independence INC
for people with disabilities

PERSONAL CARE SERVICE WORKER

Date_____ Waiver_____

Employer Name (Consumer)_____

Personal Care Service Worker Name_____

Kansas Authenticare Worker Number_____

Social Security Number_____ Birth Date_____

Street Addresss _____

City, State, Zip Code_____

Cell/Home Phone Number_____

Email Address _____

Start Date/Effective Date_____

Personal Care Service Worker Signature_____ Date_____

Consumer or Designee Signature_____ Date_____

****Personal Care Service hours cannot be turned in when the Consumer/Employer has been admitted into the hospital, either as an outpatient or inpatient. Please inform Independence Inc. when the consumer has been admitted and released from the hospital.****

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2020

Step 1: Enter Personal Information

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

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

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

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ▶ ☐

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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

Step 3: Claim Dependents

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

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

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

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

General Instructions

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2020 if you meet both of the following conditions: you had no federal income tax liability in 2019 **and** you expect to have no federal income tax liability in 2020. You had no federal income tax liability in 2019 if (1) your total tax on line 16 on your 2019 Form 1040 or 1040-SR is zero (or less than the sum of lines 18a, 18b, and 18c), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2020 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2021.

Your privacy. If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

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

1. Expect to work only part of the year;

2. Have dividend or capital gain income, or are subject to additional taxes, such as the additional Medicare tax;

3. Have self-employment income (see below); or

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

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

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

Specific Instructions

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

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

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

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

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

Step 3. Step 3 of Form W-4 provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2020 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

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

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

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

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

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

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

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

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

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

1 Enter an estimate of your 2020 itemized deductions (from Schedule A (Form 1040 or 1040-SR)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . 1 $

2 Enter:
- $24,800 if you're married filing jointly or qualifying widow(er)
- $18,650 if you're head of household
- $12,400 if you're single or married filing separately

. . . . . 2 $

3 If line 1 is greater than line 2, subtract line 2 from line 1. If line 2 is greater than line 1, enter "-0-" . . 3 $

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

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

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and 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 are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

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

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

Married Filing Jointly or Qualifying Widow(er)

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$220	$850	$900	$1,020	$1,020	$1,020	$1,020	$1,020	$1,210	$1,870	$1,870
$10,000 - 19,999	220	1,220	1,900	2,100	2,220	2,220	2,220	2,220	2,410	3,410	4,070	4,070
$20,000 - 29,999	850	1,900	2,730	2,930	3,050	3,050	3,050	3,240	4,240	5,240	5,900	5,900
$30,000 - 39,999	900	2,100	2,930	3,130	3,250	3,250	3,440	4,440	5,440	6,440	7,100	7,100
$40,000 - 49,999	1,020	2,220	3,050	3,250	3,370	3,570	4,570	5,570	6,570	7,570	8,220	8,220
$50,000 - 59,999	1,020	2,220	3,050	3,250	3,570	4,570	5,570	6,570	7,570	8,570	9,220	9,220
$60,000 - 69,999	1,020	2,220	3,050	3,440	4,570	5,570	6,570	7,570	8,570	9,570	10,220	10,220
$70,000 - 79,999	1,020	2,220	3,240	4,440	5,570	6,570	7,570	8,570	9,570	10,570	11,220	11,240
$80,000 - 99,999	1,060	3,260	5,090	6,290	7,420	8,420	9,420	10,420	11,420	12,420	13,260	13,460
$100,000 - 149,999	1,870	4,070	5,900	7,100	8,220	9,320	10,520	11,720	12,920	14,120	14,980	15,180
$150,000 - 239,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,190	16,050	16,250
$240,000 - 259,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,520	17,170	18,170
$260,000 - 279,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	13,120	15,120	17,120	18,770	19,770
$280,000 - 299,999	2,040	4,440	6,470	7,870	9,190	10,720	12,720	14,720	16,720	18,720	20,370	21,370
$300,000 - 319,999	2,040	4,440	6,470	8,200	10,320	12,320	14,320	16,320	18,320	20,320	21,970	22,970
$320,000 - 364,999	2,720	5,920	8,750	10,950	13,070	15,070	17,070	19,070	21,290	23,590	25,540	26,840
$365,000 - 524,999	2,970	6,470	9,600	12,100	14,530	16,830	19,130	21,430	23,730	26,030	27,980	29,280
$525,000 and over	3,140	6,840	10,170	12,870	15,500	18,000	20,500	23,000	25,500	28,000	30,150	31,650

