CONSUMER DIRECT CARE NETWORK

This packet is designed for single sided paper printing. Reset/clear all fields > Clear Form

DIRECT CARE WORKER EMPLOYMENT APPLICATION

APPLICANT INFORMATION

Name - First: _____ Middle: _____ Last: _____

Previously Held Names: _____

Physical Address: _____
Street City State Zip

Mailing Address: _____
Street/PO Box City State Zip

Phone - Home: _____ Cell: _____

We may reach out to you via SMS/Text Messaging concerning your services with CDCN. Please note that CDCN will never request sensitive personal information, such as your Social Security Number, banking details, address, or date of birth through text messages. If you receive an SMS message from CDCN and would like to opt-out from future SMS messages, please respond to the initial message with "STOP".

Do you consent to receiving text messages from Consumer Direct Care Network (CDCN)? ☐ Yes ☐ No

Email Address: _____ Social Security Number: ___ - ___ - ___

Are you over 18 years old? ☐ Yes ☐ No Date of Birth (mm/dd/yyyy): _____

Emergency Contact Name and Phone: _____

Primary Language: _____ Secondary Language: _____

How did you hear about working for CDCN? _____

ADDITIONAL INFORMATION/EXPERIENCE

Current Driver's License?	☐ Yes	☐ No
Current CPR certification?	☐ Yes	☐ No
Current First Aid certification?	☐ Yes	☐ No
Hoyer Lift experience?	☐ Yes	☐ No
Can you cover on short notice?	☐ Yes	☐ No
Any restrictions, such as working with certain pets, smokers, or heavy lifting?	☐ Yes	☐ No

Comments/Explanations:

CRIMINAL CONVICTIONS

Have you ever been convicted of a crime? ☐ Yes ☐ No *(If yes explain convictions, dates, and sentences imposed. Convictions will not necessarily prohibit employment, but will be considered in relation to specific job requirements.)*

LOCATIONS YOU CAN WORK/AVAILABILITY TO TRAVEL

Which areas are you willing to travel to for work?

Phoenix office: ☐ Anthem ☐ Buckeye ☐ Casa Grande ☐ Chandler ☐ Gilbert ☐ Glendale ☐ Mesa ☐ Paradise Valley ☐ Peoria ☐ Queen Creek ☐ Scottsdale ☐ Surprise ☐ Tempe ☐ Wickenburg ☐ Other: _____

Prescott office: ☐ Ash Fork ☐ Black Canyon City ☐ Bullhead City ☐ Chino Valley ☐ Cordes Lakes ☐ Cottonwood ☐ Eager ☐ Flagstaff ☐ Holbrook ☐ Kingman ☐ Lake Havasu ☐ Mayer ☐ Page ☐ Parker ☐ Prescott ☐ Prescott Valley ☐ Quartzite ☐ Sedona ☐ Seligman ☐ Snowflake ☐ St. Johns ☐ Williams ☐ Winslow ☐ Other: _____

Tucson office: ☐ Catalina ☐ Green Valley ☐ Marana ☐ Oro Valley ☐ Sabino Canyon ☐ Sahuarita ☐ South Tucson ☐ Three Points ☐ Vail ☐ Other: _____

Yuma/Sierra Vista office: _____

CONSUMER DIRECT CARE NETWORK

DIRECT CARE WORKER EMPLOYMENT APPLICATION

DAYS AND TIMES YOU ARE AVAILABLE TO WORK							
	SUN	MON	TUE	WED	THU	FRI	SAT
Start Time							
End Time							

PROSPECTS LIST/ADDITIONAL ASSIGNMENTS

Being listed on the Consumer Direct Care Network (CDCN) prospective DCW list (Prospects List) presents opportunities to connect you with additional CDCN members after your initial placement. Caregivers who are on the list may want more hours or may need a more permanent assignment. We use this list as a tool for long term, short term, and emergency employment needs. The Prospects List includes your name, phone number, availability and area of town that you wish to work. When a member needs help recruiting a caregiver, we provide them with the list or assist them in finding a caregiver from the list. The member or CDCN may call caregivers from the list to set up interviews and/or schedule work times.

To remain in good standing with our agency you are expected to adhere to conditions contained in your DCW Training Manual – current CPR, 1st Aid, Continuing Education, Background Check and Support Coordinator reviews. Should your requirements lapse, you will be removed from the Prospects List. If you are not available for scheduled work after accepting an assignment, you must notify the member and the CDCN office. A no call/no show can result in removal from the Prospects List.

Your choice below will only affect your status on the Prospects List. Once employed with a member, you may continue working with that member even if you are removed from the list.

I agree with and understand the above information regarding the Prospects List. I wish to:

☐ Be included on the Prospects List.

☐ Not be included on the Prospects List. I am not interested in additional work after initial placement with a member. I understand that, by making this choice, I will not be eligible to file Unemployment Claims.

EDUCATION				
Type of School	**Name of School**	**Location (Complete Address)**	**Circle last grade completed**	**Major & Degree**
High School			9 10 11 12	
			9 10 11 12	
College/ Business/ Trade School			1 2 3 4	
			1 2 3 4	

WORK EXPERIENCE Please list your work experience beginning with your most recent job held. If you were self-employed, give firm name. **Attach additional sheets if necessary.**			
Name of Employer:	Name of Last Supervisor	Employment Dates	Pay or Salary
Address:		From: To:	Start: Final:
Phone Number:	Your Last Job Title:		
Reason for Leaving (be specific):			
List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked at this company:			

Name of Employer:	Name of Last Supervisor	Employment Dates	Pay or Salary
Address:		From: To:	Start: Final:
Phone Number:	Your Last Job Title:		
Reason for Leaving (be specific):			
List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked at this company:			

Name of Employer:	Name of Last Supervisor	Employment Dates	Pay or Salary
Address:		From: To:	Start: Final:
Phone Number:	Your Last Job Title:		
Reason for Leaving (be specific):			
List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked at this company:			

CONSUMER DIRECT CARE NETWORK

DIRECT CARE WORKER EMPLOYMENT APPLICATION

REFERENCES

List three references that can verify your character and work history *(Required per Arizona Health Care Cost Containment System Medical Policy Manual Chapter 1200).*

1. A Previous Employer	Reference Name:	Phone:
Company Name:	Applicant Employment Dates:	
Reference Title:	Applicant Job Title:	
Additional Information:		
2. Personal or Professional	Reference Name:	Phone:
Reference Title:	Relationship:	
Additional Information:		
3. Personal or Professional	Reference Name:	Phone:
Reference Title:	Relationship:	
Additional Information:		

PLEASE READ CAREFULLY

Neither the acceptance of this information nor the subsequent entry into any type of employment relationship, either in the position applied for or any other position, and regardless of the contents of employee handbooks, personnel manuals, benefit plans, policy statements, and the like as they may exist from time to time, or other Company practices, shall serve to create an actual or implied contract of employment or to confer any right to remain an employee of this company. The relationship cannot be altered except by a written instrument signed by the President of the Company. If employed, I understand that the company may unilaterally change or revise their benefits, policies and procedures and such changes may include reduction in benefits.

I authorize investigation of all statements contained in this application. **I understand that misrepresentation or omission of facts called for is cause for dismissal at any time without previous notice.** I authorize the investigation of all matters contained on this form and hereby give the Company permission to contact schools, previous employers, references, and others, and hereby release the Company from any liability as a result of such contact. If I am hired, this Authorization will remain on file. It will be used to get updated information about me from Central Registry during my employment. A photocopy or facsimile of this Authorization is valid as the original.

The Fair Credit Reporting Act requires us to advise you that, in connection with our routine processing of your employment information, we may request from a consumer reporting agency an investigative consumer report including information as to your character, general reputation, personal characteristics, and mode of living. Upon written request from you, we will provide you with additional information concerning the nature and scope of any report requested by us.

I understand that my employment with this company shall be probationary for a period of 6 months, during which my employment relation with the company is terminable at will for any reason by either party.

