Por favor tenga en cuenta que los costos de la verificación de antecedentes son pagados por Consumer Direct Care Network

CONSUMER DIRECT CARE NETWORK

Clear Form

FORMULARIO DE DATOS DE AYUDANTE

Información del Asistente

Nombre: _____ _____ _____
Primer nombre | Segundo nombre | Apellido

Dirección física: _____
Calle | N.º depto./unidad | Ciudad | Estado | C. P.

Dirección postal: _____
(si no es la dirección física) Calle/Apartado postal | N.º depto./unidad | Ciudad | Estado | C. P.

N.º telefónico: Casa ( ) _____ Celular ( ) _____

Correo electrónico: _____

Fecha de nacimiento: __/__/____ Número de Seguro Social: ____ - ____ - ____

Relaciones de empleo

Nombre del Empleador Registrado (EOR): _____

Nombre del Consumidor: _____

Relación del Asistente con el Consumidor: _____

Condado de residencia del Consumidor: _____

Edad del consumidor (marque uno): ☐ Adulto de 18 años o mayor ☐ Menor de 18 años

Nota: Si el consumidor es menor de edad, adjunte un formulario de divulgación de información del registro central de servicios de protección de menores para CDCN.

Por favor llene la documentación del ayudante que se adjunta. Estos formularios echarán a andar el proceso de empleo con el EOR que se indicó anteriormente. El EOR gestionará la atención al consumidor indicado arriba. **El EOR mencionado antes es el empleador. CDCN no es el empleador.**

Entiendo que no puedo trabajar con el consumidor sino hasta que el EOR me indique que puedo comenzar a trabajar. El EOR recibirá un formulario de Aprobado para trabajar de CDCN. El formulario de Aprobado para trabajar confirma que CDCN ha recibido toda la información necesaria para fines de empleo.

Firma del Asistente: _____ Fecha: _____

El Programa de Servicios Dirigidos al Consumidor no discrimina a ninguna persona por motivos de raza, religión, color, género, orientación sexual, edad, origen nacional, discapacidad, condición de veterano o cualquier otro estado o condición protegidos por ley.

CONSUMER DIRECT CARE NETWORK

LISTA DE VERIFICACIÓN DE INSCRIPCIÓN DE AYUDANTE

Nombre del ayudante	Nombre del empleador	Nombre del consumidor

Por favor llene todos los formularios que se enumeran en la lista que se encuentra a continuación. Si desea una copia en papel de los formularios enviados, notifíquenos y se las enviaremos. Los solicitantes para trabajar como ayudantes no pueden comenzar a trabajar sino hasta que:

- todos los formularios de empleo que se indican a continuación se hayan enviado a, y hayan sido aprobados por, Consumer Direct Care Network; y
- el empleador haya recibido un formulario de Aprobado para trabajar de CDCN. El formulario de Aprobado para trabajar indicará la fecha de inicio de empleo aprobada.

Formularios requeridos de todos los nuevos ayudantes (marque cada elemento tras completarlo):

1. ☐ Formulario de datos de ayudante
2. ☐ Lista de verificación de inscripción para ayudante (este formulario)
3. ☐ Divulgación de relación laboral
4. ☐ Verificación de elegibilidad para el empleo I-9 - *Puede encontrar instrucciones adicionales para la I-9 en el sitio web de CDCN Virginia bajo la pestaña Formularios*
5. ☐ Certificado de exención de retenciones W-4 del ayudante
6. ☐ Hoja de trabajo de exención personal VA-4 de Virginia
7. ☐ Formulario de selección de paga - *Es posible que se requiera de un archivo adjunto. Consulte las instrucciones del formulario*
8. ☐ Formulario de certificación de ayudante
9. ☐ Solicitud de consulta de nombre en el registro de antecedentes penales - *Requiere la firma de un notario público*
10. ☐ Formulario de divulgación de información del registro central de servicios de protección de menores - *De ser el caso. Únicamente es necesario si el receptor del servicio de Medicaid es menor de edad. Se requiere la firma de un notario público.*

CONSUMER DIRECT CARE NETWORK

INFORMACIÓN DE LA RELACIÓN EMPLEADO-EMPLEADOR

Nombre del Asistente	Nombre del Empleador Registrado (EOR)	Nombre del Consumidor

Antecedentes. Los empleados que brindan servicios domésticos como el cuidado personal pueden estar exentos de ciertos impuestos de nómina. Esto se basa en la edad del Asistente y su relación con el Empleador Registrado (EOR). Consumer Direct Care Network (CDCN) aplicará cualquier exención con base en las relaciones que se describen más adelante.

Los Asistentes que viven bajo el mismo techo que el Consumidor de Medicaid al que brindan servicio pueden estar exentos de los reglamentos federales de salario mínimo y horas extras.

Determinación de la relación

Instrucciones para el Asistente. ELIJA UNA DESCRIPCIÓN A CONTINUACIÓN. Marque el recuadro que mejor describe su relación con el EOR. Si es padre o madre del EOR, responda las preguntas adicionales.

☐ **Hijo(a) del EOR. Tengo menos de 21 años.** El EOR es mi padre o madre. Soy hijo(a) (incluidos los hijos adoptivos) del EOR. Además, tengo menos de 21 años.

☐ **Hijo(a) del EOR. Tengo 21 años o más.** El EOR es mi padre o madre. Soy hijo(a) (incluidos los hijos adoptivos) del EOR. Además, tengo 21 años o más.

☐ **Cónyuge del EOR.** El EOR es mi marido o mujer.

☐ **Padre o madre del EOR.** El EOR es mi hijo(a) (incluidos los hijos adoptivos). Responda las preguntas adicionales a continuación.

☐ Sí ☐ No El EOR (mi hijo[a]) tiene un hijo(a) o hijo(a) adoptivo(a) que vive en la casa.

☐ Sí ☐ No El EOR es una persona (1) viuda; (2) divorciada; o (3) casada y vive con su cónyuge, pero su cónyuge no puede cuidar del hijo(a) o hijo(a) adoptivo(a) debido a una afección mental o física. Su cónyuge no puede brindar cuidados por al menos 4 semanas seguidas en 3 meses.

☐ Sí ☐ No El hijo(a) o hijo(a) adoptivo(a) del EOR tiene menos de 18 años o necesita cuidado personal de un adulto. Se requieren cuidados por al menos 4 semanas seguidas en 3 meses debido a una afección mental o física.

☐ **Familiar no descrito anteriormente.** El EOR es mi tío(a), hermano(a), abuelo(a), nieto(a) u otro familiar que no se menciona específicamente arriba.

Describa la relación: _____.

☐ **Sin relación con el EOR.** No tengo relación por sangre, matrimonio ni adopción con el EOR.

CONSUMER DIRECT CARE NETWORK

INFORMACIÓN DE LA RELACIÓN EMPLEADO-EMPLEADOR

Notas importantes:

- Si el Asistente y el EOR reúnen los requisitos para las exenciones de impuestos, deben tomarlas. No es posible renunciar a las exenciones.
- Si los ingresos del Asistente están exentos de estos impuestos, puede que no sean elegibles para los beneficios relacionados. Un ejemplo es el seguro de desempleo.
- Las exenciones se basan en la relación entre el Asistente y el EOR. El Consumidor puede ser o puede no ser el EOR.

Determinación de hogar compartido por Asistente y Consumidor

Instrucciones para el Asistente. ¿Vive usted bajo el mismo techo que el Consumidor? Marque Sí o No a continuación.

☐ Sí ☐ No El Asistente reside en la misma residencia que el Consumidor.

Reconocimiento de la relación. El Asistente y el EOR afirman que las relaciones definidas anteriormente son correctas. Esto puede demostrar que el Asistente y el EOR están exentos de algunos impuestos. Podrá encontrar las explicaciones de las exenciones más adelante.

Si estas relaciones cambian, el Asistente debe avisar a CDCN dentro de un plazo de 5 días. Si no se avisa a CDCN de los cambios, es posible que el Asistente tenga que reembolsar dinero que no debería haberse incluido en el pago.