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$460	$940	$1,020	$1,020	$1,470	$1,870	$1,870	$1,870	$1,870	$2,040	$2,040	$2,040
$10,000 - 19,999	940	1,530	1,610	2,060	3,060	3,460	3,460	3,460	3,640	3,830	3,830	3,830
$20,000 - 29,999	1,020	1,610	2,130	3,130	4,130	4,540	4,540	4,720	4,920	5,110	5,110	5,110
$30,000 - 39,999	1,020	2,060	3,130	4,130	5,130	5,540	5,720	5,920	6,120	6,310	6,310	6,310
$40,000 - 59,999	1,870	3,460	4,540	5,540	6,690	7,290	7,490	7,690	7,890	8,080	8,080	8,080
$60,000 - 79,999	1,870	3,460	4,690	5,890	7,090	7,690	7,890	8,090	8,290	8,480	9,260	10,060
$80,000 - 99,999	2,020	3,810	5,090	6,290	7,490	8,090	8,290	8,490	9,470	10,460	11,260	12,060
$100,000 - 124,999	2,040	3,830	5,110	6,310	7,510	8,430	9,430	10,430	11,430	12,420	13,520	14,620
$125,000 - 149,999	2,040	3,830	5,110	7,030	9,030	10,430	11,430	12,580	13,880	15,170	16,270	17,370
$150,000 - 174,999	2,360	4,950	7,030	9,030	11,030	12,730	14,030	15,330	16,630	17,920	19,020	20,120
$175,000 - 199,999	2,720	5,310	7,540	9,840	12,140	13,840	15,140	16,440	17,740	19,030	20,130	21,230
$200,000 - 249,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
$250,000 - 399,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
$400,000 - 449,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,450	19,940	21,240	22,540
$450,000 and over	3,140	6,230	8,810	11,310	13,810	15,710	17,210	18,710	20,210	21,700	23,000	24,300

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$830	$930	$1,020	$1,020	$1,020	$1,480	$1,870	$1,870	$1,930	$2,040	$2,040
$10,000 - 19,999	830	1,920	2,130	2,220	2,220	2,680	3,680	4,070	4,130	4,330	4,440	4,440
$20,000 - 29,999	930	2,130	2,350	2,430	2,900	3,900	4,900	5,340	5,540	5,740	5,850	5,850
$30,000 - 39,999	1,020	2,220	2,430	2,980	3,980	4,980	6,040	6,630	6,830	7,030	7,140	7,140
$40,000 - 59,999	1,020	2,530	3,750	4,830	5,860	7,060	8,260	8,850	9,050	9,250	9,360	9,360
$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,780	10,980	11,180	11,580	12,380
$80,000 - 99,999	1,900	4,300	5,710	7,000	8,200	9,400	10,600	11,180	11,670	12,670	13,580	14,380
$100,000 - 124,999	2,040	4,440	5,850	7,140	8,340	9,540	11,360	12,750	13,750	14,750	15,770	16,870
$125,000 - 149,999	2,040	4,440	5,850	7,360	9,360	11,360	13,360	14,750	16,010	17,310	18,520	19,620
$150,000 - 174,999	2,040	5,060	7,280	9,360	11,360	13,480	15,780	17,460	18,760	20,060	21,270	22,370
$175,000 - 199,999	2,720	5,920	8,130	10,480	12,780	15,080	17,380	19,070	20,370	21,670	22,880	23,980
$200,000 - 249,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
$250,000 - 349,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
$350,000 - 449,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,900	25,200
$450,000 and over	3,140	6,840	9,560	12,140	14,640	17,140	19,640	21,530	23,030	24,530	25,940	27,240

500518

K-4
(Rev. 11-18)

KANSAS
EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

Use the following instructions to accurately complete your K-4 form, then detach the lower portion and give it to your employer. For assistance, call the Kansas Department of Revenue at 785-368-8222.

Purpose of the K-4 form: A completed withholding allowance certificate will let your employer know how much *Kansas* income tax should be withheld from your pay on income you earn from Kansas sources. Because your tax situation may change, you may want to re-figure your withholding each year.

Exemption from Kansas withholding: To qualify for exempt status you must verify with the Kansas Department of Revenue that: **1)** last year you had the right to a refund of **all** STATE income tax withheld because you had **no** tax liability; and **2)** this year you will receive a full refund of **all** STATE income tax withheld because you will have **no** tax liability.

Basic Instructions: If you are not exempt, complete the **Personal Allowance Worksheet** that follows. The total on line F should **not** exceed the total exemptions you claim under "Exemptions and Dependents" on your Kansas income tax return.
***NOTE**: Your status of "Single" or "Joint" may differ from your status claimed on your federal Form W-4).*

Using the information from your **Personal Allowance Worksheet**, complete the **K-4** form below, sign it and provide it to your employer. If your employer does not receive a K-4 form from you, they must withhold Kansas income tax from your wages without exemption at the "Single" allowance rate.

Head of household: Generally, you may claim head of household filing status on your tax return only if you are **unmarried and pay more than 50% of the cost of keeping up a home for yourself and for your dependent(s).**

Non-wage income: If you have a large amount of non-wage Kansas source income, such as interest or dividends, consider making Kansas estimated tax payments on Form K-40ES. Without these payments, you may owe additional Kansas tax when you file your state income tax return.