Signature of Applicant: _____ Date: _____

This company is an equal opportunity employer and considers applicants qualifications without regard to gender, race, color, disability, national origin, religion, age, sexual preference or any other basis prohibited by city, state or federal law.

CONSUMER DIRECT CARE NETWORK

DCW ORIENTATION AND TRAINING CHECKLIST

_____

Print DCW's Name

Please check off the following after completion.

Forms/Actions Completed Prior to Orientation

- ☐ Employment Application
- ☐ DCW Entered in CRM
- ☐ DCW References and APS Registry checked
- ☐ DCW entered into HHAeXchange

Forms Completed with the DCW at Orientation

- ☐ I-9
- ☐ W-4
- ☐ Arizona A-4
- ☐ Pay Selection Form
- ☐ Wage Memo
- ☐ Payroll Deduction
- ☐ New Hire Expected Weekly Hours
- ☐ Equal Employment Opportunity Disclosure
- ☐ Employee Agreement
- ☐ Hep B Authorization
- ☐ Drive or No-Drive Confirmation
- ☐ Criminal History Self Disclosure

Initial Trainings/Training Documentation

- ☐ Abuse, Neglect & Exploitation Quiz
- ☐ Fraud Prevention Quiz
- ☐ Bloodborne Pathogens Quiz
- ☐ DCW Testing Documentation
- ☐ Continuing Education and Ongoing Training

Certifications/Other Provided by the DCW

- ☐ First Aid Certification
- ☐ CPR Certification
- ☐ Proof of Auto Insurance (if applicable)

Supplemental Materials Reviewed and Provided to the DCW

- ☐ DCW Handbook
- ☐ Medicaid Fraud Handout
- ☐ Payroll Calendar
- ☐ Contact Information
- ☐ HHAeXchange Telephone Call Reference Guide
- ☐ HHAeXchange Mobile App Reference Guide
- ☐ Service Code/Service ID Listing
- ☐ Task List with Task ID/Description

Administrative Steps

- ☐ OIG
- ☐ Provider Type Profile
- ☐ Okay to Work
- ☐ E-Verify
- ☐ Reference Checks
- ☐ Check Background Check
- ☐ Training Certificate
- ☐ SAM Registry Check
- ☐ Request for Search of Central Registry for Background Check (DOES form 1288A) - SEAGO only

_____ _____

CDCN Representative Signature Date

CONSUMER DIRECT CARE NETWORK

EQUAL EMPLOYMENT OPPORTUNITY DISCLOSURE

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

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

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

☐ Male ☐ Female

Race/Ethnic Identification:

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

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

-OR-

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

Decline Self Identification:

☐ I do not wish to self-identify.

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

Employee Signature: _____ **Date**: _____

Staff Option:

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

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

09525

Employment Eligibility Verification

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

USCIS Form I-9
OMB No.1615-0047
Expires 05/31/2027

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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

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

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

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

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

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
Arizona Consumer Direct Personal Care	50 N. Alvernon Way, Tucson AZ, 85711

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

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
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		**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		

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	**OR**	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

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

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

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 05/31/2027

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

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

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

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

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

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

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

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

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

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

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2025

Step 1: Enter Personal Information

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

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

TIP: Consider using the estimator at *www.irs.gov/W4App* to determine the most accurate withholding for the rest of the year if: you are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

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

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

Step 3: Claim Dependent and Other Credits

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

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

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

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

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

General Instructions

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

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2025 if you meet both of the following conditions: you had no federal income tax liability in 2024 **and** you expect to have no federal income tax liability in 2025. You had no federal income tax liability in 2024 if (1) your total tax on line 24 on your 2024 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2025 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 17, 2026.

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

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

1. Are submitting this form after the beginning of the year;

2. Expect to work only part of the year;

3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;

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

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

TIP: Have your most recent pay stub(s) from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

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. Submit a separate Form W-4 for each job.

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

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

CAUTION

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

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

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2025 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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

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

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

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

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

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

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

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

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

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

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

1 Enter an estimate of your 2025 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $

2 Enter:
- $30,000 if you're married filing jointly or a qualifying surviving spouse
- $22,500 if you're head of household
- $15,000 if you're single or married filing separately

. . . . . **2** $

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

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

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

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$700	$850	$910	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020
$10,000 - 19,999	0	700	1,700	1,910	2,110	2,220	2,220	2,220	2,220	2,220	2,220	3,220
$20,000 - 29,999	700	1,700	2,760	3,110	3,310	3,420	3,420	3,420	3,420	3,420	4,420	5,420
$30,000 - 39,999	850	1,910	3,110	3,460	3,660	3,770	3,770	3,770	3,770	4,770	5,770	6,770
$40,000 - 49,999	910	2,110	3,310	3,660	3,860	3,970	3,970	3,970	4,970	5,970	6,970	7,970
$50,000 - 59,999	1,020	2,220	3,420	3,770	3,970	4,080	4,080	5,080	6,080	7,080	8,080	9,080
$60,000 - 69,999	1,020	2,220	3,420	3,770	3,970	4,080	5,080	6,080	7,080	8,080	9,080	10,080
$70,000 - 79,999	1,020	2,220	3,420	3,770	3,970	5,080	6,080	7,080	8,080	9,080	10,080	11,080
$80,000 - 99,999	1,020	2,220	3,420	4,620	5,820	6,930	7,930	8,930	9,930	10,930	11,930	12,930
$100,000 - 149,999	1,870	4,070	6,270	7,620	8,820	9,930	10,930	11,930	12,930	14,010	15,210	16,410
$150,000 - 239,999	1,870	4,240	6,640	8,190	9,590	10,890	12,090	13,290	14,490	15,690	16,890	18,090
$240,000 - 259,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$260,000 - 279,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$280,000 - 299,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$300,000 - 319,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,170	19,170
$320,000 - 364,999	2,040	4,440	6,840	8,390	9,790	11,100	12,470	14,470	16,470	18,470	20,470	22,470
$365,000 - 524,999	2,790	6,290	9,790	12,440	14,940	17,350	19,650	21,950	24,250	26,550	28,850	31,150
$525,000 and over	3,140	6,840	10,540	13,390	16,090	18,700	21,200	23,700	26,200	28,700	31,200	33,700

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	$200	$850	$1,020	$1,020	$1,020	$1,370	$1,870	$1,870	$1,870	$1,870	$1,870	$2,040
$10,000 - 19,999	850	1,700	1,870	1,870	2,220	3,220	3,720	3,720	3,720	3,720	3,890	4,090
$20,000 - 29,999	1,020	1,870	2,040	2,390	3,390	4,390	4,890	4,890	4,890	5,060	5,260	5,460
$30,000 - 39,999	1,020	1,870	2,390	3,390	4,390	5,390	5,890	5,890	6,060	6,260	6,460	6,660
$40,000 - 59,999	1,220	3,070	4,240	5,240	6,240	7,240	7,880	8,080	8,280	8,480	8,680	8,880
$60,000 - 79,999	1,870	3,720	4,890	5,890	7,030	8,230	8,930	9,130	9,330	9,530	9,730	9,930
$80,000 - 99,999	1,870	3,720	5,030	6,230	7,430	8,630	9,330	9,530	9,730	9,930	10,130	10,580
$100,000 - 124,999	2,040	4,090	5,460	6,660	7,860	9,060	9,760	9,960	10,160	10,950	11,950	12,950
$125,000 - 149,999	2,040	4,090	5,460	6,660	7,860	9,060	9,950	10,950	11,950	12,950	13,950	14,950
$150,000 - 174,999	2,040	4,090	5,460	6,660	8,450	10,450	11,950	12,950	13,950	15,080	16,380	17,680
$175,000 - 199,999	2,040	4,290	6,450	8,450	10,450	12,450	13,950	15,230	16,530	17,830	19,130	20,430
$200,000 - 249,999	2,720	5,570	7,900	10,200	12,500	14,800	16,600	17,900	19,200	20,500	21,800	23,100
$250,000 - 399,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$400,000 - 449,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$450,000 and over	3,140	6,490	9,160	11,660	14,160	16,660	18,660	20,160	21,660	23,160	24,660	26,160