Firma del Asistente	*Fecha*	*Firma del Empleador Registrado*	*Fecha*

Explicación de las exenciones para los Asistentes

Relación con el titular del EIN (Empleador)	FICA	FUTA	SUTA
*Cónyuge	Exento	Exento	Exento
Padre o madre	**Exento ***Sujeto a impuesto	Exento	Exento
Padre o madre adoptivos	**Exento ***Sujeto a impuesto	Exento	Exento
Hijo(a) de 18 a 21 años	Exento	Exento	Exento
Hermano(a), abuelo(a), nieto(a), hijo(a) mayor de 21	Sujeto a impuesto	Sujeto a impuesto	Sujeto a impuesto
Sin relación familiar	Sujeto a impuesto	Sujeto a impuesto	Sujeto a impuesto

*Si el EOR también es el Consumidor de Medicaid, su cónyuge no puede ser su Asistente, conforme a las reglas del programa. De lo contrario, exento.

**Exento si respondió “No” a cualquiera de las 3 preguntas de la página 1 sobre el cuidado del hijo(a) del EOR.

***Sujeto a impuesto si respondió “Sí” a las 3 preguntas de la página 1 sobre el cuidado del hijo(a) del EOR.

10000

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

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

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

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

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

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

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

03149

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

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

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

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

Additional Information

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

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

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

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

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

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

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

00540

Form W-4 (2019)

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

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. You may claim exemption from withholding for 2019 if **both** of the following apply.

- For 2018 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2019 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2019 expires February 17, 2020. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2019 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at ***www.irs.gov/W4App*** to determine your tax withholding more accurately. Consider using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income not subject to withholding outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2019. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Filers with multiple jobs or working spouses. If you have more than one job at a time, or if you're married filing jointly and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

Nonwage income. If you have a large amount of nonwage income not subject to withholding, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Additional Income Worksheet on page 3 or the calculator at *www.irs.gov/W4App* to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at *www.irs.gov/W4App* to find out if you should adjust your withholding on Form W-4 or W-4P.

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

Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

Line C. ***Head of household please note:*** Generally, you may claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

Line E. Child tax credit. When you file your tax return, you may be eligible to claim a child tax credit for each of your eligible children. To qualify, the child must be under age 17 as of December 31, must be your dependent who lives with you for more than half the year, and must have a valid social security number. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

Line F. Credit for other dependents. When you file your tax return, you may be eligible to claim a credit for other dependents for whom a child tax credit can't be claimed, such as a qualifying child who doesn't meet the age or social security number requirement for the child tax credit, or a qualifying relative. To learn more about this credit, see Pub. 972. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total

---------- **Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records.** ----------

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

► **Whether you're entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2019

1 Your first name and middle initial	Last name	**2 Your social security number**
Home address (number and street or rural route)	**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married filing separately, check "Married, but withhold at higher Single rate."	
City or town, state, and ZIP code	**4 If your last name differs from that shown on your social security card, check here. You must call 800-772-1213 for a replacement card.** ► ☐	

5	Total number of allowances you're claiming (from the applicable worksheet on the following pages)	**5**	
6	Additional amount, if any, you want withheld from each paycheck	**6**	$
7	I claim exemption from withholding for 2019, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here . . . . . ►	**7**	

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

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

8 Employer's name and address (**Employer:** Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)	**9** First date of employment	**10** Employer identification number (EIN)

income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

Line G. Other credits. You may be able to reduce the tax withheld from your paycheck if you expect to claim other tax credits, such as tax credits for education (see Pub. 970). If you do so, your paycheck will be larger, but the amount of any refund that you receive when you file your tax return will be smaller. Follow the instructions for Worksheet 1-6 in Pub. 505 if you want to reduce your withholding to take these credits into account. Enter "-0-" on lines E and F if you use Worksheet 1-6.

Deductions, Adjustments, and Additional Income Worksheet

Complete this worksheet to determine if you're able to reduce the tax withheld from your paycheck to account for your itemized deductions and other adjustments to income, such as IRA contributions. If you do so, your refund at the end of the year will be smaller, but your paycheck will be larger. You're not required to complete this worksheet or reduce your withholding if you don't wish to do so.

You can also use this worksheet to figure out how much to increase the tax withheld from your paycheck if you have a large amount of nonwage income not subject to withholding, such as interest or dividends.

Another option is to take these items into account and make your withholding more accurate by using the calculator at *www.irs.gov/W4App*. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Two-Earners/Multiple Jobs Worksheet

Complete this worksheet if you have more than one job at a time or are married filing jointly and have a working spouse. If you don't complete this worksheet, you might have too little tax withheld. If so, you will owe tax when you file your tax return and might be subject to a penalty.

Figure the total number of allowances you're entitled to claim and any additional amount of tax to withhold on all jobs using worksheets from only one Form W-4. Claim all allowances on the W-4 that you or your spouse file for the highest paying job in your family and claim zero allowances on Forms W-4 filed for all other jobs. For example, if you earn $60,000 per year and your spouse earns $20,000, you should complete the worksheets to determine what to enter on lines 5 and 6 of your Form W-4, and your spouse should enter zero ("-0-") on lines 5 and 6 of his or her Form W-4. See Pub. 505 for details.

Another option is to use the calculator at *www.irs.gov/W4App* to make your withholding more accurate.

Tip: If you have a working spouse and your incomes are similar, you can check the "Married, but withhold at higher Single rate" box instead of using this worksheet. If you choose this option, then each spouse should fill out the Personal Allowances Worksheet and check the "Married, but withhold at higher Single rate" box on Form W-4, but only one spouse should claim any allowances for credits or fill out the Deductions, Adjustments, and Additional Income Worksheet.

Instructions for Employer

Employees, do not complete box 8, 9, or 10. Your employer will complete these boxes if necessary.

New hire reporting. Employers are required by law to report new employees to a designated State Directory of New Hires. Employers may use Form W-4, boxes 8, 9, and 10 to comply with the new hire reporting requirement for a newly hired employee. A newly hired employee is an employee who hasn't previously been employed by the employer, or who was previously employed by the employer but has been separated from such prior employment for at least 60 consecutive days. Employers should contact the appropriate State Directory of New Hires to find out how to submit a copy of the completed Form W-4. For information and links to each designated State Directory of New Hires (including for U.S. territories), go to ***www.acf.hhs.gov/css/employers.***

If an employer is sending a copy of Form W-4 to a designated State Directory of New Hires to comply with the new hire reporting requirement for a newly hired employee, complete boxes 8, 9, and 10 as follows.

Box 8. Enter the employer's name and address. If the employer is sending a copy of this form to a State Directory of New Hires, enter the address where child support agencies should send income withholding orders.

Box 9. If the employer is sending a copy of this form to a State Directory of New Hires, enter the employee's first date of employment, which is the date services for payment were first performed by the employee. If the employer rehired the employee after the employee had been separated from the employer's service for at least 60 days, enter the rehire date.

Box 10. Enter the employer's employer identification number (EIN).

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself	**A**	
B	Enter "1" if you will file as married filing jointly	**B**	
C	Enter "1" if you will file as head of household	**C**	
D	Enter "1" if: • You're single, or married filing separately, and have only one job; or • You're married filing jointly, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	**D**	
E	**Child tax credit.** See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $71,201 ($103,351 if married filing jointly), enter "4" for each eligible child. • If your total income will be from $71,201 to $179,050 ($103,351 to $345,850 if married filing jointly), enter "2" for each eligible child. • If your total income will be from $179,051 to $200,000 ($345,851 to $400,000 if married filing jointly), enter "1" for each eligible child. • If your total income will be higher than $200,000 ($400,000 if married filing jointly), enter "-0-"	**E**	
F	**Credit for other dependents.** See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $71,201 ($103,351 if married filing jointly), enter "1" for each eligible dependent. • If your total income will be from $71,201 to $179,050 ($103,351 to $345,850 if married filing jointly), enter "1" for every two dependents (for example, "-0-" for one dependent, "1" if you have two or three dependents, and "2" if you have four dependents). • If your total income will be higher than $179,050 ($345,850 if married filing jointly), enter "-0-"	**F**	
G	**Other credits.** If you have other credits, see Worksheet 1-6 of Pub. 505 and enter the amount from that worksheet here. If you use Worksheet 1-6, enter "-0-" on lines E and F	**G**	
H	Add lines A through G and enter the total here ►	**H**	

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, or if you have a large amount of nonwage income not subject to withholding and want to increase your withholding, see the **Deductions, Adjustments, and Additional Income Worksheet** below.
- If you **have more than one job at a time** or are **married filing jointly and you and your spouse both work,** and the combined earnings from all jobs exceed $53,000 ($24,450 if married filing jointly), see the **Two-Earners/Multiple Jobs Worksheet** on page 4 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 above.

