and ask questions as necessary to ensure that you fully understand the information presented. Then, complete, sign, date, and return this form to CDCN. **Note: The brackets ([…]) underneath each title tell you which training materials to reference for answers.**

Lifting and Moving Patients

[Reference material: *Krames #11356* booklet]

SCORE: _____

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**

Infection Control

[Reference material: *Krames #11386* booklet]

SCORE: _____

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. 09663	**T F**

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

Food Safety [Reference material: *Caregiver Training Guide*]	SCORE: _____

1. When cooking food in the microwave oven you should wrap tightly in aluminum foil. **T F**
2. The best way to put out most kitchen fires is with a bucket of water. **T F**
3. The most deadly form of food-borne illness is often caused by improperly processed canned goods. **T F**
4. All foods should be washed before cooking, including raw meats. **T F**
5. To cool foods safely, a refrigerator should be set at no more than 20 degrees. **T F**
6. To be safe, all foods should be refrigerated within 2 hours. **T F**
7. Allergic reactions to food can be fatal if the person's throat swells shut. **T F**
8. To remove excess salt, you should wash canned vegetables before cooking. **T F**
9. People with weak immune systems should avoid eating red meats. **T F**
10. Grease is a leading cause of home fires and fire injuries. **T F**

Reporting a Workplace Injury [Reference material: *Caregiver Training Guide*]	SCORE: _____

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

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

Restrictive Interventions [Reference material: *Caregiver Training Guide*]	SCORE: _____

1. Restrictive interventions include any _____ or _____ that limit clients' movement or access to other individuals, locations, or activities.
2. Caregivers may employ restrictive interventions at any time and under any circumstances. **T F**
3. If a client's behavior presents an imminent threat of harm to caregivers or to others, caregivers must _____ the premises if possible.

4. If a client's behavioral presents an imminent threat of harm to caregivers or to others, caregivers must immediately call:
   a. Police
   b. Emergency Medical Services
   c. CDCN
   d. All of the above

5. Caregivers may never employ restrictive interventions if they have not been trained in restrictive interventions or are not current with restrictive intervention training. **T F**

6. Regardless of training and/or circumstances, _____, _____, and _____ may never be used as restrictive interventions.

7. If a caregiver employs restrictive interventions, he or she must call CDCN, even if the agency is closed and the caregiver must leave a message. **T F**

Responding to Unpredictable Behaviors [Reference material: *Caregiver Training Guide*]	SCORE: _____

1. A multi-step approach to identifying unpredictable behaviors includes:
   a. Examining the behavior
   b. Trying different responses
   c. Exploring potential solutions
   d. All of the above

2. When a client does or says something over and over again, he or she is likely looking for _____, _____, or _____.

3. Negative behaviors may be related to (circle all that apply):
   a. Complicated tasks
   b. Maintaining a schedule
   c. Overstimulation
   d. Frustrating interactions
   e. Simple dislike for caregivers

4. If a client is unable to calm down, seek assistance from others, and call 911 in emergency situations. **T F**

5. A client can become anxious or agitated for many reasons. It can help to learn what _____ this response.

6. If a client is suspicious, you may respond by:
   a. Reassuring the client
   b. Trying to convince the client that everything is okay
   c. Providing the client with a lengthy explanation
   d. Switching the focus to another activity
   e. a and b
   f. a and d

7. Three appropriate responses to aggression include _____, _____, or _____.

Developmental Disabilities [Reference material: *Caregiver Training Guide*]	SCORE: _____

1. Developmental disabilities manifest before age 22 and are likely to continue indefinitely. **T F**
2. Primary development domains include:
   a. Social
   b. Speech/language
   c. Self-help
   d. Emotional
   e. All of the above
3. The most obvious sign of autism is increased social interaction. **T F**
4. Clients with cerebral palsy often have intellectual challenges. **T F**
5. Cognitive disability is also referred to as _____ _____.
6. Seizures result in involuntary changes in:
   a. Body movement/function
   b. Awareness
   c. Behavior
   d. Sensation
   e. All of the above
7. If a client experiences a seizure, a caregiver must always follow the client's _____ _____.
8. If a client is having a seizure, the caregiver should never:
   a. Time the seizure
   b. Restrain the client
   c. Call 911
   d. Stay with the client
9. After a client has a seizure, when it is safe to do so and if appropriate, a caregiver should call in a report according to CDCN's critical incident reporting policy. **T F**
10. Signs of sensory integration challenges may include:
    a. Problems with movement
    b. Sensitivity to types of fabric
    c. Difficulty with communication
    d. a and b
    e. All of the above
11. For smoother activity transitions, give a client cues about changes ahead of time. **T F**
12. Clients with developmental disabilities have the _____ rights, benefits, and privileges guaranteed in law as everyone else.
13. Examples of implicit rights include:
    a. The right to free speech
    b. The right to due process
    c. The right to public access
    d. The right to choose