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	$450	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,870	$1,870	$1,870	$1,890
$10,000 - 19,999	450	1,450	2,000	2,200	2,220	2,220	2,220	3,180	4,070	4,070	4,090	4,290
$20,000 - 29,999	850	2,000	2,600	2,800	2,820	2,820	3,780	4,780	5,670	5,690	5,890	6,090
$30,000 - 39,999	1,000	2,200	2,800	3,000	3,020	3,980	4,980	5,980	6,890	7,090	7,290	7,490
$40,000 - 59,999	1,020	2,220	2,820	3,830	4,850	5,850	6,850	8,050	9,130	9,330	9,530	9,730
$60,000 - 79,999	1,020	3,030	4,630	5,830	6,850	8,050	9,250	10,450	11,530	11,730	11,930	12,130
$80,000 - 99,999	1,870	4,070	5,670	7,060	8,280	9,480	10,680	11,880	12,970	13,170	13,370	13,570
$100,000 - 124,999	1,950	4,350	6,150	7,550	8,770	9,970	11,170	12,370	13,450	13,650	14,650	15,650
$125,000 - 149,999	2,040	4,440	6,240	7,640	8,860	10,060	11,260	12,860	14,740	15,740	16,740	17,740
$150,000 - 174,999	2,040	4,440	6,240	7,640	8,860	10,860	12,860	14,860	16,740	17,740	18,940	20,240
$175,000 - 199,999	2,040	4,440	6,640	8,840	10,860	12,860	14,860	16,910	19,090	20,390	21,690	22,990
$200,000 - 249,999	2,720	5,920	8,520	10,960	13,280	15,580	17,880	20,180	22,360	23,660	24,960	26,260
$250,000 - 449,999	2,970	6,470	9,370	11,870	14,190	16,490	18,790	21,090	23,280	24,580	25,880	27,180
$450,000 and over	3,140	6,840	9,940	12,640	15,160	17,660	20,160	22,660	25,050	26,550	28,050	29,550

Arizona Form **A-4**

Employee's Arizona Withholding Election

2025

Type or print your Full Name		Your Social Security Number
Home Address – number and street or rural route		
City or Town	State	ZIP Code

Choose either box 1 or box 2:

☐ **1** Withhold from gross taxable wages at the percentage checked **(check only one percentage)**:

☐ 0.5% ☐ 1.0% ☐ 1.5% ☐ 2.0% ☐ 2.5% ☐ 3.0% ☐ 3.5%

☐ Check this box and enter an extra amount to be withheld from each paycheck ..... $

☐ **2** I elect an Arizona withholding percentage of zero, and I certify that I expect to have no Arizona tax liability for the current taxable year.

I certify that I have made the election marked above.

SIGNATURE DATE

Employee's Instructions

Arizona law requires your employer to withhold Arizona income tax from your wages for work done in Arizona. The amount withheld is applied to your Arizona income tax due when you file your tax return. The amount withheld is a percentage of your gross taxable wages from every paycheck. You may also have your employer withhold an extra amount from each paycheck. Complete this form to select a percentage and any extra amount to be withheld from each paycheck.

What are my "Gross Taxable Wages"?

For withholding purposes, your "gross taxable wages" are the wages that will generally be in box 1 of your federal Form W-2. It is your gross wages less any pretax deductions, such as your share of health insurance premiums.

New Employees

Complete this form within the first five days of your employment to select an Arizona withholding percentage. You may also have your employer withhold an extra amount from each paycheck. If you do not give this form to your employer the department requires your employer to withhold 2.0% of your gross taxable wages.

Current Employees

If you want to change your current amount withheld, you must file this form to change the Arizona withholding percentage or to change the extra amount withheld.

What Should I do With Form A-4?

Give your completed Form A-4 to your employer.

Electing a Withholding Percentage of Zero

You may elect an Arizona withholding percentage of zero if you expect to have no Arizona income tax liability for the current year. Arizona tax liability is gross tax liability less any tax credits, such as the family tax credit, school tax credits, or credits for taxes paid to other states. If you make this election, your employer will not withhold Arizona income tax from your wages for payroll periods beginning after the date you file the form. To keep this election for the next calendar year, you must give your employer an updated Form A-4. If you do not, your employer may withhold Arizona income tax from your wages and salary until you submit an updated Form A-4.

Zero withholding does not relieve you from paying Arizona income taxes that might be due at the time you file your Arizona income tax return. If you have an Arizona tax liability when you file your return or if at any time during the current year conditions change so that you expect to have a tax liability, you should promptly file a new Form A-4 and choose a withholding percentage that applies to you.

Voluntary Withholding Election by Certain Nonresident Employees

Compensation earned by nonresidents while physically working in Arizona for temporary periods is subject to Arizona income tax. However, under Arizona law, compensation paid to certain nonresident employees is not subject to Arizona income tax withholding. These nonresident employees need to review their situations and determine if they should elect to have Arizona income taxes withheld from their Arizona source compensation. Nonresident employees may request that their employer withhold Arizona income taxes by completing this form to elect Arizona income tax withholding.

CONSUMER DIRECT CARE NETWORK

PAY SELECTION FORM

Employee Name: _____ Date of Birth: _____

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

Please check one pay option below.

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

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

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

The Name of my bank is: _____

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

AN ATTACHMENT IS REQUIRED.

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

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

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

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

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

_____ _____

Employee Signature *Date*

02593

CONSUMER DIRECT CARE NETWORK

WAGE MEMORANDUM

Employee (DCW) Name	Member Name	Member CDCN ID #

Position: ☐ Direct Care Worker (DCW) ☐ Lead Direct Care Worker (DCW)

Effective Date: _____

Program: ☐ ABT ☐ AWC

MCO/Provider: ☐ Banner UFC ☐ Mercy Care ☐ United Healthcare ☐ SEAGO ☐ Private Pay

☐ Private Pay Insurance

Wage:

☐ $ _____/hour regular wage

☐ $ _____/hour (Daily Respite only; 12 to 24 hours of continuous respite care)

☐ $ _____/hour (Daily Adult Companion Care; 6 to 24 hours of continuous care)

☐ Holiday Pay (1.5 X regular wage; applied on holidays established in the CDCN employee handbook.)

Authorized Services:

✓	Service	Banner, Mercy Care & UHC	SEAGO	Private Pay	CDAZ
☐	Respite	S5150	RSP	------	------
☐	Daily Respite (separate hourly rate, see above)	S5151	------	------	------
☐	Homemaker	S5130	HSK	------	------
☐	Personal Care	T1019	ATT	PCA	------
☐	Adult Companion Care	S5135	------	------	------
☐	Daily Adult Companion Care	S5136	-----	------	-----
☐	Agency Based Traditional (ABT) Attendant Care	S5125	------	------	------
☐	ABT Spouse	S5125 U3	------	------	------
☐	ABT Family member not living with member	S5125 U4	------	------	------
☐	ABT Family member living with member	S5125 U5	------	------	------
☐	Agency With Choice (AWC) Attendant Care Worker	S5125 U7	------	------	------
☐	AWC Spouse	S5125 U7 U3	------	------	------
☐	AWC Family member not living with member	S5125 U7 U4	------	------	------
☐	AWC Family member living with member	S5125 U7 U5	------	------	------

Note: Overtime is generally not allowed. Any exception must be approved in advance of time worked and in writing by the Consumer Direct office.

☐ New DCW/Initial Wage Memo: _____ _____

DCW Signature Date

☐ Existing DCW/Prior Wage Memo in File: I, the Consumer Direct Care Network (CDCN) Representative, have discussed this current wage information and provided accurate service code(s) via telephone to this DCW.