Deductions, Adjustments, and Additional Income Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income not subject to withholding.

1	Enter an estimate of your 2019 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 10% of your income. See Pub. 505 for details	**1**	$
2	Enter: $24,400 if you're married filing jointly or qualifying widow(er); $18,350 if you're head of household; $12,200 if you're single or married filing separately	**2**	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	**3**	$
4	Enter an estimate of your 2019 adjustments to income, qualified business income deduction, and any additional standard deduction for age or blindness (see Pub. 505 for information about these items)	**4**	$
5	**Add** lines 3 and 4 and enter the total	**5**	$
6	Enter an estimate of your 2019 nonwage income not subject to withholding (such as dividends or interest)	**6**	$
7	**Subtract** line 6 from line 5. If zero, enter "-0-". If less than zero, enter the amount in parentheses	**7**	$
8	**Divide** the amount on line 7 by $4,200 and enter the result here. If a negative amount, enter in parentheses. Drop any fraction	**8**	
9	Enter the number from the **Personal Allowances Worksheet,** line H, above	**9**	
10	**Add** lines 8 and 9 and enter the total here. If zero or less, enter "-0-". If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 of that worksheet on page 4. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	**10**	

Two-Earners/Multiple Jobs Worksheet

Note: Use this worksheet *only* if the instructions under line H from the **Personal Allowances Worksheet** direct you here.

1 Enter the number from the **Personal Allowances Worksheet,** line H, page 3 (or, if you used the **Deductions, Adjustments, and Additional Income Worksheet** on page 3, the number from line 10 of that worksheet) . . . . . 1 _____

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you're married filing jointly and wages from the highest paying job are $75,000 or less and the combined wages for you and your spouse are $107,000 or less, don't enter more than "3" . . . . . 2 _____

3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet . . . . . 3 _____

Note: If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4 Enter the number from line 2 of this worksheet . . . . . 4 _____

5 Enter the number from line 1 of this worksheet . . . . . 5 _____

6 **Subtract** line 5 from line 4 . . . . . 6 _____

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . . . 7 $ _____

8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . . 8 $ _____

9 **Divide** line 8 by the number of pay periods remaining in 2019. For example, divide by 18 if you're paid every 2 weeks and you complete this form on a date in late April when there are 18 pay periods remaining in 2019. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck . . . . . 9 $ _____

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $5,000	0	$0 - $7,000	0
5,001 - 9,500	1	7,001 - 13,000	1
9,501 - 19,500	2	13,001 - 27,500	2
19,501 - 35,000	3	27,501 - 32,000	3
35,001 - 40,000	4	32,001 - 40,000	4
40,001 - 46,000	5	40,001 - 60,000	5
46,001 - 55,000	6	60,001 - 75,000	6
55,001 - 60,000	7	75,001 - 85,000	7
60,001 - 70,000	8	85,001 - 95,000	8
70,001 - 75,000	9	95,001 - 100,000	9
75,001 - 85,000	10	100,001 - 110,000	10
85,001 - 95,000	11	110,001 - 115,000	11
95,001 - 125,000	12	115,001 - 125,000	12
125,001 - 155,000	13	125,001 - 135,000	13
155,001 - 165,000	14	135,001 - 145,000	14
165,001 - 175,000	15	145,001 - 160,000	15
175,001 - 180,000	16	160,001 - 180,000	16
180,001 - 195,000	17	180,001 and over	17
195,001 - 205,000	18		
205,001 and over	19		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $24,900	$420	$0 - $7,200	$420
24,901 - 84,450	500	7,201 - 36,975	500
84,451 - 173,900	910	36,976 - 81,700	910
173,901 - 326,950	1,000	81,701 - 158,225	1,000
326,951 - 413,700	1,330	158,226 - 201,600	1,330
413,701 - 617,850	1,450	201,601 - 507,800	1,450
617,851 and over	1,540	507,801 and over	1,540

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 who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You aren't required to provide the information requested on a form that's 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.

00540

FORM VA-4

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF TAXATION
PERSONAL EXEMPTION WORKSHEET

(See back for instructions)

1. If you wish to claim yourself, write "1" ..... _____
2. If you are married and your spouse is not claimed on his or her own certificate, write "1" ..... _____
3. Write the number of dependents you will be allowed to claim on your income tax return (do not include your spouse) ..... _____
4. Subtotal Personal Exemptions (add lines 1 through 3) ..... _____
5. Exemptions for age
   - (a) If you will be 65 or older on January 1, write "1" ..... _____
   - (b) If you claimed an exemption on line 2 and your spouse will be 65 or older on January 1, write "1" ..... _____
6. Exemptions for blindness
   - (a) If you are legally blind, write "1" ..... _____
   - (b) If you claimed an exemption on line 2 and your spouse is legally blind, write "1" ..... _____
7. Subtotal exemptions for age and blindness (add lines 5 through 6) ..... _____
8. Total of Exemptions - add line 4 and line 7 ..... _____

Detach here and give the certificate to your employer. Keep the top portion for your records

FORM VA-4 EMPLOYEE'S VIRGINIA INCOME TAX WITHHOLDING EXEMPTION CERTIFICATE

Your Social Security Number	Name	
Street Address		
City	State	Zip Code

COMPLETE THE APPLICABLE LINES BELOW

1. If subject to withholding, enter the number of exemptions claimed on:
   - (a) Subtotal of Personal Exemptions - line 4 of the Personal Exemption Worksheet ..... _____
   - (b) Subtotal of Exemptions for Age and Blindness line 7 of the Personal Exemption Worksheet ..... _____
   - (c) Total Exemptions - line 8 of the Personal Exemption Worksheet ..... _____
2. Enter the amount of additional withholding requested (see instructions) ..... _____.___
3. I certify that I am not subject to Virginia withholding. I meet the conditions set forth in the instructions ..... (check here) ☐
4. I certify that I am not subject to Virginia withholding. I meet the conditions set forth Under the Service member Civil Relief Act, as amended by the Military Spouses Residency Relief Act ..... (check here) ☐

Signature Date

EMPLOYER: Keep exemption certificates with your records. If you believe the employee has claimed too many exemptions, notify the Department of Taxation, P.O. Box 1115, Richmond, Virginia 23218-1115, telephone (804) 367-8037. Note: Employers may establish a system to electronically receive Forms VA-4 from employees, provided the system meets Internal Revenue Service requirements as specified in § 31.3402(f)(5)-1(c) of the Treasury Regulations (26 CFR).

2601064 Rev. 08/11

09935

FORM VA-4 INSTRUCTIONS

Use this form to notify your employer whether you are subject to Virginia income tax withholding and how many exemptions you are allowed to claim. You must file this form with your employer when your employment begins. If you do not file this form, your employer must withhold Virginia income tax as if you had no exemptions.

PERSONAL EXEMPTION WORKSHEET

You may not claim more personal exemptions on form VA-4 than you are allowed to claim on your income tax return unless you have received written permission to do so from the Department of Taxation.

Line 1. You may claim an exemption for yourself.

Line 2. You may claim an exemption for your spouse if he or she is not already claimed on his or her own certificate.

Line 3. Enter the number of dependents you are allowed to claim on your income tax return.

NOTE: A spouse is not a dependent.

Line 5. If you will be age 65 or over by January 1, you may claim one exemption on Line 5(a). If you claim an exemption for your spouse on Line 2, and your spouse will also be age 65 or over by January 1, you may claim an additional exemption on Line 5(b).

Line 6. If you are legally blind, you may claim an exemption on Line 6(a). If you claimed an exemption for your spouse on Line 2, and your spouse is legally blind, you may claim an exemption on Line 6(b).

FORM VA-4

Be sure to enter your social security number, name and address in the spaces provided.

Line 1. If you are subject to withholding, enter the number of exemptions from:

(a) Subtotal of Personal Exemptions - line 4 of the Personal Exemption Worksheet

(b) Subtotal of Exemptions for Age and Blindness - line 7 of the Personal Exemption Worksheet

(c) Total Exemptions - line 8 of the Personal Exemption Worksheet

Line 2. If you wish to have additional tax withheld, and your employer has agreed to do so, enter the amount of additional tax on this line.

Line 3. If you are not subject to Virginia withholding, check the box on this line. You are not subject to withholding if you meet any one of the conditions listed below. Form VA-4 must be filed with your employer for each calendar year for which you claim exemption from Virginia withholding.