Personal Allowance Worksheet (Keep for your records)

A Allowance Rate: If you are a single filer mark "Single"
If you are married and your spouse has income mark "Single"
If you are married and your spouse does not work mark "Joint"
A ☐ Single ☐ Joint

B Enter "0" or "1" if you are married or single and no one else can claim you as a dependent (entering "0" may help you avoid having too little tax withheld) ..... **B** _____

C Enter "0" or "1" if you are married and only have one job, and your spouse does not work (entering "0" may help you avoid having too little tax withheld) ..... **C** _____

D Enter "2" if you will file head of household on your tax return (see conditions under *Head of household* above) ..... **D** _____

E Enter the number of dependents you will claim on your tax return. **Do not** claim yourself or your spouse or dependents that your spouse has already claimed on their form K-4 ..... **E** _____

F **Add lines B through E** and enter the total here ..... **F** _____

▼ **Cut here and give the lower portion to your employer. Keep the top portion for your records.** ▼

Kansas Employee's Withholding Allowance Certificate

Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the Kansas Department of Revenue. Your employer may be required to send a copy of this form to the Department of Revenue.

1 Print your First Name and Middle Initial	Last Name	2 Social Security Number
Mailing address		3 Allowance Rate Mark the allowance rate selected in Line A above. ☐ Single ☐ Joint

4 Total number of allowances you are claiming (from Line F above)	4	
5 Enter any additional amount you want withheld from each paycheck (this is optional)	5	$
6 I claim exemption from withholding. (You must meet the conditions explained in the "Exemption from withholding" instructions above.) If you meet the conditions above, write "Exempt" on this line **Note: The Kansas Department of Revenue will receive your federal W-2 forms for all years claimed *Exempt*.**	6	

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.

SIGN HERE ▶ **Date**

7 Employer's Name and Address	8 EIN (Employer ID Number)

Direct Deposit Agreement Form

Authorization Agreement

I hereby authorize Independence, Inc. to initiate automatic deposits to my account at the financial institution named below. I also authorize Independence, Inc. to make withdrawals from this account in the event that a credit entry is made in error.

Further, I agree not to hold Independence, Inc. responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until Independence, Inc. receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to the Payroll Department.

Signature

Authorized Signature (Primary):_____ Date: _____

Authorized Signature (Joint): _____ Date: _____

Please attach a voided check or verification from your bank and return this form to the Payroll Department.

STATE OF KANSAS
Department for Children and Families
Prevention and Protection Services

ADULT ABUSE, NEGLECT, EXPLOITATION
CENTRAL REGISTRY
RELEASE OF INFORMATION

PPS 10400
REV 1/18

I, _____ , give permission for the release of information concerning
(PRINT ONLY)

myself in the Adult Abuse, Neglect, Exploitation Central Registry to:

Contact Person(s)* Alisa Snyder **Phone** 7858410333

Agency name Independence, Inc.

Agency mailing address 2001 Haskell Ave Lawrence KS 66046

Agency email address asnyder@independenceinc.org

☐ **Check box if agency is a CDDO, CMHC, or ILRC**

Maiden Name and/or Other Names Known By: _____
(PRINT ONLY)

Address: _____
Street **City** **State** **Zip Code**

DOB: ___/___/___ **SS#:** ___-___-___ ☐ Male ☐ Female
(mm/dd/yyyy) **(mark one)**

I understand that all information released will be for the exclusive and confidential use of the above-named organization/person. I have read and understand this form and the information provided is true and correct to the best of my knowledge.

I give permission for the release of any information concerning myself in the Adult Abuse and Neglect Central Registry each year while I am employed or associated with the above agency. _____ Yes _____ No

Signature: _____ **Date:** ___/___/___
(mm/dd/yyyy)

Per statute 65-6205: Community Service Providers, Mental Health Centers and Independent Living Centers may request information for the purpose of obtaining background information on applicants for employment without signed consent. Signature is not required from the individual for which the inquiry is made.

RETURN TO:

DCF.APSRegistry@KS.GOV
or
Adult Abuse Registry
555 S. Kansas Ave
Topeka, Kansas 66603-3444

(Please allow 3-5 days for processing email requests and an additional 5-7 days if returning by US Postal Service)

FOR PPS ADMINISTRATION USE ONLY:

Record Found? ☐ No ☐ Yes "Yes" indicates the individual is listed on the adult abuse, neglect, exploitation registry.

If yes, check all that apply ☐ Abuse ☐ Neglect ☐ Exploitation ☐ Fiduciary Abuse

Perpetrator's Name: _____ Date Substantiated: _____

Initial: _____ Date: _____

Kansas Department for Children and Families
Serving Families Make a Strong Kansas

KANSAS DEPARTMENT FOR CHILDREN AND FAMILIES
Child Abuse and Neglect Central Registry
P.O. Box 2637 • Topeka, KS 66601 • DCF.CentralRegistry@ks.gov

Release of Information

Complete form by printing legibly in ink. Fee of $10.00 per Release of Information form may be required prior to processing.