_____ _____

CDCN Representative Signature Date/Time of phone call

CONSUMER DIRECT CARE NETWORK

ADMIN WAGE MEMORANDUM

	CDAZ Admin	1005226
Employee (DCW) Name	Member Name	Member CDCN ID #

Position: ☐ Direct Care Worker (DCW) ☐ Lead Direct Care Worker (DCW)

Effective Date: _____

Program: ☐ ABT ☐ AWC

Wage: ☐ $ _____/hour regular wage

☐ $ _____/hour training wage

☐ $ _____/hour Portal-to-Portal (travel time, ABT only)

Authorized Services:

✓	Service	Banner, Mercy Care & UHC	SEAGO	Private Pay	CDAZ
☐	Paid Sick Leave	SICK1	SICK1	------	------
☐	Administrative Services	------	------	------	ADMIN
☐	Training	------	------	------	TRAINING
☐	Portal-to-Portal				PORTAL
On Call Stipend Services – All Providers					
ONCALLWKDAY ($15)		ONCALLWKEND ($20)		ONCALLHOLIDAY ($20)	

Note: Overtime is generally not allowed. Any exception must be approved in advance of time worked and in writing by the Consumer Direct office.

☐ New DCW/Initial Wage Memo: _____ _____

DCW Signature Date

☐ Existing DCW/Prior Wage Memo in File: I, the Consumer Direct Care Network (CDCN) Representative, have discussed this current wage information and provided accurate service code(s) via telephone to this DCW.

_____ _____

CDCN Representative Signature Date/Time of phone call

CONSUMER DIRECT CARE NETWORK

PAYROLL DEDUCTION

_____
Direct Care Worker Name (please print)

Consumer Direct Care Network (CDCN) shares the cost of CPR and First Aid certification with Direct Care Workers (DCWs). CDCN and the DCW each pay $20. CDCN allows DCWs to deduct their share of this cost from their first **two** paychecks.

Please check below to accept or decline this payroll deduction:

☐ I **Accept** the CPR/First Aid payroll deduction. I understand that $10.00 will be deducted from each of my first two paychecks.

☐ I **Decline** the CPR/First Aid payroll deduction because:

- ☐ I have submitted copies of CPR and 1st Aid certifications
- ☐ I have paid by: Cash $_____ or Check $_____ , Check #_____

My signature below authorizes CDCN to make the above-noted payroll deductions. I understand that if I do not elect the deduction then I must pay for my portion of the training by cash or check before I begin working.

_____ _____
Direct Care Worker Signature *Date*

CONSUMER DIRECT CARE NETWORK

EMPLOYEE AGREEMENT

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

1. Caregiver Handbook

I have received a copy of the Consumer Direct Care Network Arizona (CDCN) Caregiver Handbook. It provides employment guidelines on CDCN's policies, procedures, and programs. The Handbook is not a contract for employment.

I agree to read and understand the information in the Handbook. It is my responsibility to follow all the policies and procedures in the Handbook. I can ask CDCN if I have questions. CDCN can revise or update policies, procedures or any information in the Handbook at any time.

2. Service Model

If hired under a co-employment service model, the Member is my Managing Employer. They select, schedule, manage and dismiss caregivers. CDCN is my legal Employer of Record. CDCN provides administrative and payroll services to the Member. CDCN can also terminate my employment without the Member's permission.

If hired under an agency-based service model, CDCN is both my Managing Employer and Employer or Record. CDCN is solely responsible to select, schedule, manage and dismiss Direct Care Workers (DCWs).

3. I will submit to CDCN:

- A copy of First Aid/CPR Training Certificate (CDCN offers First Aid/CPR at a split cost with me). Online training is not accepted.
- Verification of current automobile liability insurance in order to complete certain personal care tasks. I agree to maintain insurance and provide updated insurance to CDCN. If there is no driving to perform any tasks, I will complete a No Driving form.
- Notice of changes to my name, address or telephone number within 10 days of the change. Pending criminal charges occurring after my hire date must also be disclosed within 10 days.

4. Training

I will complete the initial DCW training in order to be eligible to start work. I will also complete six hours of continuing education per year. No one will assist me or complete the trainings on my behalf. Misrepresentation as to who completed the training constitutes Medicaid Fraud and may result in termination of my employment.

CDCN has a library of training modules to choose from. A CDCN Service Coordinator will work with me to identify appropriate trainings. The Member can also decide on individualized training for me to take based on their care needs. For example, if the Member has diabetes, they may have me complete the diabetes training module.

The Member will orient me to their home services and talk about their needs and preferences. The Service Coordinator will also orient me to the Member's needs.

5. Payment *(Employee, please initial each item below to indicate agreement and understanding).*

_____ I have received a CDCN payroll calendar.

_____ I will be paid at an hourly rate for approved services I provide to the Member. Hourly rates are identified in a wage memo.

_____ I must submit time for each shift worked through an approved Electronic Visit Verification method. The Member/PR must approve each shift worked. **All corrections and approvals must be done within 10 days of the date of service or my pay may be affected.**

_____ Portal-to-portal (Agency Based Traditional program only) and daily respite care (12-24 hours of continuous respite care), are paid at an hourly rate equal to the current minimum hourly wage in Arizona or in the municipality where services are provided, whichever is greater.

_____ I will earn paid sick time. I will accrue one hour of paid sick time for every 30 hours worked and may accrue or use up to 40 hours of earned paid sick time per year. Paid sick time may be used for myself or a family member for the following reasons:

- Medical care or mental or physical illness, injury, or health condition.
- A public health emergency.
- Absence due to domestic violence, sexual violence, abuse, or stalking.

Sick time used and received is shown on my pay stubs. For more information I can contact CDCN.

_____ CDCN is <u>not</u> responsible to pay me if:

- The Member becomes ineligible for Medicaid.
- The Member/Personal Representative (PR) allows me to:
  - Work overtime (more than 40 hours per week) without prior written notice from CDCN.
  - Perform unapproved tasks or work more hours than are approved.
- Hours worked are when the Member is in the hospital or not in the home.

_____ Anytime there is an alleged misrepresentation on time submitted, CDCN has the right to withhold payment until the matter is resolved.

6. Automatic (Direct) Deposit

CDCN wants all employees to be paid in a timely and consistent manner. There are two direct deposit pay options. I can specify a bank account for the direct deposit or choose a pay card. Pay stubs (summary of pay) and W-2s are sent by first class mail to my address on file or electronically.

7. Effective Date

Employment can start once I complete the CDCN Employee Enrollment Packet and it is approved by CDCN. I must also pass the DCW exam. CDCN will contact and notify me when I can begin work.

8. My DCW responsibilities include, but are not limited to:

- Provide attendant care, personal care, housekeeping and/or respite services.

- Program compliance (follow all policy and procedures).
- Accurate documentation and record keeping (includes reporting of work no-shows).
- Confidentiality.
- Report Member hospitalization and/or emergency room visit to CDCN.
- Report work-place injuries immediately to the CDCN Risk Manager on the 24-hour Injury Hotline (888-541-1701).
- Status change notification.
- Report to appropriate authorities if concerned about abuse, neglect or exploitation.
- Keep current with background check, First Aid, CPR, and completing six (6) hours of continuing education. If my background check, First Aid or CPR expires or I do not complete continuing education, I know my employment will be suspended. I will not be paid for any work time while suspended. This means I cannot work until I submit documentation to CDCN that my training has been renewed or updated.
- Awareness of additional services in the home. I also understand other non-medical in-home services may not be provided at the same time, such as Attendant Care and Respite.
- Do not transport the Member as part of job duties.
- Do not administer medications as part of job duties.

9. Reportable Offenses

I understand I am required to immediately report to CDCN if:

- A law enforcement entity charges me with any crime listed in Arizona Revised Statute 41-1758.03 B or C. These offenses are listed on the Arizona Department of Economic Security Criminal History Self Disclosure Affidavit, which I am required to complete annually.
- Adult Protective Services alleges I have abused, neglected or exploited a vulnerable adult.