(a) You had no liability for Virginia income tax last year and you do not expect to have any liability for this year.

(b) You expect your Virginia adjusted gross income to be less than the amount shown below for your filing status:

	Taxable Years 2005, 2006 and 2007	Taxable Years 2008 and 2009	Taxable Years 2010 and 2011	Taxable Years 2012 and Beyond
Single	$7,000	$11,250	$11,650	$11,950
Married	$14,000	$22,500	$23,300	$23,900
Married, filing a separate return	$7,000	$11,250	$11,650	$11,950

(c) You live in Kentucky or the District of Columbia and commute on a daily basis to your place of employment in Virginia.

(d) You are a domiciliary or legal resident of Maryland, Pennsylvania or West Virginia whose only Virginia source income is from salaries and wages and such salaries and wages are subject to income taxation by your state of domicile.

Line 4. Under the Servicemember Civil Relief Act, as amended by the Military Spouses Residency Relief Act, you may be exempt from Virginia income tax on your wages if (i) your spouse is a member of the armed forces present in Virginia in compliance with military orders; (ii) you are present in Virginia solely to be with your spouse; and (iii) you maintain your domicile in another state. If you claim exemption under the SCRA check the box on Line 4 and attach a copy of your spousal military identification card to Form VA-4.

00540 - Delete

CONSUMER DIRECT CARE NETWORK

FORMULARIO DE SELECCIÓN DE PAGO

Nombre del Asistente:_____

(escriba en letra de imprenta)

Consumer Direct Care Network (CDCN) emite pagos por depósito directo a la cuenta bancaria del Asistente o una tarjeta de pago. Los depósitos directos evitan todos los retrasos posibles relacionados con el envío de correo, y eso ayuda a que usted pueda acceder a su dinero el día de pago. **Si no selecciona una opción de las que se encuentran a continuación, será inscrito automáticamente para la opción de US Bank.** Puede obtener un comprobante de pago (un resumen de su pago) en línea en nuestro portal de Internet seguro, DirectMyCare.com.

CDCN ofrece las siguientes opciones de pago. Elija una opción a continuación.

☐ **Depósito directo a una Tarjeta Focus de US Bank:** Autorizo a CDCN para que expida una Tarjeta Focus de US Bank a mi nombre, utilizando mi Número de Seguro Social y otros datos de identificación en mi expediente, y a iniciar depósitos de nómina a la cuenta de mi tarjeta. Debe recibir su tarjeta de débito en aproximadamente dos semanas.

☐ **Depósito directo a banco o cooperativa de crédito:** Autorizo a CDCN para que inicie depósitos de nómina a (nombre del banco o institución financiera): _____

Tipo de cuenta (marque una): ☐ Cheques ☐ Ahorro

Para cuentas de cheques:

Adjunte (pegue) un cheque cancelado aquí

No adjunte un comprobante de depósito.

Para cuentas de ahorro: proporcione un documento de su banco con los números exactos para procesar depósitos directos a su cuenta. Adjunte por separado si se trata de un cheque más grande del tamaño estándar. No adjunte una ficha de depósito. No cuenta con todos los números necesarios.

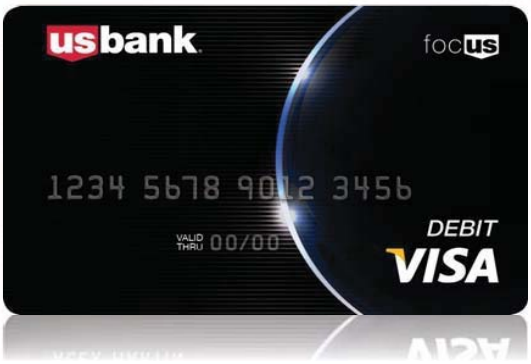
Autorizo a CDCN para que procese mi método de pago seleccionado como se indica más arriba. En caso de que se depositen fondos a mi cuenta por error, autorizo a CDCN para que retire dinero de mi cuenta para corregir el error. Es mi responsabilidad confirmar que se haya realizado cada depósito y pagar cualquier cargo ocasionado por sobregiros en mi cuenta. Los depósitos se harán cada día de pago, a menos que solicite a mi empleador, por escrito, la cancelación de los depósitos directos. Entiendo que CDCN se reserva el derecho de rechazar cualquier solicitud de depósito directo, que todos los depósitos directos se hacen a través de una Cámara de Compensación Autorizada (ACH) y que el procesamiento está sujeto a los términos y limitaciones de la ACH, así como los de mi institución financiera. Si la cuenta designada se cierra o no cuenta con saldo suficiente para hacer un retiro, autorizo a CDCN para que retenga cualquier pago que me deba hasta que se reembolsen las cantidades depositadas de forma incorrecta. **Entiendo que todavía puedo recibir un cheque de papel mientras se configura mi método de pago seleccionado.**

_____ _____

Firma *Fecha*

Su pago

MÁS RAPIDO, SEGURO Y FÁCIL.



Con la U.S. Bank Focus Card™ sus fondos:

Se cargan de inmediato a su tarjeta el día del pago | **Lista para usarse** de inmediato | **Protegida** en caso de pérdida o robo[1]

Acerca de la Focus Card

Es una tarjeta de débito prepagada Visa® , una alternativa conveniente a recibir cheques de papel. Sus pagos se depositarán automáticamente a su tarjeta en cada fecha de paga. Tendrá acceso a sus fondos de inmediato y podrá usarla para hacer compras u obtener efectivo donde sea que acepten tarjetas de débito Visa. ¡Así de fácil!

HAGA COMPRAS | RECARGUE | OBTENGA EFECTIVO PAGUE SERVICIOS | RASTREE SUS GASTOS

Comenzar es fácil.

1. Inscríbase hoy.
2. Su paga se depositará automáticamente a su tarjeta. Consulte su saldo en línea.
3. ¡Úsela en donde sea que acepten tarjetas de débito Visa!

¡Inscríbase!

$0.00 Inscríbase sin costo.

No necesita tarjeta de crédito ni cuenta de banco.[2]

¡Y ahorre!

Conserve más de su dinero. No hay honorarios por cobrar su cheque de paga.

No necesita esperar su cheque o ir varias veces al banco.

Para inscribirse, seleccione la opción de depósito directo en la US Bank Focus Card en su formulario de selección de pago de Consumer Direct Care Network.

CONSUMER DIRECT CARE NETWORK

[1] La política Visa Zero Liability lo protege de compras no autorizadas. Tarjetas emitidas en EE. UU. únicamente. No aplica a transacción en cajero o transacciones con PIN que no procese Visa. Debe denunciar de inmediato el uso no autorizado.

[2] Se requiere de verificación correcta de identidad. Para ayudar al gobierno a luchar contra el financiamiento del terrorismo y el lavado de dinero, las leyes federales requieren que todas las instituciones obtengan, verifiquen y registren información que identifique a cada persona que abra una cuenta. De ser necesario, podríamos pedir ver su licencia de conducir u otras identificaciones.

focus

Primeros pasos

Por seguridad, su tarjeta llegará en un sobre blanco sin marcar

Siga las instrucciones de activación que la acompañan.

Características

Recompensas de reembolsos
Por compras en ciertas restaurantes y comercios minoristas.

Cuenta de ahorro
Cree una cuenta de ahorro que genere intereses sin ir al banco.

Redes de recarga de efectivo[5]
Además de depósitos de nómina, hay una variedad de maneras de añadir efectivo a su cuenta de Focus Card.

Alertas por SMS y correo electrónico[4]
Notificación instantánea cuando se añade dinero o cuando su saldo sea bajo.

Aplicación de banca móvil[4]
Vea rápidamente el saldo de su cuenta y su historial de transacciones.