All releases and fees are to be sent to the address or email listed above (see below for specifics)

CONFIDENTIALITY: ***Kansas Department for Children and Family records are confidential. No individual, association, partnership, corporation, or other entity shall willfully or knowingly disclose, permit, or encourage disclosure of the contents of records or reports in violation of the confidentiality requirements of K.S.A. 38-2209. Violation of this statute is a class A nonperson misdemeanor and the court may impose a civil penalty of up to $1,000.***

Contact Person: Alisa Snyder Agency/Org.: Independence Inc.

Phone #: 785 841 0333 x120 Address: 2001 Haskell Ave

Email: ASNYDER@INDEPENDENCEINC.ORG City/State/Zip: Lawrence KS 66046

Return Results by: ☒ Encrypted email (list if different than above): _____ ☐ Postal Mail

Payment/Account Information (check box which applies)

☐ *Fee included*	$10 per request. Check, Money Order (payable to DCF) or cash. ***Postal mail only.***	
☐ *Online Payment**	www.dcf.ks.gov – 'Online DCF Payments' icon at bottom of page. Submit receipt with ROI form(s).	
☒ *Pre-Pay Account**	Agency/Org. has Pre-Pay Account.	FEIN: 48-0875993
☐ *Mentoring Account**	As listed in the Kansas Mentors' Partner Directory. http://mentorkansas.org/Find-a-Program	
☐ *Exempt**	No fee for State government agencies (Sub-contracting agencies not included).	

*Release of Information forms may be submitted via email to DCF.CentralRegistry@ks.gov

APPLICANT: *Instructions: PRINT CLEARLY. All requested information is required for processing. Incomplete or illegible information will result in processing delays for the Release of Information. Use 'N/A' rather than leaving a space blank.*

FIRST, MIDDLE, LAST NAME: _____

I give permission for the release of any of my information in the Child Abuse/Neglect Central Registry to the contact listed above. I understand the information released is for their exclusive and confidential use: ☐ *Yes* ☐ *No*

This organization/person/agency may check my information each year I am employed or associated with them: ☐ *Yes* ☐ *No*

OTHER NAMES USED: (Any/all aliases, married, maiden, nicknames, etc. 'N/A' if none used.): _____

DATE OF BIRTH: _____ **RACE:** _____

SOCIAL SECURITY #: _____ **GENDER:** ☐ *Male* ☐ *Female*

CURRENT ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE: _____ **EMAIL:** _____

SIGNATURE: _____ **DATE:** _____

DCF ONLY:

MATCH		CLEARED
This applicant is listed in the Child Abuse/Neglect Central Registry. *Per KSA 65-504 and 65-516 this person prohibited from working, residing, or volunteering in a licensed child care home or facility.* (see attached document for more info.)		

Kansas Central Repository

Certified Record Check Request Form

Regular name-based record checks are to be requested on-line at www.kansas.gov/kbi/criminalhistory

To: Kansas Bureau of Investigation
Attn: Central Repository
1620 SW Tyler
Topeka, KS 66612-1837

From: Independence, Inc.
(Requestor's Full Name or Organization) (Please Print)
Alisa Snyder FMS/Business Manager
(Requestor's Point of Contact and title)
2001 Haskell Ave
(Requestor's Mailing Address)
Lawrence KS 66046
(City, State or Country and Zip)
785 841 0333
(Requestor's Phone Number)

1. A criminal history record check of the Kansas Central Repository is requested for the following individual. The **Full Name** and **Date of Birth** are mandatory:

Full Name: _____
(Last Name) (First Name) (Middle Name)

Maiden or Alias Name: _____
(Last Name) (First Name) (Middle Name)

Date of Birth: _____ Social Security Number: _____

Sex: _____ Race: _____ Place of Birth: _____

2. A fingerprint card [is] [is not] included.

3. Purpose for the criminal history record check (Please be specific): _____

4. Mailing address for the results of the record check, if different from the "From" address, above:

[ ] Same as the "From" address above.

5. Enclosed is payment made payable to the **KBI Record Check Fee Fund** for the record check in the sum of:

[ ] $30.00 for a certifed name-based check

[ ] $45.00 for a certified Kansas fingerprint-based check
[ ] $57.00 for a certified Kansas/national fingerprint-based check*
* A state or federal statute allowing a national search is required

6. Dissemination of criminal history information is governed by statutes, laws and regulations. The Requestor will comply with and be subject to the provisions of both State and Federal law regulations, including, but not limited to Title 28 (Judicial Administration) of the Code of Federal Regulations and Kansas Statutues Annotated 22-4107 et seq.

7. Requestor agrees to limit disclosure of the information received to personnel who have a clear, distinct "need to know," and ensure that the information is used only for the purpose for which provided. Further, Requestor shall:
   a. Implement reasonable procedures to insure the confidentiality and security of any information received.
   b. Indemnify and hold harmless the KBI, their employees, including their heirs, executors, administrators, personal representatives, successors, and assigns, from and against any and all causes of actions, claims, demands, suits, rights and other proceedings of any nature which seek damages or ther remedies arising from the providing of criminal

8. The KBI has the right to demand return of all information provided to the Requestor when any rule, policy, procedure, regulation or law described in this request is violated or appears to be violated or for non-payment of any service.