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14. Which of these options are examples of person-first language?
    a. She's autistic
    b. She has a cognitive disability
    c. She's learning disabled
    d. She is crippled
    e. She has brain damage

15. Professional relationship properties include:
    a. Being strongly influenced by emotion
    b. Involve all parties sharing personal information and feelings
    c. Contribute to the quality of life for clients
    d. Are more casual
    e. Contributes to the quality of life for all parties involved

16. People use behavior to achieve a _____.

17. Caregivers cannot know the specific reasons for client behavior until they get to know clients, so it is important to remember that:
    a. Every client is unique
    b. All behavior that persists serves some purpose
    c. Behavior is a bad thing
    d. a and b

18. General reasons for behavior to occur include:
    a. To communicate
    b. To express intense feelings
    c. When something is wanted or needed
    d. All of the above

19. One role for caregivers is to help prevent or minimize difficult, challenging behavior. **T F**

20. Ways to support positive behavior include:
    a. Listen and empathize with the client
    b. Assure the client has as much choice and control as possible
    c. Tell the client "No" if needed
    d. a and b
    e. All of the above

21. One method of positively managing conflict is to do something _____.

22. Behavioral problems can be greatly influenced by the reaction of caregivers to situations. **T F**

23. When feeding a client who has a cognitive disability, avoid:
    a. Changes
    b. Isolating the client
    c. Using a calm voice
    d. a and b

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24. Signs of choking include all of the following except:
    a. Inability to talk
    b. Difficulty breathing or noisy breathing
    c. Loss of consciousness
    d. Coughing forcefully

25. If a client is choking/unable to cough forcefully, immediately _____ _____!

Documentation of Education

[No reference material required]

Alaska law requires caregivers to demonstrate their ability to read instructions and to write appropriate case notes. This module will help you to meet that requirement. Please complete the sections below, following all instructions carefully.

Part 1: Indicate (check) the highest level of education you have completed.

☐ Less than high school
☐ High school/GED
☐ Some college
☐ College degree or higher
☐ Professional degree
Describe: _____
☐ Professional licensure
Describe: _____

Part 2: Read the following case study. Using the space provided, write a short case note describing how the client's condition changed, what the caregiver did to address the change, and how the client responded to care.

Max is an 87-year-old man who lives by himself in an apartment. He has a caregiver, Dan, who helps him with personal care, household tasks, and getting around town.

At the start of the week, Max was feeling fine, but on Tuesday he developed a fever and a cough. After talking things over with Max, Dan called the doctor and asked if Max should be seen. The doctor told Dan to give Max some medicine he would prescribe, to make sure Max got plenty of fluids, and to call again if Max got any worse. Dan did as the doctor instructed, and by Saturday Max was feeling much better.

_____
_____
_____
_____
_____
_____
_____
_____
_____

Acknowledgement

I acknowledge that:

- I have completed the *Caregiver Training* packet to the best of my ability.
- If I have misrepresented another's work as my own, I will lose my eligibility to be employed by CDCN, among other potential consequences.
- If I have further questions about the materials contained in the *Caregiver Training* packet it is my responsibility to contact CDCN staff for clarification or additional training.

_____ _____

Caregiver Signature Date

CDCN Use Only

The caregiver has completed the required training and adequately demonstrated his or her ability to read instructions and to write appropriate case notes. ☐ Yes ☐ No (if no, forward to Administrative Supervisor for review)

_____ _____

CDCN Signature Date

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_____

Print Caregiver Name

INSTRUCTIONS: Review the training materials provided to you and ask questions as necessary to ensure that you fully understand the information presented. Then, complete, sign, date, and return this form to CDCN. **Note: The brackets ([…]) underneath each title tell you which training materials to reference for answers.**

Assistance with Self-Administration of Medication (ASAM)

[Reference material: *Caregiver Training Guide*]