Rastree sus gastos
En línea | Teléfono | Email | SMS | App móvil

Tabla de tarifas

Actividad		Costo		
Mantenimiento mensual de cuenta		Sin costo		
Compras en punto de venta (nacional)		Sin costo		
Reembolsos con compras (nacional)		Sin costo		
Transacciones en cajero Dueño de cualquiera que no sea U.S. Bank o MoneyPass El cajero puede aplicar un sobrecargo adicional por cualquier transacción en cajero que complete.	Cajero U.S. Bank Cajero MoneyPass® Cajero Allpoint® Otro cajero internacional	Retiro de efectivo Sin costo Sin costo Sin costo $2.00 $3.00	Retiro declinado Sin costo Sin costo Sin costo $0.50 $0.50	Consulta de saldo Sin costo Sin costo Sin costo $1.00 $1.00
Retiro de efectivo en ventanilla		Sin costo		
Retiro de efectivo en ventanilla declinado		$0.00		
Servicio al cliente Servicio telefónico automatizado, Servicio en línea, Representante en vivo por teléfono		Sin costo		
Alertas por SMS o correo electrónico[4]		Sin costo		
Inactividad Tras 90 días consecutivos. No se aplica si el saldo es $0.00		$2.00 al mes		
Estado de cuenta mensual en papel		De solicitarse - $2.00		
Reemplazo de tarjeta No personalizada emitida por el empleador (si aplica a su programa) Personalizada		$5.00 Estándar $5.00; Entrega urgente $15.00; Día siguientes $25.00		
Cheques con cargo a su tarjeta CheckToday (si aplica a su programa)	Autorización de cheques Solicitud de cheques Devolución de cheques Detener pago Cheque perdido/robado Cheque cancelado Cheque anulado Copias de	Sin costo Sin costo; Entrega urgente $35.00 $25.00 $25.00 $25.00 Sin costo $25.00 $10.00		
Transacciones en el extranjero		Hasta 3% del monto de la transacción		

Límites de transacciones	Número	Cantidad
Saldo máximo en la tarjeta	N/D	$40,000
Compras (incluyendo reembolsos)	20 al día	$4,000 al día
Cargas de efectivo (si aplican a su programa)	3 al día	$950 al día
Retiros de efectivo en ventanilla	5 al día	$2,525 al día
Retiros del cajero automático	5 al día	$1,525 al día; máx. de $1,025 por transacción
Cargas o depósitos	10 al día	$20,000 al día
Devoluciones en punto de venta con firma	4 al día	N/D
Créditos pendientes de ACH	5 al día	$5,000 al día
Cargas de ACH	5 al día	$20,000 al día

Nos reservamos el derecho de cambiar la tabla de tarifas previa mediante una notificación por escrito para usted conforme a la legislación aplicable.

[4]US Bank no cobra tarifas por el uso de la banca móvil. Pueden aplicar tarifas estándar por mensajes de texto y datos a través de su proveedor de telefonía móvil.

[5]Las empresas que realicen la recarga podrían cobrar una cuota. Los servicios de recarga de efectivo son prestados por terceros independientes.

FORMULARIO DE CERTIFICACIÓN DE AYUDANTE

Nombre del ayudante _____ Nombre de empleador de registro (EOR) _____

Este acuerdo se redactó el _____ /_____/_____ (FECHA) entre el empleador de registro (EOR, por sus siglas en inglés) y el ayudante con el fin de establecer las responsabilidades que las partes tendrán la una con la otra. Las partes aceptan las siguientes políticas y procedimientos del programa de servicios dirigidos por el consumidor de Virginia.

Este acuerdo entrará en vigor una vez que lo firmen ambas partes. Ambas partes pueden rescindir el acuerdo. Se deberá dar previo aviso ya sea verbalmente o por escrito al EOR con al menos cinco (5) días de anticipación antes de la recisión. Cuando termine el empleo, el empleador deberá notificar a Consumer Direct Care Network Virginia a través de un aviso de empleo cesado relacionado con este ayudante.

Las partes aceptan acatar las políticas y procedimientos determinados por los programas de exención, Organización de Atención Administrada (MCO, por sus siglas en inglés) y el Departamento de Servicios de Asistencia y Servicios Médicos (DMAS, por sus siglas en inglés). El ayudante, el consumidor y el empleador de registro acuerdan eximir al programa de servicios dirigidos por el consumidor del Departamento de Servicios de Asistencia y Servicios Médicos de Virginia y a Consumer Direct Care Network Virginia de toda responsabilidad en cuanto a reclamaciones o daños que puedan surgir de cualquier acción u omisión del ayudante o el consumidor.

Reconocimiento – Reconozco lo siguiente:

- Soy un empleado del consumidor del programa o el empleador de registro del representante designado y no de CDCN o del Departamento de Servicios de Asistencia Médica de Virginia.
- Tengo al menos 18 años.
- Cuento con un número de Seguridad Social válido y tengo autorización para trabajar en los Estados Unidos.
- Declaro que soy un empleado que recibe pagos bajo un programa estatal de Servicios basados en el hogar y la comunidad de Medicaid.
- La tarifa por hora del ayudante es determinada por la Asamblea General de Virginia para servicios dirigidos por el consumidor con base en la dirección del Consumidor. Esta tarifa no es negociable.
- Como asistente, reconozco que mi empleo depende de la inscripción del consumidor en el programa de servicios dirigidos por el consumidor de Virginia. Cuando el consumidor cese de estar inscrito en el programa de servicios dirigidos por el consumidor, no podré seguir siendo empleado de dicho consumidor con cargo al programa de servicios dirigidos por el consumidor de Virginia.
- El acuerdo no garantiza al ayudante un número específico de horas de trabajo ni evita que el consumidor del programa o empleador de registro pueda contratar a otros asistentes bajo el programa de servicios dirigidos por el consumidor de Virginia.
- Este acuerdo no garantiza el empleo o el pago de salarios por cualquier periodo de tiempo.
- Este acuerdo no prohíbe que el asistente trabaje para más de un consumidor bajo el programa de servicios dirigidos por el consumidor de Virginia.

- Comprendo que la información compartida con el empleador de registro o el programa de servicios dirigidos por el consumidor de Virginia y agencias afiliadas relacionada con el consumidor del programa debe ser confidencial.
- El EOR acuerda proporcionar capacitación y dirección al ayudante para la prestación de servicios que forman parte del plan de atención del consumidor.
- Acepto cumplir con los deberes y responsabilidades asignadas que indique el consumidor/empleador de registro como se detallan en el plan de atención del consumidor.
- Comprendo que se espera que sea confiable y me presente a trabajar a tiempo.
- Acuerdo llamar al consumidor/empleador de registro con toda la anticipación posible si estoy enfermo o no podré presentarme a trabajar a tiempo.
- Acepto notificar al empleador de registro de forma verbal o por escrito con al menos cinco (5) días de anticipación en caso de que desee cesar este empleo.
- Comprendo que el consumidor/empleador de registro determinará las condiciones de empleo y que tiene la prerrogativa de cesar el empleo.

Verificaciones de antecedentes

- Entiendo y acepto someterme a una verificación obligatoria de antecedentes penales de la policía estatal de Virginia y a una revisión en los expedientes del registro central de servicios de protección de menores/Departamento de servicios sociales (según sea necesario) a través del Departamento de servicios sociales de Virginia antes del empleo. De igual forma, acepto que los resultados de la verificación de antecedentes pueden compartirse con el programa de servicios dirigidos por el consumidor de Virginia, el consumidor que recibirá los servicios o con el empleador de registros con quien trabajo. Reconozco que no se me pagará por servicios prestados luego de que se informe al EOR de un resultado no aprobatorio en las verificaciones. El Departamento de Servicios de Asistencia Médica será quien pague la verificación de antecedentes. El ayudante no pagará por la verificación de antecedentes.
- Comprendo que los resultados de mis verificaciones de antecedentes se pondrán a disposición de mi posible empleador y otros administradores del programa según se requiera.
- Comprendo que de no aprobar mi verificación de antecedentes penales por un delito inhabilitante en cualquier momento durante mi empleo en el programa de servicios dirigidos por el consumidor, no se me permitirá trabajar en el programa ni se me pagará a través de él.
- Comprendo que CDCN debe verificar que no aparezca en la Lista de Individuos/Entidades Excluidas (LEIE, por sus siglas en inglés) de la Oficina del Inspector General del Departamento de Salud y Servicios Humanos de los Estados Unidos. En caso de que aparezca en la lista, no se me permitirá trabajar en este programa ni recibir pagos a través del él.
- Comprendo que el empleador acepta emplearme de forma provisional por no más de 30 días a la espera de los resultados de una verificación de antecedentes penales, la verificación de maltrato y abandono de menores del registro central y la búsqueda en la base de datos LEIE.
- Comprendo que el Consumidor/Empleador de registro despedirá inmediatamente al Empleado si (1) se descubre que figuran en el Registro de Descalificación de Proveedores o una Lista que lleve la

Mancomunidad de Virginia; (2) haya cometido maltrato, abandono o uso indebido de fondos o pertenencias de un consumidor que reciba servicios, (3) haya cometido fraude o violado los términos de este Acuerdo o (4) no mantenga los requisitos de capacitación obligatoria.