9. I have read and understand my responsiblities when receiving record check information from the Kansas Central Repository, and I agree to safeguard and properly use all information I receive.

_____
(Signature of Requestor)

independence
for people with disabilities

Health Insurance Portability and

Accountability Act (HIPAA) Confidentiality Agreement

The HIPAA Privacy Rule applies to health care providers, health plans, health care clearinghouses, and any business associate that transmits health information in any form or media, including electronic, paper or oral. The Privacy Rule calls this information protected health information (PHI).

A Personal Care Service Worker (PCSW) performs various services for individuals with disabilities and may come in contact with protected health information. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that you ensure the integrity and confidentiality of all PHI you obtain or possess concerning individuals you assist.

Therefore as a Personal Care Service Worker:

1. I agree to protect all PHI against threats to the integrity of the information or unauthorized uses or disclosures of it.
2. I will not reproduce, disclose, or provide to third parties any confidential information relating to people with disabilities who receive services from Independence, Inc. (consumers), without written authorization from the consumer(s). I will only make available PHI in accordance with applicable law.
3. I will report to Independence, Inc. any use or disclosure of PHI not provided for by this agreement of which I become aware.
4. Upon termination for any reason, I will return or destroy all PHI received from Independence, Inc. or the consumer. I will not retain copies of the PHI and remain obligated not to use, disclose, or provide such information to third parties unless otherwise required to do so by law.
5. I will appropriately safeguard confidential information made available to me.

Signature_____ **Date**_____

independence INC
for people with disabilities

Safe Work Performance Expectations

PCSW Responsibilities

We expect our Personal Care Service Workers (PCSW's) to follow all objectives for safe work performance and be responsible for their own actions and conduct. OSHA requires that we furnish employees a place of employment "free from recognized hazards that are causing or are likely to cause death of serious physical harm to employees." Our Personal Care Service Workers also play a significant role in the success or failure of our program.

General Safety Expectation

All PCSW'S are expected to perform their jobs to the best of their ability as well as perform them in a safe manner. It is critical that employees do not circumvent safety features and safe work behaviors that can cause them or others to be at risk. All accidents are preventable. We must each carry out our safety responsibility. We each share a common goal and these are our expectations of each person working for our consumers.

- Follow the safe job procedures established by your consumer. Perform only those jobs to which you have been assigned and properly instructed.
- Wear the protective equipment (latex gloves, etc.) required for your job as established by your consumer.
- Report damaged equipment immediately for replacement or repair. Do not perform your task without the appropriate protection.
- Report unsafe work practices and/or unsafe conditions immediately.
- Report all incidents immediately. Summon first aid as soon as possible when injuries demand prompt attention. Contact your physician or "walk-in" clinic. Contact Independence, Inc. within 3 days of the incident at (785) 841-0333 x 113.
- When using a lift, keep all mechanical safeguards in position during operation.
- Under no circumstances should "assistive equipment" be used in an unsafe manner or with safety features missing, malfunctioning, or circumvented.

Lifting and/or Transferring

- Do not lift awkwardly.
- Never lift beyond your strength. If your consumer is too heavy, find help or utilize assistive equipment (Hoyer Life, etc.)
- Be sure you fully understand how to operate the lifting/hoisting equipment before you start.
- Avoid reaching as you lift or lower. If something is in your way, move it before beginning to lift. Set feet firmly, placing one foot alongside the person to be lifted, and the other slightly behind them. Keep the person close to your body. Position comfortably and then set muscles of your legs, hips, and back readying to take the strain.
- Lift gradually, avoid jerking, twisted motions.
- If a helper is needed, decide how the move will be handled. Keep in step and communicate stopping, placing, etc.
- For consumers with lifts, utilize only well maintained and appropriate slings and chains for the weight of the consumer. Check for defects and visual signs of fatigue in the slings and hoist components before attempting a lift. Report any problems to your consumer to obtain a replacement part, sling, or repairs.
- Do not compromise a safe lift by using damaged lifts even for a short time.

Housekeeping

- Make sure ovens/stoves are free of grease and clean before using. Turn off ovens/stove after use.
- Return all cleaning supplies to their proper storage place after use.
- Dispose of any blood, stool, and urine soiled items in the appropriate manner and do not let it accumulate.
- Do not use any defective equipment or appliances; notify the consumer of the need to repair or replace the equipment or appliance.
- Isolate all flammable/combustible materials from possible ignition sources (e.g., open flames, heated surfaces)
- Check appliances/ vacuum for frayed, defective cords or plugs; notify consumer of any findings.

I have read and understood the above expectations and agree to comply with them fully.

