Please note background check(s) costs are paid by Consumer Direct Care Network.

Clear Form

CONSUMER DIRECT CARE NETWORK

ATTENDANT DATA FORM

Attendant Information

Name: _____ _____ _____
First Middle Last

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

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

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

Email: _____

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

Employment Relationships

Name of Employer of Record (EOR): _____

Name of Consumer: _____

Attendant's Relationship to Consumer: _____

County of Residence of Consumer: _____

Age of Consumer (check one): ☐ Adult 18 years old or older ☐ Minor under age 18

Note: If the Consumer is a minor, submit a Child Protective Services Central Registry Release of Information Form to CDCN.

Please fill out the attached attendant paperwork. These forms will start the employment process with the EOR named above. The EOR will manage the care of the Consumer named above. **The EOR listed above is the employer. CDCN is not the employer.**

I understand I cannot work with the Consumer until the EOR tells me that I can begin work. The EOR will receive an Okay to Work form from CDCN. The Okay to Work form confirms that CDCN has received all needed information for employment purposes.

Signature of Attendant: _____ Date: _____

The Consumer-Directed Services Program does not discriminate against any person on the basis of race, religion, color, gender, sexual orientation, age, national origin, disability, veteran status or any other status or condition protected by law.

CONSUMER DIRECT CARE NETWORK

ATTENDANT ENROLLMENT CHECKLIST

Attendant Name	Employer Name	Consumer Name

Please complete all the forms in the list below. If you would like a paper copy of submitted forms, please let us know and we will send copies to you. Attendant applicants may not begin work until:

- all employment forms listed below have been submitted to, and approved by, Consumer Direct Care Network (CDCN); and
- the Employer has received an Okay to Work form from CDCN. The Okay to Work form will state the approved employment start date.

Forms required for all new Attendants (please check each item as they are completed):

1. ☐ Attendant Data Form
2. ☐ Attendant Enrollment Checklist (this form)
3. ☐ Employment Relationship Disclosure
4. ☐ I-9 Employment Eligibility Verification - *Additional I-9 instructions are available on the CDCN Virginia website under the Forms tab*
5. ☐ W-4 Attendant's Withholding Allowance Certificate
6. ☐ VA-4 Virginia Personal Exemption Worksheet
7. ☐ Pay Selection Form – *Attachment may be required, see form instructions*
8. ☐ Attendant Attestation Form
9. ☐ Criminal History Record Name Search Request – *Requires signature of Notary Public*
10. ☐ Child Protective Services Central Registry Release of Information Form – *If applicable. Only required if the Medicaid service recipient is a minor. Requires signature of Notary Public.*

CONSUMER DIRECT CARE NETWORK

EMPLOYEE-EMPLOYER RELATIONSHIP DISCLOSURE

Attendant Name	Employer of Record (EOR) Name	Consumer Name

Background. Employees providing domestic services such as personal care may be exempt from some payroll taxes. This is based on the Attendant's age and relationship to the Employer of Record (EOR). Consumer Direct Care Network (CDCN) will apply any exemptions based on the relationships identified below.

Attendants that live under the same roof as the Medicaid Consumer they provide service to may be exempt from federal minimum wage and overtime regulations.

Relationship Determination

Instructions to Attendant. CHOOSE ONE DESCRIPTION BELOW. Check the box that best describes your relationship to the EOR. If you are the EOR's parent, answer the additional questions.

☐ **Child of EOR. I am less than 21 years old**. The EOR is my parent. I am the child (including adoptive child) of the EOR. I am also less than 21 years old.

☐ **Child of EOR. I am 21 years old or older**. The EOR is my parent. I am the child (including adoptive child) of the EOR. I am also 21 years old or older.

☐ **Spouse of EOR**. The EOR is my husband or wife.

☐ **Parent of EOR.** The EOR is my son or daughter (including adoptive child). Please answer additional questions below.

☐ Yes ☐ No The EOR (my son or daughter) has a child or step child that lives in the home.