Requisitos

- Comprendo que debo denunciar posible abandono, maltrato o uso indebido de fondos o pertenencias de un consumidor del programa al Departamento de Servicios Sociales.
- Comprendo y reconozco que los salarios provienen de fondos estatales y federales. Cualquier presentación falsa de servicios prestados con el fin de obtener un pago indebido será objeto de investigación como fraude de Medicaid. El fraude de Medicaid es un delito grave y puede generar multas considerables y condenas a prisión.
- Comprendo que se retendrán impuestos federales sobre la renta, así como Medicare, seguridad social e impuesto sobre la renta de Virginia (de ser el caso) de mis salarios conforme al formulario W-4 del IRS y el formulario VA-4 de Virginia. También comprendo que se podrían retener de mi paga embargos, órdenes de manutención, gravámenes y las cuotas de procesamiento asociadas.
- Comprendo que no se me podrá pagar con fondos de Medicaid si (1) el consumidor cesa de ser elegible para recibir servicios de Medicaid o (2) el ayudante realiza tareas no autorizadas o trabaja más horas de las aprobadas en el plan de servicio del consumidor.
- Entiendo que no se me pagará por servicios cuando el consumidor esté hospitalizado o por cualquier otro servicio que no se autorice específicamente en el plan de servicio del consumidor.
- Entiendo que no puedo recibir pago por servicios prestados si soy otro familiar/cuidador que vive en el mismo hogar a menos que exista documentación objetiva por escrito por parte del facilitador de servicios que explique por qué no está disponible otro asistente.
- Comprendo que el pago será por servicios prestados conforme lo asignado por el consumidor/empleador de registro y de acuerdo con lo que se detalla en el plan de servicio al consumidor en apego a las tarifas descritas en este documento.
- Comprendo que debo notificar a CDCN si hay cambios a mi dirección o información personal o si deseo cambiar mis preferencias de pago y retención de impuestos.
- Comprendo que no recibiré cobertura de seguro de indemnización laboral. (Bajo el Código de Virginia, Sección 65.2-100 Sección 2f, los empleados de servicio doméstico no son elegibles para seguro de indemnización laboral).

Hojas de asistencia y pagos

- Comprendemos que las hojas de asistencia deben completarse correctamente y tanto el empleador como el ayudante deben firmarlas. Las horas registradas en la hoja de asistencia no pueden superar el número autorizado de horas.
- Comprendo que CDCN me pagará en representación del consumidor de forma quincenal tras la presentación de hojas de asistencia precisas y aprobadas, así como documentación de servicio.
- Comprendemos que las hojas de asistencia deben enviarse a CDCN antes de las 5:00 p.m. hora del este el viernes siguiente al final del periodo de pago.

- Comprendemos que las hojas de asistencia que contengan errores se devolverán y no se emitirán cheques de paga sino hasta que las hojas de asistencia se corrijan y envíen nuevamente, tras lo cual el cheque se emitirá en el siguiente ciclo regular de nómina.
- Comprendemos que presentar documentación de inscripción incorrecta o faltante retrasará el pago y provocará que no se emita un cheque de paga.
- Comprendemos que todos los salarios aprobados por DMAS se pagan a través de una Transferencia Electrónica de Fondos (EFT, por sus siglas en inglés) de CDCN.
- Comprendemos que las hojas de asistencia y los cheques de paga son procesados por CDCN. CDCN únicamente es la Organización de Servicios de Administración Financiera (FMS, por sus siglas en inglés) y no podrá pagar ningún servicio que no sea autorizado por DMAS, el MCO o el contratista de autorización de servicio; por cualquier servicio prestado durante periodos de inelegibilidad para Medicaid o para una exención; ni por cualquier solicitud que exceda la autorización de servicio del consumidor.
- Comprendemos que no se pagará al ayudante bajo el programa de servicios dirigidos por el consumidor por cualquier trabajo realizado que supere el monto autorizado por DMAS o el MCO o realizado para un consumidor que no esté aprobado para una exención de atención a largo plazo para servicios dirigidos por el consumidor. En este caso, el ayudante deberá buscar pago directamente con el empleador. Esto incluye casos en los que un consumidor sea hospitalizado o se encuentre en un asilo u otra institución.
- Comprendemos que es necesario enviar las hojas de asistencia en un plazo de 12 meses a partir de la fecha del servicio para que estas puedan pagarse. Cualquier hoja de asistencia que se envíe después de este plazo no se pagará. Asimismo, si alguna hoja de asistencia se envía incorrectamente y no se paga en un plazo de un año tras el servicio debido a un dictamen pendiente, dicha hoja de asistencia no se pagará. Para poder pagarse, el dictamen pendiente debe resolverse en menos de un año a partir de la fecha límite de presentación.
- Comprendemos que los pagos son autorizados por el Departamento de Servicios de Asistencia Médica de la Mancomunidad de Virginia y el Plan de Medicare Medicaid. El ayudante únicamente trabajará dentro de los horarios autorizados de servicio del plan de atención y no será remunerado por la Mancomunidad de Virginia, el Departamento de Servicios de Asistencia Médica o el plan Medicare Medicaid. Los horarios autorizados son aprobados para el consumidor antes de que el ayudante comience a prestar servicios.

Certificación

Al firmar a continuación, mi empleador de registro y yo certificamos que hemos leído y comprendemos todas las reglas y responsabilidades del programa. Comprendo que debo firmar y devolver este formulario como condición del empleo en este programa. Asimismo, al firmar a continuación certifico que comprendo lo que se solicita de mí y acepto acatar estos términos y condiciones. Adicionalmente, comprendo y acepto que la violación de cualquier término o condición puede llevar a la recisión de este acuerdo.

Autorizo al empleador de registro y al programa de servicios dirigidos por el consumidor de Virginia proceder con todas las verificaciones de antecedentes penales y registros que requieren las leyes

estatales y federales. Esta información no puede divulgarse con cualquier otro fin sin mi permiso por escrito.

El empleador de registro comprende que es su responsabilidad completar debidamente el formulario I-9 de USCIS, como se define en las instrucciones para la verificación de elegibilidad de empleados del Departamento de Seguridad Interior. CDCN proporcionará el formulario I-9 en los paquetes de empleo y el empleador de registro retendrá el formulario I-9 original y reenviará una copia completada a CDCN, la cual CDCN retendrá en sus expedientes de empleados.

Empleador de registro, Nombre	*Firma*	Fecha
Ayudante, Nombre	*Firma*	Fecha

SP-167 (Revised 12-01-2012)

CRIMINAL HISTORY RECORD NAME SEARCH REQUEST

PURPOSE OF THIS REQUEST (Check only one):

☐ DOMESTIC ADOPTION ☐ INTERNATIONAL ADOPTION _____ COUNTRY

☐ VISA (INTERNATIONAL TRAVEL) ☑ OTHER (please specify) Employment Screening

NAME INFORMATION TO BE SEARCHED:

LAST NAME FIRST NAME MIDDLE NAME MAIDEN NAME

RACE	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER
		/ / (MM/DD/YYYY)	

AFFIDAVIT FOR RELEASE OF INFORMATION:

I hereby give consent and authorize the Virginia State Police to search the files of the Central Criminal Records Exchange for a criminal history record and report the results of such search to the agent or individual authorized in this document to receive same.

_____
Signature

State of _____ ☐ County ☐ City of _____ ; to wit: Subscribed and sworn to before me on: _____ (MM/DD/YYYY)

_____ My commission expires: _____ My registration # is: _____
Signature of Notary Public

SIGNATURE OF PERSON MAKING REQUEST:

As provided in Section 19.2-389, Code of Virginia, I hereby request the criminal history record of the individual named above and swear or affirm I have the consent of the individual to obtain their record and will not further disseminate the information received, except as provided by law.