SCORE: _____

1. Which of the following is true about ASAM?
   a. It does not include actually placing a medication into or onto a client's body
   b. It can involve reassuring a client that a dosage is being taken as prescribed
   c. It does not involve crushing or splitting a pill
   d. All of the above
2. Reminding a client to take medication is considered ASAM. **T F**
3. Opening a medication container is not allowed as part of ASAM. **T F**
4. Reading a medication label to a client is considered ASAM. **T F**
5. You may not provide foods or liquids as part of ASAM—a client must do that. **T F**
6. Which of the following are allowed as part of ASAM?
   a. Observing a client while he/she takes a medication
   b. Checking a dosage against the label of a medication container
   c. Directing or guiding the hand of a client at the client's request
   d. All of the above
7. Helping with ASAM means that caregivers do not actually place medication into or onto a client's body. **T F**
8. While assisting a client with ASAM, you may pour, measure, or prepare a dose, or place a medication into a client's mouth. **T F**
9. While helping with ASAM, you may not observe a client placing sublingual medication under his/her tongue. **T F**
10. While helping with ASAM, you may administer a suppository by placing it into a client's body. **T F**
11. To better assist a client with ASAM, you should review a client's service plan/plan of care to understand his/her medication needs. **T F**
12. Even though CDCN requires all caregivers to receive basic ASAM training, not all clients are approved to receive ASAM assistance. **T F**
13. ASAM ***may*** be provided under chore services. **T F**
14. Which of the following is a medication error?
   a. Delivering a medication at the time scheduled
   b. Delivering a medication to the intended client
   c. Failing to document assisting with ASAM
   d. Checking that a medication is delivered via the right route

15. While helping Melissa with ASAM, you notice that one of her medications is going to expire next week. What should you do?
    a. Talk to Melissa and/or her responsible party about ordering new medications
    b. Remind Melissa that she should not take expired medications
    c. Document in your case notes that you discussed expiring medications with Melissa and/or her responsible party
    d. All of the above

16. There may be situations when you have to force a client to take his/her medications. **T F**

17. If a client refuses to take medication because he/she says the pills are hard to swallow, the ***best response*** would be to:
    a. Tell the client you don't really like swallowing pills either
    b. Do nothing because the client is allowed to refuse
    c. Call 911—it is important that the client take ALL medications on time
    d. Suggest that the client or the client's care team talk with the doctor to see if the medication might be available in another form

18. If a client refuses medication because he/she is agitated or confused, it can be helpful to:
    a. Reattempt several minutes later
    b. Offer gentle encouragement
    c. Remove environmental distractions, such as noise
    d. All of the above

19. You observe a client experiencing a change in physical condition that you suspect might be a side effect from a new medication. You should:
    a. Observe and report the change to CDCN and to the client's care team
    b. Document the change (and who you reported the change to) in your case notes
    c. Call 911 immediately if the change appears to be life threatening
    d. All of the above

20. If a side effect, adverse reaction, or allergic reaction appears to be life threatening, you must act immediately by contacting 911. **T F**

Mandatory Reporting [Reference material: *Caregiver Training Guide*]	SCORE: _____

1. Alaska law requires you to report mistreatment involving vulnerable adults and children, and these kinds of reports are often called reports of harm. **T F**

2. The types of mistreatment you are required to report include:
    a. Abandonment
    b. Abuse
    c. Exploitation
    d. Neglect
    e. Self-neglect
    f. Undue influence
    g. All of the above

3. If a caregiver frequently doesn't show up to care for his/her client, that may be considered abandonment. **T F**

4. A caregiver convinces a client to put her name on the client's checking account. The caregiver then takes some money from the account and tells the client that the money is for some extra time worked. The caregiver may be involved in:
   a. Abandonment
   b. Exploitation
   c. Neglect
   d. Self-neglect
   e. All of the above
   f. None of the above
5. Constantly humiliating a client isn't nice, but it isn't really abuse and shouldn't be reported. **T F**
6. Shoving a client into the shower may be abuse. **T F**
7. Your 7-year-old client, Joe, tells you that his 15-year-old friend keeps touching Joe's private areas. Joe's dad says everything is fine. This shouldn't concern you because:
   a. Both Joe and his friend are under 18, so anything going on can't really be wrong.
   b. Joe's dad doesn't care, so you shouldn't either.
   c. Joe's friend is probably just roughhousing.
   d. The situation should concern you, and you should report what you've heard.
8. Your client tells you that his son, who is the client's primary caregiver, makes him lie on his bedpan for hours and hours. The client's son may be neglecting the client. **T F**
9. You notice that your elderly client seems depressed and has stopped paying the bills, making doctor's appointments, or keeping himself clean. The client may be suffering from self-neglect. **T F**
10. If a client's family member threatens to stop taking the client to see friends or to the doctor's office unless the client makes the family member a power of attorney, the family member might be using undue influence. **T F**
11. You must report suspected mistreatment to the authorities _____ after you have a fair reason for concern, and absolutely within _____.
12. If you believe that there is a risk of imminent harm to a client, you must notify law enforcement. **T F**
13. So long as you report in good faith, you will not get into trouble if you make a report and the authorities do not find evidence of mistreatment. **T F**
14. Before you report, you must personally determine that any mistreatment meets the legal definition of abuse. **T F**
15. The phone numbers for APS, OCS, and law enforcement are:
    - APS: _____
    - OCS: _____
    - Law enforcement: _____
16. If you report mistreatment to CDCN, you don't have to worry about contacting the authorities. **T F**
17. If you fail to report mistreatment, you may be held legally liable. **T F**