☐ Yes ☐ No The EOR is (1) a widow or widower; (2) divorced; or (3) married and lives with a spouse but the spouse can't care for their child or step child due to a mental or physical condition. The spouse is unable to provide care for at least 4 straight weeks in 3 months.

☐ Yes ☐ No The EOR's child or stepchild is less than 18 years old or needs personal care from an adult. Care is needed for at least 4 straight weeks in 3 months due to a mental or physical condition.

☐ **Relative not described above.** The EOR is my aunt, uncle, sibling, grandparent, grandchild or other relative not specifically listed above.

Please describe the relationship: _____.

☐ **Not related to the EOR**. I am not related by blood, marriage or adoption to the EOR.

CONSUMER DIRECT CARE NETWORK

EMPLOYEE-EMPLOYER RELATIONSHIP DISCLOSURE

Important Notes:

- If the Attendant and EOR qualify for tax exemptions, they must be taken. Exemptions cannot be waived.
- If the Attendant's earnings are exempt from these taxes, they may not qualify for related benefits. An example is unemployment insurance.
- Exemptions are based on the relationship between the attendant and EOR. The Consumer may or may not be the EOR.

Attendant-Consumer Live-in Determination

Instructions to the Attendant. Do you live under the same roof as the Consumer? Check Yes or No below.

☐ Yes ☐ No The Attendant resides at the same residence as the Consumer.

Relationship Acknowledgment. The Attendant and EOR attest the relationships defined above are accurate. This may show that the Attendant and EOR are exempt from some taxes. Explanations of exemptions are provided below.

If these relationship change, the Attendant must notify CDCN within 5 days. If CDCN is not notified of changes, the Attendant may have to pay back money that should have been withheld from pay.

Attendant Signature	*Date*	*Employer of Record Signature*	*Date*

Explanation of Attendant Exemptions

Relationship to EIN Holder (Employer)	FICA	FUTA	SUTA
*Spouse	Exempt	Exempt	Exempt
Parent	**Exempt ***Subject to Tax	Exempt	Exempt
Adoptive or Step Parent	**Exempt ***Subject to Tax	Exempt	Exempt
Child age 18-21	Exempt	Exempt	Exempt
Sibling, Grandparent, Grandchild, Child over age 21	Subject to Tax	Subject to Tax	Subject to Tax
No Relationship	Subject to Tax	Subject to Tax	Subject to Tax

*If the EOR is also the Medicaid Consumer, their spouse is not permitted to be their attendant by program rule. Otherwise exempt.

**Exempt if answered "No" to any of the 3 questions on page 1 regarding care for the EOR's child.

***Subject to Tax if answered "Yes" to all 3 questions on page 1 regarding care for the EOR's child.

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

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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

PAY SELECTION FORM

Attendant Name: _____
(please print)

Consumer Direct Care Network (CDCN) issues pay via direct deposit to the Attendant's bank account or a pay card. Direct deposits avoid all possible delays associated with delivery of mail - and that helps you access your pay on pay day. **If you do not select an option below, you will be automatically enrolled in the US Bank option.** Pay stubs (a summary of your pay) are available online through our secure web portal, DirectMyCare.com.

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

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

☐ **Bank or Credit Union Direct Deposit**. I authorize CDCN to initiate payroll deposits to (name of bank or financial institution): _____

Account Type (check one): ☐ Checking ☐ Savings

For Checking Accounts:

Attach (tape) a voided check here.

Do not attach a deposit slip.

For Savings Accounts: Provide a document from your bank with exact numbers to process direct deposits to your account. Attach separately if larger than a standard-sized check. Do not attach a deposit slip. It does not have all the necessary numbers.