10. Non-Emergent Care

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

11. Relationship Disclosure

I am not the Member's legal guardian, Personal Representative, or parent (if the Member is under 18 years old). I will inform CDCN if I live in the Member's home. I will also inform CDCN of my family relationship to the Member. This is a state requirement.

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

CONSUMER DIRECT CARE NETWORK

INSTRUCTIONS/DECLINATION HEPATITIS B VACCINE

Direct Care Worker Name (please print)

The above-named employee is authorized to receive or complete the Hepatitis B vaccination series through the Health Department and have the charges reimbursed by Consumer Direct Care Network Arizona (CDCN):

Consumer Direct Care Network Arizona
50 North Alvernon Way
Tucson, Arizona 85711-2801

Phone: (520)-398-8409
Fax: (520)-398-8413

This authorization is valid while you are a CDCN employee. If you lose this authorization you may request a new one from your Support Coordinator.

*****INSTRUCTIONS*****

If you choose to be vaccinated, please visit a local Health Department Hepatitis B immunization facility. Make an appointment to receive the first of the three part series as soon as possible. Afterwards, you will need to schedule appointments for the remaining two parts of the series.

*****BE SURE TO KEEP YOUR RECIEPTS*****

Bring your receipts from all three parts of the vaccination series along with this authorization to CDCN for reimbursement. CDCN cannot reimburse for lost or missing receipts. Likewise, reimbursable immunization shots must occur at the Health Department and while employed with CDCN.

HEPATITIS B DECLINATION

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to receive hepatitis B vaccination at no charge. I choose to decline the hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. I understand that I may elect to receive the vaccine at a future date, while employed with CDCN.

I choose to: ☐be vaccinated ☐decline vaccination for Hepatitis B

Direct Care Worker Signature *Date*

00765

CONSUMER DIRECT CARE NETWORK

DRIVING CONFIRMATION

Employee (DCW) Name	Member Name

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

For a DCW to be paid for driving-related services, program rules require:

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

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

Attachments Required

Please attach a photocopy of the following documents:

DCW's Driver's License

State: _____ Number: _____ Expiration Date: _____

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

Expiration Date: _____ Vehicle owner: _____

Acknowledgement

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

_____ _____ _____ _____

DCW Signature *Date* *Member/Representative Signature* *Date*

CONSUMER DIRECT CARE NETWORK

NO DRIVING CONFIRMATION

Employee (DCW) Name	Member Name

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

Acknowledgement

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

DCW Signature	*Date*	*Member/Representative Signature*	*Date*

CRIMINAL HISTORY SELF DISCLOSURE AFFIDAVIT

Your fingerprints will be submitted to the Arizona Department of Public Safety (DPS) and the Federal Bureau of Investigation (FBI) for a criminal history check. Your self-disclosure on this affidavit and the information provided by your criminal history check will be used, as authorized by Public Law and Arizona Revised Statues, to help us determine your fitness to have unsupervised access to vulnerable persons. **Your failure to disclose true and accurate information on this affidavit will be sufficient grounds to end your employment or to deny, suspend, or revoke your license and may be referred to the State Attorney General's Office for prosecution.**

Be sure that you go over all six (6) pages of the self-disclosure affidavit.

You have the right to obtain a copy of any background check report and challenge the accuracy or completeness of information contained in the report. If you challenge the information, you also have a right to prompt determination as to the validity of your challenge. To obtain a copy of your background check report, contact the DPS Records Unit, ACJIS Division at (602) 223-2222.

Name *(First, Middle, Last)*: _____ Date of Birth *(MM/DD/YY)*: _____

Address *(No., Street, Apt. No.)*: _____

City: _____ State: _____ ZIP Code: _____

Check one of the following and provide information as directed:

☐ I have not been convicted of nor am I under pending indictment for any crimes.

☐ I have been convicted of or I am under pending indictment for the following crime(s) *(Provide dates, location/ jurisdiction, circumstances and outcome. Attach additional pages as needed)*:

ALSO – Check one of the following:

☐ I am not subject to registration as a sex offender in Arizona or in any other jurisdiction.

☐ I am subject to registration as a sex offender in Arizona or in any other jurisdiction. *(If you are subject to registration as a sex offender in this state or any other jurisdiction, DPS will deny you a Level 1 Fingerprint Clearance Card and you **WILL NOT** be eligible to appeal the decision.)*

I certify that I understand this affidavit. My self-disclosure is true, accurate, and complete to the best of my knowledge.

Signature: _____ Date: _____

Notary Public

State of Arizona, County of _____

Subscribed and sworn or affirmed and acknowledged before me this _____ day of _____, 20____

Commission Expiration date: _____ Notary Public's Signature: _____

See page 6 for EOE/ADA disclosures

Non-Appealable Offenses

Are you awaiting trial for or have you ever been convicted of committing, attempting to commit, soliciting or facilitating or conspiring to commit one or more of these crimes in this state or a similar crime in another jurisdiction? Mark "Yes" or "No" as applicable.

If you are subject to registration as a sex offender in this state or any other jurisdiction, or awaiting trial on or been convicted of committing, attempting to commit, soliciting or facilitating, or conspiring to commit one or more of the crimes in this section DPS will deny you a Level 1 Fingerprint Clearance Card and you **WILL NOT** be eligible to appeal the decision.

Expunged convictions from any court other than juvenile court must be identified.

	YES	NO
1. Sexual abuse of vulnerable adult	☐	☐
2. Incest	☐	☐
3. Homicide, including first or second-degree murder, manslaughter and negligent homicide	☐	☐
4. Sexual assault	☐	☐
5. Sexual exploitation of a minor or vulnerable adult	☐	☐
6. Commercial sexual exploitation of a minor or vulnerable adult	☐	☐
7. Child prostitution as prescribed in A.R.S. § 13-3212	☐	☐
8. Child abuse	☐	☐
9. Felony child neglect	☐	☐
10. Sexual conduct with a minor	☐	☐
11. Molestation of a child or vulnerable adult	☐	☐
12. Dangerous crime against children as defined in A.R.S. § 13-705	☐	☐
13. Exploitation of minors involving drug offenses	☐	☐
14. Taking a child for the purposes of prostitution as defined in A.R.S. § 13-3206	☐	☐
15. Neglect or abuse of a vulnerable adult	☐	☐
16. Sex trafficking	☐	☐
17. Sexual abuse	☐	☐
18. Production, publication, sale, possession and presentation of obscene items as prescribed in A.R.S. § 13-3502	☐	☐
19. Furnishing harmful items to minors as prescribed in A.R.S. § 13-3506	☐	☐
20. Furnishing harmful items to minors by internet activity as prescribed in A.R.S. § 13-3506.01	☐	☐
21. Obscene or indecent telephone communications to minors for commercial purposes as prescribed in A.R.S. § 13-3512	☐	☐
22. Luring a minor for sexual exploitation	☐	☐
23. Enticement of persons for purposes of prostitution	☐	☐
24. Procurement by false pretenses of persons for purposes of prostitution	☐	☐
25. Procuring or placing persons in a house of prostitution	☐	☐
26. Receiving earnings of a prostitute	☐	☐
27. Causing one's spouse to become a prostitute	☐	☐
28. Detention of persons in a house of prostitution for debt	☐	☐
29. Keeping or residing in a house of prostitution or employment in prostitution	☐	☐
30. Pandering	☐	☐
31. Trafficking of persons for forced labor or services as defined in A.R.S. § 13-1308	☐	☐

	YES	NO
32. Transporting persons for the purpose of prostitution, polygamy and concubinage	☐	☐
33. Portraying adult as a minor as prescribed in A.R.S. § 13-3555	☐	☐
34. Admitting minors to public displays of sexual conduct as prescribed in A.R.S. § 13-3558	☐	☐
35. Any felony offense involving contributing to the delinquency of a minor	☐	☐
36. Unlawful sale or purchase of children	☐	☐
37. Child bigamy	☐	☐
38. Any felony offense involving domestic violence as defined in A.R.S. § 13-3601, except for a felony offense only involving criminal damage in an amount more than $250, but less than $1000 if the offense was committed before June 29, 2009	☐	☐
39. Felony indecent exposure	☐	☐
40. Felony public sexual indecency	☐	☐
41. Felony driving under the influence, driving under the extreme influence or aggravated driving under the influence if committed within 5 years of the date you apply for a Level 1 Clearance Card	☐	☐
42. Terrorism	☐	☐
43. Any offense involving a violent crime as defined in A.R.S. § 13-901.03	☐	☐

Appealable 5 Years After Conviction

The following **felony** offenses are non-appealable if committed within 5 years of the date you apply for a Level 1 Fingerprint Clearance Card. If you have been convicted of committing, attempting to commit, soliciting or facilitating or conspiring to commit one or more of the crimes in this section *within 5 years* of applying for a Level 1 Fingerprint Clearance Card, DPS will deny you a Level 1 Fingerprint Clearance Card and you **WILL NOT** be eligible to appeal the denial.