Critical Incident Reporting (CIR) [Reference material: *Caregiver Training Guide*]	SCORE: _____

1. Some injuries, accidents, and serious service events must be reported by clients and caregivers to CDCN, and by CDCN to the state. **T F**
2. Critical incidents are considered significant events that are out of the ordinary and may include:
   - **a.** A missing client
   - **b.** Client behavior that results in harm to self or harm to others
   - **c.** Use of a restrictive intervention that results in the need for client evaluation by or consultation with medical personnel
   - **d.** The death of a client
   - **e.** An accident, injury or other unexpected event affecting a client's health, safety, or welfare
   - **f.** A medication error
   - **g.** An unexpected hospitalization or emergency room visit
   - **h.** An event that involves a client and requires a law enforcement response
   - **i.** All of the above
3. If caregivers are involved in, witness, or become aware of a critical incident, they must contact CDCN to make a report, even if the agency is closed and they must leave a message. **T F**
4. Caregivers must report a critical incident to the agency no later than _____ after they become aware of the event.
5. If a critical incident is a medical emergency, caregivers should call CDCN because the agency can provide emergency care or medical services. **T F**
6. If caregivers are unsure whether an event is a critical incident, they must still report it. **T F**

Fraud Prevention [Reference material: *Caregiver Training Guide*]	SCORE: _____

1. Fraud is a crime against all taxpayers and is a State and Federal crime. **T F**
2. CDCN is a mandatory reporter of any suspected fraud. **T F**
3. Fraud is the intentional deception or misrepresentation that an individual knows, or should know, to be false, or does not believe to be true, and makes, knowing that the deception could result in some unauthorized benefit to himself/herself or some other person(s). **T F**
4. What are some examples of fraud? _____, _____, _____, _____.
5. Giving false information and/or failing to report fraud could lead to suspension, termination, fines, or jail time. **T F**
6. What is the fraud hotline phone number? _____.
7. When should you call the fraud hotline? _____.

Acknowledgement

I acknowledge that:

- I have completed the *Caregiver Training* packet to the best of my ability.
- If I have misrepresented another's work as my own, I will lose my eligibility to be employed by CDCN, among other potential consequences.
- If I have further questions about the materials contained in the *Caregiver Training* packet it is my responsibility to contact CDCN staff for clarification or additional training.

_____ _____

Caregiver Signature Date

CDCN Use Only

Expiration Date: _____ (expiration must match expiration date of **current** CPR/FA)

00540

PRIVACY AWARENESS QUIZ AND CONFIDENTIALITY AGREEMENT

Print Caregiver Name: _____

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

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

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

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

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

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

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

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

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

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

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

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

_____ _____

Caregiver Signature *Date*

wisely® by ADP

Financial control: You've got it!

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

Get paid early.[2]

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

Save and manage your money on your terms.

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

Shop with confidence.

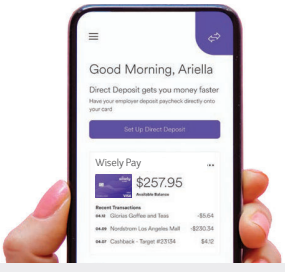
Pay online, in store, in app, or by phone everywhere Visa® debit cards are accepted or where Debit Mastercard® is accepted.

Skip ATM fees.

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

Get Wisely today!

Talk to your Payroll Department.