_____
Signature of Individual Making Request

State of _____ ☐ County ☐ City of _____ ; to wit: Subscribed and sworn to before me on: _____ (MM/DD/YYYY)

_____ My commission expires: _____ My registration # is: _____
Signature of Notary Public

NAME AND MAILING ADDRESS OF AGENCY, INDIVIDUAL OR AUTHORIZED AGENT MAKING REQUEST:

Mail Reply To:

NAME
Consumer Direct Care Network Virginia, LLC

ATTENTION
Virginia Consumer-Directed Services Program

ADDRESS
2112 W. Laburnum Ave Suite #112

CITY Richmond STATE VA ZIP CODE 23227

FEES FOR SERVICE:

☑ $15.00 CRIMINAL HISTORY SEARCH
☐ $20.00 COMBINATION CRIMINAL HISTORY & SEX OFFENDER SEARCH

* FEES For Volunteers with Non-Profit Organizations:
☐ $8.00 CRIMINAL HISTORY SEARCH
☐ $16.00 COMBINATION CRIMINAL HISTORY & SEX OFFENDER SEARCH

* To be entitled to reduced price, services must be on volunteer basis for a non-profit organization with a tax exempt number. Attach documentation to form which supports volunteer status and include organization's name, address, and the tax exempt identification number.

METHOD OF PAYMENT: (Note: Personal Checks Not Accepted)

☐ Business or Certified check or Money order (payable to Virginia State Police)

CHARGE CARD: ☐ MasterCard OR ☐ Visa

Account Number: - - - Expiration: /

Signature of Cardholder: _____

☐ Virginia State Police Charge Account Number: _____

Mail Request To:

Virginia State Police
Central Criminal Records Exchange – NF
P. O. Box 85076
Richmond, Virginia 23261-5076

ATTN: NEW FORM

FOR STATE POLICE USE ONLY – DO NOT WRITE BELOW THIS LINE

Response based on comparison of name information submitted in request against a master name index maintained in the Central Criminal Records Exchange only.

☐ No Conviction Data – Does Not Preclude the Existence of an Arrest Record
☐ No Criminal Record – Name Search Only ☐ No Criminal Record – Fingerprint Search
☐ No Sex Offender Registration Record ☐ Criminal Record Attached

Date: _____ By CCRE/ _____

Purpose code: ☐ C ☐ N ☐ O

CRIMINAL HISTORY RECORD NAME SEARCH REQUEST

INSTRUCTIONS FOR COMPLETING THE CRIMINAL HISTORY REQUEST FORM

Pay By: Certified Check/Money Order or Business check made payable to "Virginia State Police"
OR we accept VISA and MasterCard
Personal Checks Not Accepted

Effective November 1, 2010, the public is hereby placed upon notice that returned checks or dishonored money orders and/or credit card payment denials will incur a handling fee of $50 in addition to the amount of the original payment. Requesting goods or services will be deemed to be acceptance of these terms. Code of Virginia §2.2-4805.

Discard these Instructions Prior to Submitting to State Police

Refer to Page 2 of these Form Instructions for Pricing Structure and Types of Name Searches Available

If you are interested in obtaining a name search of the "Sex Offender and Crimes Against Minors Registry," refer to the instructions on page 2 of this form.

The Form Must be **TYPED OR NEATLY HAND-PRINTED**.
Complete the Criminal History Record Request by following these instructions:
***

PURPOSE OF THIS REQUEST:	Primary reason for request.
NAME INFORMATION TO BE SEARCHED:	Name, race, sex, date of birth, and social security number on whom the criminal record name search is to be conducted. Providing the social security number is voluntary; however, it is a screening tool that is used for this request to be processed in a more timely manner. Failure to provide this number may result in an inability to process this request due to multiple records with similar names and demographics. Without this additional identifier, the form may be returned to the requestor unprocessed, and the applicant will be required to submit a set of fingerprints along with this request form to determine if this applicant has a criminal record. Social Security Numbers provided will be used to help identify the proper record and will be used for no other purpose.
AFFIDAVIT FOR RELEASE OF INFORMATION:	Individual's signature on which the search is to be conducted. The signature indicating consent must be notarized for the search to be conducted and mailed to the individual or authorized agent (if applicable).
SIGNATURE OF PERSON MAKING REQUEST:	Affidavit must be signed by authorized agent and notarized to receive the search results.
NAME AND MAILING ADDRESS OF AGENCY, INDIVIDUAL OR AGENT MAKING REQUEST:	Name and complete mailing address of the individual, agency or authorized agent to receive processed criminal record search must be completed.
FEES FOR SERVICE:	Indicate fee that is submitted, based upon type of request. Fees for volunteer of non-profit organizations must be accompanied with their tax exempt number.
METHOD OF PAYMENT:	Indicate method of payment

Mail the Completed SP-167 "Criminal History Record Request" to:

Virginia State Police
Central Criminal Records Exchange – NF
P.O. Box 85076
Richmond, Virginia 23261-5076

VA Department of Social Services
Office of Background Investigations – Search Unit
801 East Main Street, 6th Floor, Richmond, VA 23219-2901

Central Registry Release of Information Form

Search Fee $10.00

INSTRUCTIONS

Purpose

The Virginia Child Abuse and Neglect Central Registry is mandated by the Virginia Child Protective Law and contains the names of individuals identified as an abuser or neglector in founded child abuse and/or neglect investigations conducted in the state of Virginia. The findings are made by Child Protective Services staff in local departments of social services and are maintained by the Virginia Department of Social Services. Legal mandates for the Virginia Department of Social Services to provide a Central Registry and a mechanism for conducting searches of the registry are found in § 63.2-1515 of the Code Virginia.

Read all instructions before completing the form: (Incomplete forms will be returned)

1. Answer all questions completely and accurately by printing clearly in black ink or typing your answers. Failure to complete or print clearly may delay or deny your request. Given the nature of the form and the actions to be taken when received, the **Office of Background Investigations shall not accept forms that have been altered in any fashion.** Forms that contain strike outs, correction tape or white-out will be returned.
2. If a middle name is an initial, indicate “initial only” otherwise, enter a full middle name given at birth.
3. For “other names used” list all previous names; nick names, all previous married names, legal name changes, changes due to adoption, etc. Circle appropriate title description on the form.
4. If the answer to any question is none, write “N/A“.
5. Sign the Central Registry Release of Information Form in the presence of an official Notary Public. Each request form must be notarized. Only original signatures will be accepted. No copies of the form will be accepted.
6. A $10.00 fee is charged for each search. Payment must accompany search forms. Only money orders, company/business checks, or cashier checks will be accepted. (If multiple requests are mailed together, payment may be combined on in one money order, company/business check, or cashier’s check. (ex. 4 requests at $10.00 each will total $40.00). A $50 fee will be charged for all returned checks.)

   All money orders, company/business checks, or cashier checks should be made payable to: Virginia Department of Social Services.

   Personal checks and cash will not be accepted.
7. For agencies and facilities that require several searches per year, an agency code will be assigned to expedite processing of the search requests.
8. If additional space is needed to complete the form (ie. providing information on addresses, spouses, and children) attach an 8x11 sheet sheet of paper along with your form to be mailed.
9. Search results are not transferable and are not considered official beyond the requesting agency or individual.
10. Mail your completed form and additional sheets (if used) to:

    Virginia Department of Social Services
    Office of Background Investigations - Search Unit
    801 East Main Street, 6th Floor
    Richmond, VA 23219-2901

VA Department of Social Services
Office of Background Investigations – Search Unit
801 East Main Street, 6th Floor, Richmond, VA 23219-2901

Central Registry Release of Information Form

Search Fee $10.00

Purpose of Search, Check one: ☐ Adam Walsh Law ☐ Adoptive Parent ☐ Babysitter/Family Day Care ☐ CASA ☐ Children's Residential Facility ☐ Custody Evaluation ☐ Day Care Center ☐ Foster Parent ☐ Institutional Employee ☑ Other Employment ☐ School Personnel ☐ Volunteer ☐ Other

MAIL SEARCH RESULTS TO: Agency, Individual or Authorized Agent Requesting Search

Name	Consumer Direct Care Network Virginia, LLC
Address	2112 W. Laburnum Ave Suite 112
City	Richmond **State** VA **Zip** 23227
Contact Name	CDCN Representative **Tel.#** 888-444-8182 **Ext**
Contact E-Mail	InfoCDVA@ConsumerDirectCare.com

Payment/FIPS Code
(Use only if assigned by OBI-CRU)

B11226

Mandatory if agency code has been assigned

PART I: DETAILS OF INDIVIDUAL WHOSE NAME MUST BE SEARCHED

Last Name	First Name	Full Middle Name – (given at birth) - **No initials** (if middle name is an initial, indicate "Initial Only")

Maiden Name (last name before marriage)	Sex	Date of Birth **(MM/DD/YYYY)**	Race
	☐ Male ☐ Female	/ /	

Driver's License Number or ID #	Social Security Number	Other names used; nicknames, legal names (refer to instruction page)

Current Address (Include Street # and Apt #)	City	State	Zip

Applicant's Prior Addresses

Include Street # and Apt #	City	State	Zip	Start Date **(MM/YY)**	End Date **(MM/YY)**

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner

If married, list current spouse. If previously married, list all previous spouses. If you have never been married, write 'N/A'.