PCSW Signature_____ **Date**_____

Employer Signature_____ **Date**_____

The Safe Work Performances Expectations are established in the interest of protecting lives and property. All Personal Care Service Workers are asked to follow these rules to help safeguard themselves and their consumers.

independence inc
for people with disabilities

Notice of Injury

As provided in K.S.A. 44-520 it is the duty of all employees to notify Independence, Inc. FMS/PASS Department within three (3) days of any accident that occurs during the scope of that employee's duties.

Such notice shall be in writing, shall contain the name and address of the employee and a statement of the time, place, nature and cause of the injury or death. The notice shall be signed by the employee not by some person on his/her behalf.

Notice shall be given to Independence, Inc. FMS/PASS Department in writing by delivering it or by sending it by mail addressed to:

Independence, Inc.
Attn: FMS/PASS Department
2001 Haskell Avenue
Lawrence, KS 66046

Failure to provide such notice may prevent compensation for the employee's injury.

We have read and understand the above notice.

PCSW's full name_____Date_____

Employer's Signature_____Date_____

Employment Termination Notification Policy

As a Personal Care Service Worker being paid by Independence, Inc., it is my responsibility to follow the policies and procedures stated in the Personal Care Service Worker application package. If, for any reason, my employment should end with a consumer, I will contact the FMS/PASS Department at 785-841-0333 within 3 days. Failure to do so will indicate that I am no longer interested in providing personal services through this payroll agency.

I understand that an Employment Termination Form will be mailed to me so that Independence, Inc. can have a written explanation of the reason for my termination. Before receiving my last paycheck, I will complete this form and return it to:

Independence, Inc.
Attn: FMS/PASS Department
2001 Haskell Avenue
Lawrence, KS 66046

I have read and understand the above employment notification policy. I agree to notify Independence, Inc. within 3 days of my employment termination.

We have read and understand the above notice.

PCSW's full name_____ Date_____

Employer's Signature_____ Date_____

EMPLOYMENT AGREEMENT

THIS EMPLOYMENT AGREEMENT (the **"Agreement"**) is effective on this _____ day of_____, 20___, between _____ (the **"Employer"**), an individual, and _____, (the **"Caregiver"**), an individual.

W I T N E S S E T H:

WHEREAS, the Employer is a participant in a Home and Community Based Services waiver program under Medicaid (the **"Program"**) administered by the Kansas Department of Aging and Disability Services (**"KDADS"**) through KanCare and has elected to self-direct his/her services under the Program by employing one or more direct support workers;

WHEREAS, the purpose of a direct support worker (or caregiver) under the Program is to provide assistance and support to a Program participant in accordance with the participant's integrated service plan under the Program (the **"ISP"**);

WHEREAS, the Employer desires to hire the Caregiver to be his/her direct support worker under the Program;

WHEREAS, the Caregiver desires to be employed by the Employer as a direct support worker under the Program; and

WHEREAS, the Employer uses Independence, Inc. (the **"FMS Provider"**) to provide financial management services (**"FMS"**) under the Program to the Employer, including but not limited to (i) processing of time worked by the Caregiver, (ii) billing KanCare on the Employer's behalf, (iii) distributing pay checks or electronic deposits for services rendered by the Caregivers under the ISP, (iv) withholding, filing and paying appropriate taxes for Caregiver services under the ISP, and (v) information and assistance services to assist the Employer in understanding his/her role and requirements as the employer of the Caregiver and his/her responsibilities under participant-direction.

NOW, THEREFORE, in consideration of the premises and of the mutual covenants and agreements hereinafter contained, the parties hereto agree as follows:

Section 1. **Employment.** The Employer hereby employs the Caregiver, and the Caregiver hereby accepts employment with the Employer, upon the terms and conditions hereinafter set forth.

Section 2. **"At-Will" Employment.** The Caregiver is an "at-will" employee of the Employer, which means that the Caregiver's employment may be terminated by the Employer, with or without notice, and with or without cause, at any time, for any reason not prohibited by law.

Section 3. **Duties under this Agreement.** The duties of the Caregiver under this Agreement shall be as set forth in the Employer's ISP (the **"Covered Duties"**). The Caregiver agrees to use his/her best efforts in performing his/her Covered Duties for the Employer and to comply with all Employer directives, both written and oral. The Caregiver understands and agrees that his/her assignment, duties, and responsibilities may be changed at any time by the Employer, subject to the limitations in the ISP.

Section 4. **Compensation for Covered Duties.**

(a) The Employer shall pay the Caregiver for performing Covered Duties, in such amount as is agreed upon between the Employer and the Caregiver from time to time. Compensation for Covered Duties shall be made using Medicaid funds exclusively, in accordance with Kansas regulation 30-5-308.

(b) The Caregiver understands and agrees that although payment for Covered Duties will be made by the FMS Provider, on behalf of and as payroll agent for the Employer, the FMS Provider shall not be liable to the Caregiver for payment of any compensation. The FMS Provider is a third party beneficiary of this Section 4(b).