If the conviction was *more than 5 years* before you apply for a Level 1 Fingerprint Clearance Card, DPS will deny you a Level 1 Fingerprint Clearance Card, but you will be eligible to appeal the denial to the Arizona Board of Fingerprinting.

Mark "Within 5 Years," "Over 5 Years" or "No" as applicable.

	WITHIN 5 YEARS	OVER 5 YEARS	NO
1. Endangerment	☐	☐	☐
2. Threatening or intimidating	☐	☐	☐
3. Assault	☐	☐	☐
4. Aggravated assault	☐	☐	☐
5. Unlawfully administrating intoxicating liquors, narcotic drugs or dangerous drugs	☐	☐	☐
6. Dangerous or deadly assault by prisoner or juvenile	☐	☐	☐
7. Prisoners who commit assault with intent to incite to riot or participate in riot	☐	☐	☐
8. Assault by vicious animals	☐	☐	☐
9. Drive by shooting	☐	☐	☐
10. Assaults on public safety employees or volunteers and state hospital employees	☐	☐	☐
11. Discharging a firearm at a structure	☐	☐	☐
12. Prisoner assault with bodily fluids	☐	☐	☐
13. Aiming a laser pointer at a peace officer	☐	☐	☐
14. Possession and sale of peyote	☐	☐	☐
15. Possession and sale of a vapor-releasing substance containing a toxic substance	☐	☐	☐

	WITHIN 5 YEARS	OVER 5 YEARS	NO
16. Selling or giving nitrous oxide to underage persons	☐	☐	☐
17. Sale of regulated chemicals	☐	☐	☐
18. Sale of precursor chemicals	☐	☐	☐
19. Production or transportation of marijuana	☐	☐	☐
20. Possession, use or sale of marijuana, dangerous drugs or narcotic drugs	☐	☐	☐
21. Possession, use, administration, acquisition, sale, manufacture or transportation of prescription-only drugs	☐	☐	☐
22. Administration, acquisition, manufacture or transportation of dangerous drugs or narcotic drugs	☐	☐	☐
23. Manufacturing methamphetamine under circumstances that cause physical injury to a minor under the age of 15	☐	☐	☐
24. Involving or using minors in drug offenses	☐	☐	☐
25. Possession, use, sale or transfer of marijuana, peyote, prescription drugs, dangerous drugs, or narcotic drugs or manufacture of dangerous drugs in a drug-free school zone	☐	☐	☐
26. Possession, manufacture, delivery and advertisement of drug paraphernalia	☐	☐	☐
27. Use of wire communication or electronic communication in drug-related transactions	☐	☐	☐
28. Using a building for sale or manufacture of dangerous or narcotic drugs	☐	☐	☐
29. Manufacture or distribution of prescription-only drug	☐	☐	☐
30. Manufacture, distribution, possession or possession with intent to use imitation controlled substances, imitation prescription-only drugs or imitation over-the-counter drugs	☐	☐	☐
31. Manufacture of certain substances and drugs by certain means	☐	☐	☐

Appealable Offenses

Are you awaiting trial for or have you ever been convicted of committing, attempting to commit, soliciting or facilitating or conspiring to commit one or more of these crimes in this state or a similar crime in another jurisdiction? Mark “Yes” or “No” as applicable.

If you are awaiting trial on or been convicted of committing, attempting to commit, soliciting or facilitating or conspiring to commit one or more of these crimes, DPS will deny you a Level 1 Fingerprint Clearance Card, but you will be eligible to appeal the decision to the Arizona Board of Fingerprinting.

	YES	NO
1. Theft	☐	☐
2. Theft by extortion	☐	☐
3. Shoplifting	☐	☐
4. Forgery	☐	☐
5. Criminal possession of a forgery device	☐	☐
6. Obtaining a signature by deception	☐	☐
7. Criminal impersonation	☐	☐
8. Theft of a credit card or obtaining a credit card by fraudulent means	☐	☐
9. Receipt of anything of value obtained by fraudulent use of a credit card	☐	☐
10. Forgery of a credit card	☐	☐

	YES	NO
11. Fraudulent use of a credit card	☐	☐
12. Possession of any machinery, plate or other contrivance or incomplete credit card	☐	☐
13. False statements as to financial condition or identity to obtain a credit card	☐	☐
14. Fraud by persons authorized to provide goods or services	☐	☐
15. Credit card transaction record theft	☐	☐
16. Misconduct involving weapons	☐	☐
17. Misconduct involving explosives	☐	☐
18. Depositing explosives	☐	☐
19. Misconduct involving simulated explosives	☐	☐
20. Concealed weapon violation	☐	☐
21. Misdemeanor indecent exposure	☐	☐
22. Misdemeanor public sexual indecency	☐	☐
23. Aggravated criminal damage	☐	☐
24. Adding poison or other harmful substance to food, drink or medicine	☐	☐
25. A criminal offense involving criminal trespass under Title 13, Chapter 15	☐	☐
26. A criminal offense involving criminal burglary under Title 13, Chapter 15	☐	☐
27. A criminal offense involving organized crime or fraud as prescribed in Title 13, Chapter 23, except terrorism	☐	☐
28. Misdemeanor offenses involving child neglect	☐	☐
29. Misdemeanor offenses involving contributing to the delinquency of a minor	☐	☐
30. Misdemeanor offenses involving domestic violence as defined in A.R.S. § 13-3601	☐	☐
31. Felony offenses involving domestic violence if the offense only involved criminal damage in the amount of $250 but less than $1000 and the offense was committed before June 29, 2009	☐	☐
32. Arson	☐	☐
33. Criminal damage	☐	☐
34. Misappropriation of charter school monies as prescribed in A.R.S. § 13-1818	☐	☐
35. Taking identity of another person or entity	☐	☐
36. Aggravated taking identity of another person or entity	☐	☐
37. Trafficking in the identity of another person or entity	☐	☐
38. Cruelty to animals	☐	☐
39. Prostitution as described in A.R.S. § 13-3214	☐	☐
40. Sale or distribution of material harmful to minors through vending machines as prescribed in A.R.S. § 13-3513	☐	☐
41. Welfare fraud	☐	☐
42. Kidnapping	☐	☐
43. Robbery, aggravated robbery or armed robbery	☐	☐
44. Misdemeanor endangerment	☐	☐
45. Misdemeanor threatening or intimidating	☐	☐
46. Misdemeanor assault	☐	☐
47. Misdemeanor aggravated assault	☐	☐
48. Misdemeanor unlawfully administering intoxicating liquor, narcotic drugs or dangerous drugs	☐	☐