Last Name	First Name	Full Middle Name (given at birth)	Maiden Name	Race	Sex	Date of Birth **(MM/DD/YYYY)**
					☐ Male ☐ Female	
					☐ Male ☐ Female	
					☐ Male ☐ Female	

List all of your children. If you have none, write **'N/A'.** Include all adult children, step and foster children not living with you.

Last Name	First Name	Full Middle Name (given at birth)	Relationship	Sex	Date of Birth **(MM/DD/YYYY)**
				☐ Male ☐ Female	
				☐ Male ☐ Female	
				☐ Male ☐ Female	

VA Department of Social Services
Office of Background Investigations – Search Unit
801 East Main Street, 6th Floor, Richmond, VA 23219-2901

Central Registry Release of Information Form

Search Fee $10.00

PART II: CERTIFICATION AND CONSENT FOR RELEASE OF INFORMATION

I hereby certify that the information contained on this form is true, correct and complete to the best of my knowledge. Pursuant to Section 2.2-3806 of the *Code of Virginia*, I authorize the release of personal information regarding me which has been maintained by either the Virginia Department of Social Services or any local department of social services which is related to any disposition of founded child abuse/neglect in which I am identified as responsible for such abuse/neglect. I have provided proof of my identity to the Notary Public prior to signing this in his/her presence.

_____ _____

Signature of person whose name is being searched (Sign in presence of Notary)

Parent or Guardian signature required for minor children under the age of 18

PART III: CERTIFICATE OF ACKNOWLEDGEMENT OF INDIVIDUAL

City/County of _____

Commonwealth/State of _____

Acknowledged before me this _____ day of _____, year_____

_____ _____

Notary Public Signature **Notary Number**

My Commission Expires: _____ Notary Seal

PART IV: CENTRAL REGISTRY FINDINGS – COMPLETED BY CENTRAL REGISTRY STAFF ONLY

1. We are unable to determine at this time if the individual for whom a search has been requested is listed in the Central Registry. Please answer the following questions and return to the Central Registry Unit in order for us to make a determination:

_____

_____

_____

_____

_____

Worker: _____ Date: _____

2. _____ Based on information provided by the Local Department of Social Services, we have determined that

_____ is listed in the Child Abuse/Neglect Central Registry with a founded disposition of child abuse/neglect. For more detailed information, contact the

_____ Dept. of Social Services in reference to referral _____ phone#_____

_____ Dept. of Social Services in reference to referral _____ phone#_____

3. _____ As of this date, based on the information provided, the individual whose name was being searched is **NOT** identified in the Central Registry of Child Abuse/Neglect.

Signature of worker completing search: _____ Date: _____

OBI Staff Only

CONSUMER DIRECT CARE NETWORK

Calendario de nómina 2019

Clave de símbolos: ▭ Entrega de hojas ◯ Día de paga △ Asuetos bancarios y postales

ENERO

Dom	Lun	Mar	Mié	Jue	Vie	Sáb
		△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		

FEBRERO

Dom	Lun	Mar	Mié	Jue	Vie	Sáb
					▭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		

MARZO

Dom	Lun	Mar	Mié	Jue	Vie	Sáb
					▭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						

ABRIL

Dom	Lun	Mar	Mié	Jue	Vie	Sáb
	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				

MAYO

Dom	Lun	Mar	Mié	Jue	Vie	Sáb
			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	

JUNIO

Dom	Lun	Mar	Mié	Jue	Vie	Sáb
						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						

JULIO

Dom	Lun	Mar	Mié	Jue	Vie	Sáb
	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			

AGOSTO

Dom	Lun	Mar	Mié	Jue	Vie	Sáb
				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

SEPTIEMBRE

Dom	Lun	Mar	Mié	Jue	Vie	Sáb
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					

OCTUBRE

Dom	Lun	Mar	Mié	Jue	Vie	Sáb
		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		

NOVIEMBRE

Dom	Lun	Mar	Mié	Jue	Vie	Sáb
					◯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

DICIEMBRE

Dom	Lun	Mar	Mié	Jue	Vie	Sáb
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				

Asuetos bancarios y de las oficinas postales en 2019

- ***Día de Año Nuevo -** Martes 1 de Enero
- ***Día de Martin Luther King, Jr. -** Lunes 21 de Enero
- **Día de los Presidentes -** Lunes 18 de Febrero
- ***Día de los Caídos -** Lunes 27 de Mayo
- ***Día de la Independencia -** Jueves 4 de Julio
- ***Día del Trabajo -** Lunes 2 de Septiembre
- **Día de Colón -** Lunes 14 de Octubre
- **Día de los Veteranos -** Lunes 11 de Noviembre
- ***Día de Acción de Gracias -** Jueves 28 de Noviembre
- ***Día de Navidad -** Miércoles 25 de Diciembre

*Asuetos y cierre de oficinas de Consumer Direct Care Network

CONSUMER DIRECT CARE NETWORK

Los periodos de paga de dos semanas van de jueves a miércoles. Las hojas de asistencia deben presentarse no más de 2 días después de la fecha de finalización del periodo de paga, el viernes antes de la MEDIANOCHE. Las hojas de asistencia atrasadas o que contengan errores pueden causar retrasos en el pago.

Periodo de paga de dos semanas		Fecha de entrega de la hoja de asistencia	Fecha de pago
Fecha de inicio	Fecha de finalización		
Jueves	Miércoles	Viernes	Viernes
12/20/2018	1/2/2019	1/4/2019	1/11/2019
1/3/2019	1/16/2019	1/18/2019	1/25/2019
1/17/2019	1/30/2019	2/1/2019	2/8/2019
1/31/2019	2/13/2019	2/15/2019	2/22/2019
2/14/2019	2/27/2019	3/1/2019	3/8/2019
2/28/2019	3/13/2019	3/15/2019	3/22/2019
3/14/2019	3/27/2019	3/29/2019	4/5/2019
3/28/2019	4/10/2019	4/12/2019	4/19/2019
4/11/2019	4/24/2019	4/26/2019	5/3/2019
4/25/2019	5/8/2019	5/10/2019	5/17/2019
5/9/2019	5/22/2019	5/24/2019	5/31/2019
5/23/2019	6/5/2019	6/7/2019	6/14/2019
6/6/2019	6/19/2019	6/21/2019	6/28/2019
6/20/2019	7/3/2019	7/5/2019	7/12/2019
7/4/2019	7/17/2019	7/19/2019	7/26/2019
7/18/2019	7/31/2019	8/2/2019	8/9/2019
8/1/2019	8/14/2019	8/16/2019	8/23/2019
8/15/2019	8/28/2019	8/30/2019	9/6/2019
8/29/2019	9/11/2019	9/13/2019	9/20/2019
9/12/2019	9/25/2019	9/27/2019	10/4/2019
9/26/2019	10/9/2019	10/11/2019	10/18/2019
10/10/2019	10/23/2019	10/25/2019	11/1/2019
10/24/2019	11/6/2019	11/8/2019	11/15/2019
11/7/2019	11/20/2019	11/22/2019	11/29/2019
11/21/2019	12/4/2019	12/6/2019	12/13/2019
12/5/2019	12/18/2019	12/20/2019	12/27/2019
12/19/2019	1/1/2020	1/3/2020	1/10/2020

Días de paga marcados con círculos - se pagará un periodo de paga que incluye el primer día del mes. Si el empleador es responsable del reembolso de paga del paciente al empleado, debe pagarlo en esta fecha.

CDVATimesheets@ConsumerDirectCare.com

Consumer Direct Care Network Virginia
2112 W. Laburnum Avenue, Suite 112
Richmond, VA 23227-4358

Teléfono: 888-444-8182
Fax: 877-861-4523
www.ConsumerDirectVA.com