(c) If the Caregiver has concerns or questions about his/her compensation, the Caregiver is required to contact the Employer (not the FMS Provider) immediately in order to resolve those concerns or questions.

Section 5. **Non-Covered Duties are Outside this Agreement.** This Agreement does not prohibit the Employer from employing the Caregiver to perform duties that are not Covered Duties (**"Non-Covered Duties"**). To the extent that the Caregiver performs Non-Covered Duties, the parties agree that the Employer is obligated to pay the Caregiver directly for those Non-Covered Duties, with no involvement by the FMS Provider, in such amount as is agreed upon between the Employer and the Caregiver from time to time, and that the Employer is responsible for paying any overtime wages that are not properly payable under the Program. The parties understand that the Program does not provide funds to pay for any Non-Covered Duties.

Section 6. **Work Schedule and Overtime.**

(a) The Caregiver's work schedule shall be set by the Employer (not the FMS Provider). The Caregiver understands that he/she is expected to adhere to the work schedule and to provide the Employer with advance notice of any absence or requests for schedule changes.

(b) The Caregiver understands and agrees not to work more than forty hours in any workweek for the Employer without advance approval from the Employer. The Caregiver's workweek shall be the 7-day period starting at 12:01 A.M. on Sunday and ending at midnight on the following Saturday.

Section 7. **Time Records.** The Caregiver shall report all time worked on Covered Duties using the AuthentiCare® KS IVR system and shall *not* report any time worked on Non-Covered Duties using the AuthentiCare® KS IVR system. Time worked on Non-Covered Duties (if any) shall be reported to the Employer, in the manner directed by the Employer (not by the FMS Provider).

Section 8. **Supervision, Cooperation, and Compliance with ISP, the Program, Instructions, Policies, Rules, Regulations, and Laws.**

(a) The Caregiver shall be directly supervised and managed by the Employer or the Employer's "Designated Representative" (if any) set forth in the ISP.

(b) The Caregiver agrees to adhere to all rules, policies, and regulations of the Employer.

(c) The Caregiver and the Employer agree to strictly comply with the ISP, the Customer Service Worksheet (if any), and any and all other Program requirements.

(d) The Caregiver and the Employer agree to strictly comply with any instructions, rules, or policies maintained by the FMS Provider with regard to the billing and payment for Covered Duties services rendered by the Caregiver.

(e) The Caregiver and Employer agree to strictly comply with any and all Kansas statutes, regulations, or policies (including, but not limited to, the KDADS's Field Services Manual, as amended) relating or pertaining to Covered Duties services to the Employer and for payment for such services.

(f) The Caregiver agrees to cooperate fully with the FMS Provider and with KDADS, the Employer's case manager, case management agency (if any) from whom the Employer receives case management services under the Program, and the Case Management Entity (if any) from whom the Employer receives case management services under the Program (the **"CME"**), regarding any questions and/or inquiries about the Employer's case and services provided by the Caregiver under the Program.

Section 9. FMS Provider is Not the Common Law Employer for Purposes of Patient Protection and Affordable Care Act. The parties hereby understand and agree that ***the FMS Provider is not the "common law employer" of the Caregiver for purposes of the Patient Protection and Affordable Care Act ("PPACA") or under any other law and that the FMS Provider has no legal obligation to offer health care coverage to any Caregiver.*** The parties further agree and understand that, under the legal standards established by the Internal Revenue Service, the "common law employer" for purposes of PPACA compliance is the Employer. The parties agree never to argue or raise as a defense in any legal proceeding that the FMS Provider is the "common law employer" of the Caregiver for purposes of PPACA or for any other purpose. The FMS Provider is a third-party beneficiary of Section 9 of this Agreement.

Section 10. FMS Provider is Not the "Employer" for Purposes of the Fair Labor Standards Act. The parties hereby understand and agree that ***the FMS Provider is not the "employer" of the Caregiver for purposes of the Fair Labor Standards Act or under any other law that uses the "economic reality test" to determine employer/employee status.*** The parties agree never to argue or raise as a defense in any legal proceeding that the FMS Provider is the "employer" of the Caregiver for purposes of the Fair Labor Standards Act or for any other purpose. The FMS Provider is a third-party beneficiary of Section 10 of this Agreement.

Section 11. Changes in Information. The Caregiver agrees to notify the Employer of any change in the Caregiver's name, address, telephone number, e-mail address, emergency contact information, and/or Form W-4 and Form K-4 elections.

Section 12. Safety. The Caregiver is expected to follow generally accepted safety procedures while performing Covered Duties and must promptly report all safety concerns to the Employer.

(a) If an accident results in injury to the Employer and the Employer has a Designated Representative, the Caregiver must report the accident to the Designated Representative as soon as possible.

(b) If a work-related accident results in injury to the Caregiver, the Caregiver must report such accident to the Employer as soon as possible, but no later than 24 hours after such injury.