	YES	NO
49. Misdemeanor dangerous or deadly assault by prisoner or juvenile	☐	☐
50. Misdemeanor prisoners who commit assault with intent to incite riot or participate in riot	☐	☐
51. Misdemeanor assault by vicious animals	☐	☐
52. Misdemeanor drive-by shooting	☐	☐
53. Misdemeanor assaults on public safety employees or volunteers and state hospital employees	☐	☐
54. Misdemeanor discharging a firearm at a structure	☐	☐
55. Misdemeanor prisoner assault with bodily fluids	☐	☐
56. Misdemeanor aiming a laser pointer at a peace officer	☐	☐
57. Misdemeanor possession and sale of peyote	☐	☐
58. Misdemeanor possession and sale of a vapor-releasing substance containing a toxic substance	☐	☐
59. Misdemeanor selling or giving nitrous oxide to underage persons	☐	☐
60. Misdemeanor sale of regulated chemicals	☐	☐
61. Misdemeanor sale of precursor chemicals	☐	☐
62. Misdemeanor production or transportation of marijuana	☐	☐
63. Misdemeanor possession, use or sale of marijuana, dangerous drugs or narcotic drugs	☐	☐
64. Misdemeanor possession, use, administration, acquisition, sale, manufacture or transportation of prescription-only drugs	☐	☐
65. Misdemeanor administration, acquisition, manufacture or transportation of dangerous drugs or narcotic drugs	☐	☐
66. Misdemeanor manufacturing methamphetamine under circumstances that cause physical injury to a minor under the age of 15	☐	☐
67. Misdemeanor involving or using minors in drug offenses	☐	☐
68. Misdemeanor possession, use, sale or transfer of marijuana, peyote, prescription drugs, dangerous drugs, or narcotic drugs or manufacture of dangerous drugs in a drug-free school zone	☐	☐
69. Misdemeanor possession, manufacture, delivery and advertisement of drug paraphernalia	☐	☐
70. Misdemeanor use of wire communication or electronic communication in drug-related transactions	☐	☐
71. Misdemeanor using a building for sale or manufacture of dangerous or narcotic drugs	☐	☐
72. Misdemeanor manufacture or distribution of prescription-only drug	☐	☐
73. Misdemeanor manufacture, distribution, or possession with intent to use imitation controlled substances, imitation prescription-only drugs or imitation over-the-counter drugs	☐	☐
74. Misdemeanor manufacture of certain substances and drugs by certain means	☐	☐

CONSUMER DIRECT CARE NETWORK

EXPECTED WEEKLY HOURS - NEW HIRE

CAREGIVER/NURSE
(Non-FEA)

Employee Name: _____

Entity: CDAZ

Email Address: _____

-- Office Use Only --

Hire Date: _____

Anticipated Weekly Hours:

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

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

Comments:

CDCN Representative Name: _____

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

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

10402

CONSUMER DIRECT CARE NETWORK

2025 Annual Safety Training

Protect Yourself & Others

As a healthcare provider, you're exposed to germs daily, putting you at risk of infection and potentially spreading illness to Clients and loved ones. Protect yourself and others by following standard and transmission-based precautions recommended by organizations like the Center for Disease Control (CDC).

Why this training matters: Bloodborne Pathogens, Personal Protective Equipment (PPE), and Hazardous Chemicals

Emerging Infectious Diseases
Diseases like Ebola, COVID-19, SARS, MERS, Syphilis, Zika, and Viral Hemorrhagic Fever are serious threats. Always follow Standard and Transmission-based precautions.

- **Standard precautions** are used with all patients, at all times. These protect you from infections that spread through blood and other potentially infectious materials (OPIM), such as vomit, feces, and spinal fluid.
- **Transmission-based precautions** are used in some cases in addition to standard precautions. They can be specific to how certain germs are transmitted.

Always use precautions, even if someone doesn't appear ill.

Do:

- Get help when using sharps near confused or aggressive individuals.
- Wear PPE when exposed to blood or other potentially infectious materials (OPIM).
- Wash hands regularly.
- Clean spills thoroughly.

OPIM includes: Blood, semen, vaginal fluids, cerebrospinal fluid, visibly bloody saliva, unfixed tissues, and lab specimens containing HIV, HBV, or HCV.

Saliva, urine, feces, and tears are NOT OPIM unless they are contaminated with blood or other tissues listed above.

Bloodborne Pathogens

Bloodborne Pathogens are harmful microorganisms found in human blood and body fluids that can cause diseases like HIV, Hepatitis B (HBV), and Hepatitis C (HCV).

Bloodborne Pathogens enter the body by:

- Contaminated instrument injuries
- A break in the skin (cut, lesion)
- Mucus membranes (eyes, nose, mouth)
- Sexual contact
- Injection drug use (shared needles)

Job duties that may lead to bloodborne pathogen exposure include:

- Handling sharps
- Cleaning blood or OPIM
- Providing first aid or dental procedures
- Dealing with infected, combative individuals
- Handling contaminated laundry or surfaces
- Disposing of contaminated waste
- Picking up discarded syringes in public places

HBV Vaccination:

- Occupational Health and Safety Administration (OSHA) standard requires employers to provide free HBV vaccination to employees exposed to blood or infectious materials.
- You choose to receive your vaccine or not during your hiring process. If you decline, you can request to receive the vaccine at a later time.
- Contact InfoSafety@ConsumerDirectCare.com to ask questions or schedule your vaccine.

Maintaining Cleanliness

Cleaning your hands often and thoroughly is the best way to prevent infection. The sooner you clean your hands after exposure, the less likely you are to catch or spread infection.

When to practice hand hygiene

- When first arriving at work and before leaving.
- Before and after treatment.
- After touching blood or any other body fluid or substance, broken skin, or mucus membranes.
- After touching an object or surface that is or may be contaminated.
- As soon as you remove your gloves and other PPE. (Gloves may have tiny holes, too small to be seen, through which germs can travel.)
- Before and after eating, drinking, or smoking. Also clean your hands after coughing, sneezing, blowing your nose, or using the restroom.

How to wash your hands

1. Carefully remove gloves and other PPE.
2. Use clean, running water and plenty of soap. Work up a good lather. Don't just wipe—rub well.
3. Clean your whole hand, under your nails, between your fingers, and up your wrists. Lather for at least 20 seconds.
4. Rinse your hands well. Let the water run off your fingertips, not up your wrists.
5. Dry your hands well with a clean towel. If you must touch the faucet or door when you are done, use a paper towel or a towel to prevent recontaminating your hands.

All work surfaces and equipment contaminated with blood or OPIM must be cleaned up with an appropriate disinfectant as soon as possible.

Cleaning Contaminated Surfaces

- Use paper/absorbent towels to soak up any spilled materials.
- Clean the area with disinfectant wipes.
- Wipe the area well. Leave for 10 minutes (or as specified by product manufacturer) or allow to air dry.
- Properly dispose of paper towels and cleaning materials into designated waste containers.

Laundry contaminated with blood or OPIM

Laundry contaminated with blood or OPIM must be cleaned up and handled properly so it can be disinfected as soon as possible.

- Handle laundry as little as possible.
- Bag at point of use (do not transfer laundry to another room to bag).
- Don't sort or rinse at point of use.
- Place wet laundry in leak-proof, labeled, or color-coded container/bags.

Using Personal Protective Equipment (PPE)

Gloves and other PPE protect you by creating a barrier between you and germs. The following are some guidelines for what PPE to wear and when.

When to wear gloves

Before wearing gloves, wash and dry your hands well. Cover cuts, scratches, or scrapes with bandages.

- Wear gloves whenever contact is possible with blood or OPIM. This includes any body fluids and substances (except sweat), broken skin, or mucous membranes.
- Wear gloves when touching any item that is or may be contaminated.
- Choose gloves that fit. Check gloves for cracks and tears after you put them on.
- Don't touch uncontaminated areas or items with contaminated gloves.
- Remove gloves right after use. Wash hands and put on clean gloves between clients and procedures.
- Do not reuse disposable gloves.

Removing gloves safely: To remove gloves without spreading germs, never touch your skin with the outside of either glove. Follow these steps:

Grasp the palm of one glove near your wrist. Carefully pull the glove off.

Hold the glove in the palm of the still-gloved hand. Slip two fingers under the wrist of the remaining glove.