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

_____ _____

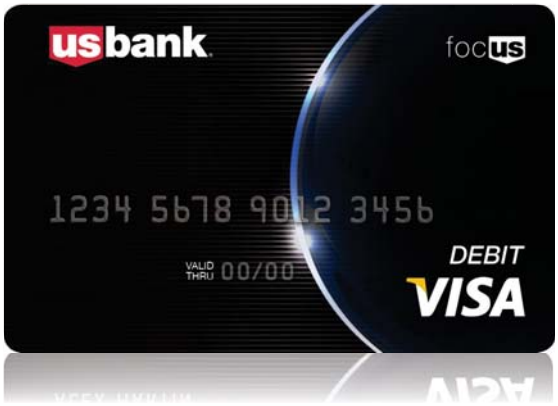
Signature *Date*

Rev. 2/18/2019

10004

Your Pay

FASTER. SAFER. EASIER.



With the U.S. Bank Focus Card™ Your Funds Are:

Immediately loaded to your card on payday | **Available to use** right away | **Protected** if lost or stolen[1]

About the Focus Card

It is a Visa® prepaid debit card that is a convenient alternative to receiving paper checks. Your payments will automatically be direct deposited to your card each payday. You have access to your funds right away and you can use it to make purchases or get cash wherever Visa debit cards are accepted. It's that simple!

MAKE PURCHASES | **RELOAD** | GET CASH
PAY BILLS | TRACK SPENDING

Getting Started is Easy

1. Sign up today.
2. Your pay will be automatically deposited to your card. Go online to check your balance.
3. Use your card anywhere Visa debit cards are accepted!

Sign Up!

$0.00 No cost to sign up.

No credit check or bank account required.[2]

And Save!

Keep more of your money. No fees to cash a paycheck.

No waiting for your paycheck or extra trips to the bank.

To enroll, please select the US Bank Focus Card Direct Deposit option on your Consumer Direct Care Network Pay Selection Form.

CONSUMER DIRECT CARE NETWORK

[1] The Visa Zero Liability Policy protects you against unauthorized purchases. U.S.-issued cards only. This does not apply to ATM transactions or to PIN transactions not processed by Visa. You must immediately report any unauthorized use.
[2] Successful identity verification required. To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. If necessary, we may also ask to see your driver's license or other identifying documents.

focus

Getting Started

For security, your card comes in a plain white windowed envelope.

Follow the activation instructions that accompany your card.

Features

Cash Back Rewards

For purchases at certain retail and restaurant locations.

Savings Account

Create an interest-bearing savings account without ever going to a bank.

Cash Reload Networks[5]

In addition to payroll deposits, there are a variety of ways to add cash to your Focus Card account.

Text and Email Alerts[4]

Instant notification when money is added or your card balance gets low.

Mobile Banking App[4]

Quickly see your account balance and transaction history.

Track Spending

Online | Phone | Email | Text[4] | Mobile App

Fee Schedule

Activity		Cost		
Monthly Account Maintenance		Free		
Purchases at Point-of-Sale (Domestic)		Free		
Cash Back with Purchases (Domestic)		Free		
ATM Transactions		Cash Withdrawal	Declined Withdrawal	Balance Inquiry
The owner of any Non-U.S. Bank or Non-MoneyPass ATM may assess an additional surcharge fee for any ATM transaction that you complete.	U.S. Bank ATM	Free	Free	Free
	MoneyPass® ATM	Free	Free	Free
	Allpoint® ATM	Free	Free	Free
	Other ATM	$2.00	$0.50	$1.00
	International ATM	$3.00	$0.50	$1.00
Teller Cash Withdrawal		Free		
Teller Cash Withdrawal Decline		$0.00		
Customer Service Automated Phone Service, Online, Live Phone Representative		Free		
Text or Email Alerts[4]		Free		
Inactivity After 90 consecutive days. Not assessed if balance is $0.00.		$2.00 Per Month		
Monthly Paper Statement		If requested – $2.00		
Card Replacement Non-Personalized Issued by employer (If applicable to your program) Personalized		$5.00 Standard $5.00; Expedited $15.00; Overnight $25.00		
ChekToday Convenience Checks (If applicable to your program)	Check Authorization	Free		
	Check Order	Free; Expedited $35.00		
	Check Return	$25.00		
	Stop Payment	$25.00		
	Lost/Stolen Check	$25.00		
	Void Check	Free		
	Check Reversal	$25.00		
	Check Copy	$10.00		
Foreign Transaction		Up to 3% of transaction amount		