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

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

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

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

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

CONSUMER DIRECT CARE NETWORK

2024 Benefits Summary
Caregivers

Benefit	Eligibility Requirements	Enrollment	Important Details
Health Insurance	30+ Hours per week	First of the month following 30 days of employment	Free preventative care. In-network co-pays: $15 doctor visit, $25 specialist, $400 emergency room, $400 outpatient imaging.
TransChoice Advance (Medical Buy Up)	30+ Hours per week and enrolled in company Medical Insurance Plan	First of the month following 30 days of employment	Add to your Medical Plan a hospital/surgical benefit. Pays $250/day in-hospital and/or surgery payments per calendar year maximums. Note: Minimum participation requirement of 10 enrollees.
Telemedicine by 98point6	30+ Hours per week and enrolled in company Medical Insurance Plan	First of the month following 30 days of employment	App allows you to text directly with a doctor about non-emergency medical issues. Doctors are available 24/7 by text messaging and can prescribe some medications. Prescription and lab fees are at your own expense.
Health Care Flexible Spending Account (FSA)	30+ Hours per week	First of the month following 30 days of employment	Employees can defer up to $3,200 per calendar year in pre-tax dollars to use for eligible medical expenses. Unused funds (up to $640) are rolled over to the following year's FSA.
Dependent Care Flexible Spending Account (FSA)	10+ Hours per week	First of the month following 30 days of employment	Employees can defer up to $5,000 per calendar year in pre-tax dollars to use for daycare or disabled adult dependent care expenses. Unused funds are forfeited at the end of the year.
Vision Insurance	10+ Hours per week	First of the month following 30 days of employment	Plan participants receive a free annual eye exam with in-network providers, and can choose between new lenses or frames with $20 copay OR free contacts (within allowance). Additional discounts available.
Voluntary Dental Insurance	10+ Hours per week	First month following 30 days of employment	FREE preventative care (cleanings). Additional services subject to $50 deductible and $1,000 maximum benefit per year.
Basic Life/AD&D Insurance	10+ Hours per week	**Automatic:** First of the month following 30 days of employment	In the event of an employee's death, this **company paid** plan pays their beneficiary a benefit equal to $10,000. Life and AD&D Benefits reduce to 65% at age 65 and to 45% at age 80.
Voluntary Supplemental Life Insurance	10+ Hours per week	First of the month following 30 days of employment	Employees can elect amounts in $10,000 increments, up to the lesser of $300,000 or 5 times your annual earnings. Verification may be required in certain circumstances. Life Benefits reduce to 65% at age 65 and to 45% at age 80.
Unum Supplemental Insurances	10+ Hours per week	First of the month following 30 days of employment	Coverages Available: Critical Illness, Accident and Hospital Insurance
Employee Assistance Program (EAP)	No hours requirement	**Automatic:** All employees and eligible family members	The EAP offers free and confidential counseling and assistance resolving situations that may inpact your personal or professional life. Employees are given 3 counseling sessions per issue.
401(k) Retirement Plan	No hours requirement Must be age 18 or older	First of the month following 90 days of employment	Employees can defer pre-tax dollars into the company's 401(k) plan.
Pet Insurance	No hours requirement	No waiting period	MetLife Pet Insurance offers assistance to pay for your pet's medical care, including check-ups, testing, surgery, and hospitalization. Contact MetLife at www.metlife.com/getpetquote or 800-438-6388.

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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 11-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the Human Resources Department.

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

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name	4. Employer Identification Number (EIN)
Alaska Consumer Direct	20-1610152
5. Employer address	6. Employer phone number
100 Consumer Direct Way	844.360.4747

7. City	8. State	9. ZIP code
Missoula	MT	59808

10. Who can we contact about employee health coverage at this job?	
Human Resources Department	
11. Phone number (if different from above)	12. Email address
	infobenefits@consumerdirect.com

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

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☑ Some employees. Eligible employees are:

Regular status employees working at least 30 hours/week

- With respect to dependents:

☑ We do offer coverage. Eligible dependents are:

Spouse or domestic partner, child(ren) up to age 26

☐ We do not offer coverage.