Section 13. **Driving.** The Caregiver is prohibited from providing transportation services to the Employer unless the duties specified in the Employer's ISP include providing transportation services. If the Caregiver's duties under the ISP include providing transportation services, the Caregiver (a) must have a current, valid driver's license and must have automobile insurance in the minimum amount required by the State of Kansas or in such greater amount as the Employer otherwise requires and (b) must notify the Employer immediately if the status of the Caregiver's driver's license or automobile insurance changes.

Section 14. **Medicaid Fraud.** The parties agree and understand that if either of them submits false or inaccurate information to the FMS Provider or through the AuthentiCare® KS IVR system regarding the work times or duties performed by the Caregiver under the Program, it will be considered Medicaid fraud and exploitation of benefits, which the FMS Provider is required to report to the State of Kansas.

Section 15. **Consent to Release of Confidential Information.** The Caregiver consents and authorizes the FMS Provider and the Employer to release and exchange information related to the services provided by the Caregiver to the following agencies and individuals: the Employer's case manager; the Employer's case management agency or CME (as applicable), including, but not limited to, a Managed Care Organization (**"MCO"**) that is a CME; the Employer's Community Developmental Disability Organization (**"CDDO"**); KDADS; the Division of Health Care Finance of the Kansas Department of Health and Environment; HP Enterprises/KS Medicaid Fiscal Agent; the KDADS's Quality Assurance Department; AuthentiCare® KS; and any other governmental agency as required by law and Kansas FMS requirements.

Section 16. **Termination of the Agreement.** This Agreement shall remain in effect while the Caregiver is employed by the Employer. The Caregiver understands and agrees that his/her employment, and this Agreement, will terminate upon the earliest occurrence of one of the following events:

(a) Denial of the Employer's Medicaid and/or KanCare eligibility;

(b) Termination/closure of the Employer's applicable HCBS case;

(c) Termination of the Employer's right to self-direct his/her care; or

(d) A decision of either party to terminate the employment relationship.

Section 17. **Third Party Beneficiary.** Though KDADS and the CME (if any) are not parties to this Agreement, the parties specifically intend that KDADS and the CME (if any) each be a third-party beneficiary and, as a result thereof, further acknowledge and agree that KDADS and/or the CME (if any) may, at their option, enforce the terms of this Agreement.

Section 18. **Assignment.** The parties shall not assign, subcontract, or delegate any duties or obligations required by this Agreement to any other individual, agency, or organization. Subject to that limitation, this Agreement shall be binding upon and inure to the benefit of the parties and their heirs, personal representatives, successors, and assigns.

Section 19. **Amendment.** This Agreement may only be modified by a written agreement signed by the parties hereto. No failure by either party to insist upon the strict performance of this Agreement on one or more occasions shall constitute a waiver of any right or remedy hereunder.

Section 20. **Severability.** The invalidity or unenforceability of any provision of this Agreement shall not affect the other provisions hereof and this Agreement shall be construed in all respects as if such invalid or unenforceable provision were omitted.

Section 21. **Entire Agreement.** This Agreement has been entered into in good faith by the parties. This Agreement sets forth the entire agreement and understanding of the parties with respect to the subject matter hereof and supersedes any and all prior and contemporaneous negotiations, understandings, and agreements with regard to the subject matter hereof, whether oral or written. In entering into this Agreement, none of the parties have made or relied upon any representation or provision not set forth herein.

Section 22. **State Law.** The terms and provisions of this Agreement shall be construed in accordance with and governed by the laws of the State of Kansas. The titles of the Sections, Subsections, Paragraphs, and Subparagraphs in this Agreement have been inserted for convenient reference only and shall not affect the construction of this Agreement.

Section 23. **Venue.** For any action to enforce this Agreement by KDADS or CME (if any), venue shall solely be in the District Court of Shawnee County, Kansas. For all other actions to enforce this Agreement, venue shall solely be in the District Court of Douglas County, Kansas.

Section 24. **Compliance with Program.** It is the intent of the parties that this Agreement be interpreted to comply with the Program requirements.

Section 25. **Signatures.** This Agreement (and any amendments, modifications, or waivers in respect hereof) may be executed in any number of counterparts, each of which shall be deemed to be an original, but all of which shall constitute one and the same document. Facsimile signatures or signatures emailed in portable document format (PDF) shall be acceptable and deemed binding on the parties hereto as if they were originals.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the day and year first above written.

CAREGIVER

_____
Signature

_____
Print name

EMPLOYER

_____
Signature

_____
Print name

_____
If Employer does not sign, the relationship of the person signing to the Employer

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

STOP *Employer Completes Next Page* STOP

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

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

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		
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		**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		

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.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name		4. Employer Identification Number (EIN)
5. Employer address		6. Employer phone number
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above)	12. Email address	

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

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☐ Some employees. Eligible employees are:
- With respect to dependents:
  - ☐ We do offer coverage. Eligible dependents are:
  - ☒ We do not offer coverage.

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

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

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