Transaction Limits	Count	Amount
Maximum Card Balance	N/A	$40,000
Purchases (includes cash back)	20 per day	$4,000 per day
Cash Loads (If applicable to your program)	3 per day	$950 per day
Teller Cash Withdrawal	5 per day	$2,525 per day
ATM Withdrawal	5 per day	$1,525 per day; $1,025 max transaction
Loads or Deposits	10 per day	$20,000 per day
Signature-based POS returns	4 per day	N/A
Pending ACH Credits	5 per day	$5,000 per day
ACH Loads	5 per day	$20,000 per day

We reserve the right to change the above fee schedule upon written notification to you as required by applicable law.

[4]US Bank does not charge a fee for mobile banking. Standard messaging and data rates may apply through your mobile carrier.

[5]Businesses performing your reload may charge a fee. Cash reload services are provided by unaffiliated third parties.

CONSUMER DIRECT CARE NETWORK

ATTENDANT ATTESTATION FORM

Print Attendant's Name _____ Print Employer of Record's (EOR) Name _____

This agreement is made as of _____/_____/_____ (DATE) between the Employer of Record (EOR) and the Attendant to establish the responsibilities of the parties to each other. The parties agree to follow the policies and procedures of the Virginia Consumer-Directed Services Program.

This agreement will be effective when it is signed by both parties. Either party may terminate this agreement. Notice must be provided either orally or in writing to the EOR at least (5) five days prior to termination. When employment is ended, the Employer must provide notification to Consumer Direct Care Network Virginia by sending the Notice of Discontinued Employment for that Attendant.

The parties agree to follow the policies and procedures set forth by DMAS, the MCO and the Waiver Programs. The Attendant and Consumer and Employer of Record agree to hold harmless, release and forever discharge the Virginia Department of Medical Assistance and Services Consumer Directed Services Program and Consumer Direct Care Network Virginia from any claims and/or damages that might arise out of any action or omissions by the Attendant or Consumer.

Acknowledgement - I acknowledge the following:

- I am an Employee of the Program Consumer or Designated Representative Employer of Record, and am not the Employee of CDCN or the Virginia Department of Medical Assistance Services.
- I am at least 18 years of age.
- I have a valid Social Security Number and I am authorized to work in the United States.
- I declare that I am an Employee receiving payments under a state Medicaid Home and Community-Based Services program.
- The attendant's hourly rate is established by the Virginia General Assembly for consumer-directed services based on the Consumer's address. This rate is not negotiable.
- As the Attendant, I recognize my employment is contingent upon the Consumer's enrollment in the Virginia Consumer-Directed Services Program. When the Consumer is no longer enrolled in the Consumer-Directed Services Program, I may no longer be employed by that Consumer payable under the Virginia Consumer-Directed Services Program.
- This Agreement does not guarantee the Attendant a specific number of hours of work, nor does it limit the Program Consumer or Employer of Record from hiring other Attendants under the Virginia Consumer-Directed Services Program.
- This Agreement does not guarantee employment or payment of wages for any time period.
- This Agreement does not prohibit the Attendant from working for more than one consumer under the Virginia Consumer- Directed Services Program.
- I understand information shared by the Employer of Record or the Virginia Consumer-Directed Services Program and affiliated agencies regarding the Program Consumer shall be confidential.
- The EOR agrees to provide training and to direct the Attendant in providing services that are within the Consumer's Plan of Care.