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

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

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

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

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

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

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

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $20.03
b. How often? ☐ Weekly ☐ Every 2 weeks ☑ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

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

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

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

CONSUMER DIRECT CARE NETWORK

2024 Payroll Calendar

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

JANUARY

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

FEBRUARY

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

MARCH

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

APRIL

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

MAY

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

JUNE

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

JULY

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

AUGUST

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

SEPTEMBER

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

OCTOBER

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

NOVEMBER

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

DECEMBER

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

2024 Bank & Post Office Holidays

*Consumer Direct Care Network office closures

- ***New Year's Day** - Monday, January 1
- ***Martin Luther King, Jr. Day** - Monday, January 15
- **Presidents Day** - Monday, February 19
- ***Memorial Day** - Monday, May 27
- ***Juneteenth** - Wednesday, June 19
- ***Independence Day** - Thursday, July 4
- ***Labor Day** - Monday, September 2
- **Columbus Day** - Monday, October 14
- ***Veterans Day** - Monday, November 11
- ***Thanksgiving Day** - Thursday, November 28
- ***Christmas Day** - Wednesday, December 25

CONSUMER DIRECT CARE NETWORK

Work weeks are Sunday through Saturday. Time must be submitted by MONDAY at 5:00 PM, unless your service is submitted via Electronic Visit Verification (EVV). Late time or time with mistakes may result in late pay. Thank you!

Pay Period - Week 1 Sunday through Saturday	**Pay Period - Week 2** Sunday through Saturday	**Pay Date** Friday
12/17/2023 to 12/23/2023	12/24/2023 to 12/30/2023	1/12/2024
12/31/2023 to 1/6/2024	1/7/2024 to 1/13/2024	1/26/2024
1/14/2024 to 1/20/2024	1/21/2024 to 1/27/2024	2/9/2024
1/28/2024 to 2/3/2024	2/4/2024 to 2/10/2024	2/23/2024
2/11/2024 to 2/17/2024	2/18/2024 to 2/24/2024	3/8/2024
2/25/2024 to 3/2/2024	3/3/2024 to 3/9/2024	3/22/2024
3/10/2024 to 3/16/2024	3/17/2024 to 3/23/2024	4/5/2024
3/24/2024 to 3/30/2024	3/31/2024 to 4/6/2024	4/19/2024
4/7/2024 to 4/13/2024	4/14/2024 to 4/20/2024	5/3/2024
4/21/2024 to 4/27/2024	4/28/2024 to 5/4/2024	5/17/2024
5/5/2024 to 5/11/2024	5/12/2024 to 5/18/2024	5/31/2024
5/19/2024 to 5/25/2024	5/26/2024 to 6/1/2024	6/14/2024
6/2/2024 to 6/8/2024	6/9/2024 to 6/15/2024	6/28/2024
6/16/2024 to 6/22/2024	6/23/2024 to 6/29/2024	7/12/2024
6/30/2024 to 7/6/2024	7/7/2024 to 7/13/2024	7/26/2024
7/14/2024 to 7/20/2024	7/21/2024 to 7/27/2024	8/9/2024
7/28/2024 to 8/3/2024	8/4/2024 to 8/10/2024	8/23/2024
8/11/2024 to 8/17/2024	8/18/2024 to 8/24/2024	9/6/2024
8/25/2024 to 8/31/2024	9/1/2024 to 9/7/2024	9/20/2024
9/8/2024 to 9/14/2024	9/15/2024 to 9/21/2024	10/4/2024
9/22/2024 to 9/28/2024	9/29/2024 to 10/5/2024	10/18/2024
10/6/2024 to 10/12/2024	10/13/2024 to 10/19/2024	11/1/2024
10/20/2024 to 10/26/2024	10/27/2024 to 11/2/2024	11/15/2024
11/3/2024 to 11/9/2024	11/10/2024 to 11/16/2024	11/27/2024 (Wed.)
11/17/2024 to 11/23/2024	11/24/2024 to 11/30/2024	12/13/2024
12/1/2024 to 12/7/2024	12/8/2024 to 12/14/2024	12/27/2024
12/15/2024 to 12/21/2024	12/22/2024 to 12/28/2024	1/10/2025

Consumer Direct Care Network Alaska
www.ConsumerDirectAK.com

Contact us at:
Local: 907-357-7962
Toll Free: 888-900-7962
Email: infoCDAK@consumerdirectcare.com

Submit timesheet documentation to:
Fax: 800-349-0704
Email: CDAKAdmin@consumerdirectcare.com

Work Opportunity Tax Credits - Consumer Direct Care Network

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

Applicant Instructions

- Open https://tcs.adp.com/consumerdirectcare or scan the QR code below.
  ***Note: If using a shared screening device, ensure the device does not have an autofill/auto complete function enabled*
- Please answer each question to complete the voluntary screening.
- Eligible applicants will be asked to **Electronically Sign and click Submit** to complete the screening.
- Ineligible applicants will be asked to click **Submit** to finish the screening. You will not be asked to electronically sign.

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

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

IVR CODE: 410849