- I agree to carry out assigned duties and responsibilities explained by the Consumer/ Employer of Record, as outlined in the Consumers Plan of Care.
- I understand I am expected to be dependable and report to work on time.
- I agree to call the Consumer/Employer of Record with as much advance notice as possible if I am ill or unable to report to work on time.
- I agree to give the Employer of Record notice either orally or in writing at least (5) five days prior to termination of this employment.
- I understand the Consumer/Employer of Record shall set the conditions of employment, and termination of employment shall be the prerogative of the Consumer/Employer of Record.

Background Checks

- I understand and consent to be subject of the required Virginia State Police criminal background screening and the Department of Social Services/Child Protective Services Central Registry records check (as required) through the Virginia Department of Social Services prior to employment and that the results of the background screening may be shared with the Virginia Consumer-Directed Services Program and/or the Consumer receiving services and/or the Employer of Record with whom I work. I acknowledge that I will not be paid for services performed after failed results of the checks have been communicated to the EOR. The background check will be paid for by the Department of Medical Assistance Services. The Attendant does not pay for the background check.
- I understand the results of my background checks will be made available to my prospective Employer and other program administrators as necessary and/or required.
- I understand that if I have failed a criminal background check for a barrier crime at any time while employed in the Consumer-Directed Services Program, I will not be permitted to work in this program or be paid through it.
- I understand that CDCN must verify that I do not appear on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (LEIE). In the event I appear on this list, I will not be permitted to work in this program or to be paid through it.
- I understand that the Employer agrees to employ me on a contingent basis for no more than 30 days, pending the results of the criminal background history record check, the Central Registry child abuse and neglect check, and the LEIE database search.
- I understand the Consumer/Employer of Record will immediately dismiss the Employee if (1) they have been found to have been placed on an Provider Disqualification Registry or List maintained by either the Commonwealth of Virginia, (2) have committed abuse, neglect, or misuse of funds or property of a Consumer receiving services, (3) have committed fraud or violated the terms of this Agreement, or (4) do not maintain any required training requirements.

Requirements

- I understand that I must report possible neglect, abuse or misuse of funds or property of a Program Consumer to the Department of Social Services.
- I understand and acknowledge that wages are from federal and state funds. Any untruthful submission of services provided in an attempt to obtain improper payment is subject to

investigation as Medicaid Fraud. Medicaid Fraud is a felony and can lead to substantial penalties and/or imprisonment.

- I understand Federal Income Tax, and Medicare, Social Security and Virginia Income Tax (as applicable), will be withheld from my wages per IRS Form W-4 and Virginia Form VA-4. I also understand that garnishments, support orders, liens and their associated processing fees could be withheld from my pay.
- I understand that I cannot be paid by Medicaid funds if (1) the Consumer becomes ineligible for Medicaid Services, or (2) the Attendant performs unauthorized tasks or works more hours than are approved on the Consumer Service Plan.
- I understand I will not be paid for services when the Consumer is hospitalized or for any other services not specifically authorized on the Consumer service plan.
- I understand that I may not be paid for services furnished if I am another family member/caregiver living in the same household unless there is objective written documentation by the Services Facilitator explaining why no other attendants are available to provide the care.
- I understand that payment will be for services rendered as assigned by the Consumer/Employer of Record and as outlined in the Consumer Service Plan at the rate(s) described in this document.
- I understand that I must notify CDCN if/when my address or personal information changes or if I wish to change my payment and tax withholding preferences.
- I understand that I will not be covered by workers' compensation insurance. (Under Code of Virginia Section 65.2-100 Section 2f, domestic service employees are not eligible for Worker's Compensation Insurance).

Timesheets and Payments

- We understand timesheets must be accurately completed and signed by the Employer AND Attendant. Hours recorded on the timesheet cannot exceed the authorized number of hours.
- I understand that CDCN will pay me on behalf of the Consumer on a biweekly basis, following the submission of accurate and approved timesheets and service documentation.
- We understand timesheets are due to CDCN by 5:00 PM Eastern Time on the Friday following the end of the pay period.
- We understand incorrect timesheets will be returned and no paycheck will be issued until the timesheet is corrected and resubmitted, at which point the paycheck will be issued the next regular payroll cycle.
- We understand incorrect or missing enrollment paperwork will delay payment and a paycheck will not be issued.
- We understand all DMAS-approved wages are paid by CDCN through Electronic Funds Transfer (EFT).
- We understand that timesheets and paychecks will be processed by CDCN. CDCN is the Financial Management Service (FMS) Organization only, and not able to pay for any services that are not authorized by DMAS, the MCO or the service authorization contractor; nor for any services

provided during periods of Medicaid or waiver ineligibility; nor for any request that exceeds the Consumers Service Authorization.

- We understand that the Attendant will not be paid under the Consumer-Directed Services Program for any work performed over the amount authorized by DMAS or the MCO or performed for a Consumer who is not approved for the Long-Term Care waiver for Consumer-Directed Services. In this case, the Attendant will need to seek payment directly from the Employer. This includes when a Consumer is hospitalized, or in a nursing or other facility.
- We understand timesheets must be submitted within 12 Months from the date of service in order to be paid. Any timesheets submitted after this timely filing will not be paid. In addition, if any timesheet is incorrectly submitted and not paid within one year of service due to a pending rule the timesheet will not be paid. The pending rule must be resolved prior to the 1 year timely filing deadline in order to be paid.
- We understand payments are authorized by the Commonwealth of Virginia Department of Medical Assistance Services and the Medicare Medicaid Plan. The Attendant shall only perform work within the authorized service hours in the Plan of Care and will not be compensated by the Commonwealth of Virginia, Department of Medical Assistance Services or the Medicare Medicaid Plan for work performed in excess of the authorized amount. Authorized hours are approved for the Consumer prior to the Attendant starting services.

Attestation

By signing below, my Employer of Record and I attest that we have read and understand all program rules and responsibilities. I understand I must sign and return this form as a condition of employment in this program. I further attest by signing below, that I understand what is being requested of me, and I agree to abide by these terms and conditions. I further understand and agree that violation of any of the terms and/or conditions may result in termination of this agreement.

I authorize the Employer of Record and Virginia Consumer-Directed Services Program to proceed with all registry and criminal record checks required by state and federal law. This information cannot be released for any other purpose without my written permission.

The Employer of Record understands that it is their responsibility to properly execute the USCIS Form I-9, as defined in Instructions for Employment Eligibility Verification by the Department of Homeland Security. CDCN provides the Form I-9 in the employment packets, and the Employer of Record retains the original Form I-9 and forwards a completed copy to CDCN which CDCN will retain in the Employee's files.

Employer of Record, Printed Name	*Signature*	Date

Attendant, Printed Name	*Signature*	Date

09986

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

2019 Payroll Calendar

Symbol Key: ☐ Time Due ◯ Pay Day △ Postal & 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		

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				

2019 Bank & Post Office Holidays

*__New Year's Day__ - Tuesday, January 1

*__Martin Luther King, Jr. Day__ - Monday, January 21

__President's Day__ - Monday, February 18

*__Memorial Day__ - Monday, May 27

*__Independence Day__ - Thursday, July 4

*__Labor Day__ - Monday, September 2

__Columbus Day__ - Monday, October 14

__Veterans Da__y - Monday, November 11

*__Thanksgiving Day__ - Thursday, November 28

*__Christmas Day__ - Wednesday, December 25

*Consumer Direct Care Network holidays and office closures

CONSUMER DIRECT CARE NETWORK

Two-week long pay periods are Thursday through Wednesday. Time must be submitted within 2 days of the pay period end date, by FRIDAY at MIDNIGHT. Late time or time with mistakes may result in late pay.

Two Week Pay Period		Time Sheet Due Date	Pay Date
Start Date	End Date		
Thursday	Wednesday	Friday	Friday
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)

(Circled Paydays) - payment for pay period that includes the first day of the month. If employer is responsible for Patient Pay reimbursement to employee, it is due on this date.

CDVATimesheets@ConsumerDirectCare.com

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

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