Pull the glove until it comes off inside out. The first glove should end up inside the glove you just took off. Dispose of the gloves safely.

Always wash your hands after removing gloves. Gloves can have holes in them that are too small to be seen.

When to wear other PPE

Gowns, masks, goggles, and other PPE can help keep you and others safe. In addition to wearing gloves, you may need to wear some of the following PPE while completing your caregiving tasks.

- A gown, apron, or lab coat may be necessary in certain situations. Wear a fluid resistant gown or apron, or an impermeable lab coat, if body fluids could splash or spray.
- Mouth, nose, and eye protection should be worn if any body fluid may splash or spray near you.een patients and procedures.
- When around patients with COVID-19 or active TB, you must wear an approved respirator. A respirator should be fit-tested before you first wear it.

If you have any questions about requesting PPE contact InfoSafety@consumerdirectcare.com.

How to Use your N95 Respirator

You can find instructions for wearing your N95 mask from the CDC with pictures by scanning the QR code.

Sequence for putting on personal protective equipment (PPE)

- **Gown:** Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back.
- **Mask or Respirator:** Secure ties or elastic bands at middle of head and neck. Fit flexible band to nose bridge. Fit snug to face and below chin. Fit-check respirator.
- **Goggles or Face Shield:** Place over face and eyes and adjust to fit.
- **Gloves:** Extend to cover wrists of isolation gown.

Handling Needles & Other Sharps

Used needles, lancets, blades, and other sharps can cut or prick you. This can expose you to bloodborne pathogens. To avoid exposing yourself or others to infection, take the time to handle sharps safely.

Always move carefully while handling sharps. To prevent exposure to blood and OPIM:

- Never put a used sharp down. Instead, dispose of it in a marked sharps container as soon as you are done with it. Never throw a sharp into the trash.
- Don't bend, break, or recap needles. Never remove used needles from disposable syringes.
- Make sure used sharps don't get left in linens or on bedside tables.
- Never clean broken glass by hand.

Disposing of sharps safely

Your client or their Authorized Representative will provide sharps disposal containers. These containers must be puncture-proof and leakproof. They should be clearly marked with a biohazard label.

Follow these tips for safe use of sharps containers:

- Never overfill a sharps container. Dispose of containers when they're 2/3 full.
- Never force a sharp into a sharps container. Be careful and watch as you place sharps into the container.
- Never reach into a sharps container.
- Never open, empty, or reuse a sharps container.
- **Never handle discarded syringes with bare hands or toss them into general garbage.**

Precautions based on transmission type

When to use airborne precautions

Use airborne precautions with clients known or suspected to be infected with Covid-19, active TB, measles, or chickenpox.

- Wear approved respiratory protection.
- Put on respiratory protection before entering the room. Take it off only after leaving the room.
- Fit-check your respirator each time you wear it to be sure that air leaks don't expose you to infection.

When to use droplet precautions

Use droplet precautions with clients known or suspected of having Pertussis (whooping cough, Flu, or MRSA in sputum).

- Wear a mask within 3 feet of the client. Or you may wear a mask at all times when with the client.
- Keep others at least 3 feet away from the infected client.
- Have family members and other visitors wear masks and other appropriate PPE.

Exposure Response

If you're exposed to blood and OPIM:

- Get medical care right away. Time can be crucial in preventing infection.
- Confidential evaluation includes testing for HIV, HBV, and HCV and also includes preventive treatment, if needed.
- Report the exposure to your Supervisor and **call the confidential Injury Hotline immediately at 877-532-8542.**

Chemical Hazard Communication

We use chemicals daily in our homes and often at work. This section will teach you to identify hazardous chemicals, how they can affect your body, and how to protect yourself.

There are three ways chemicals can enter the body

Inhalation: Inhaling chemicals can be especially hazardous. When gases and vapors are breathed in, they can enter the bloodstream directly from the lungs.

Skin Absorption: The skin can act as a barrier to prevent harmful substances from entering the body, but it can also be directly affected by certain chemicals. Some chemicals can pass through the skin into the body and cause health problems while others can directly affect the skin, causing irritation.

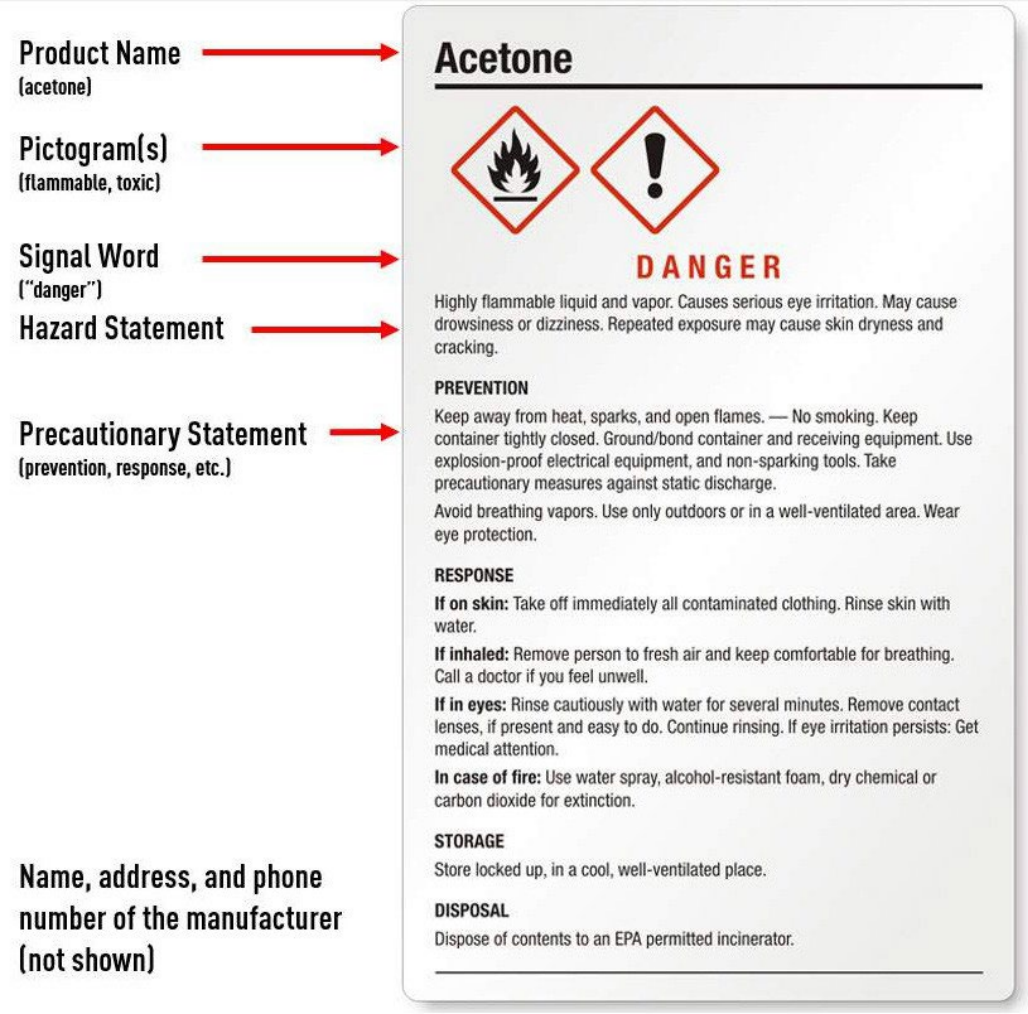
Ingestion (swallowing): Chemicals that are swallowed can be absorbed into the digestive tract. Always wash your hands before touching any food, especially after using cleaning products.

Reducing risk at home:

- To minimize chemical hazards in home cleaning products, the safest approach is to avoid mixing any home chemicals.
- Proactively ensure proper ventilation by opening windows and doors when using chemicals.
- Wear protective gloves and eyewear to protect against skin and eye irritation.
- **In the event of exposure, symptoms like shortness of breath or chest pain necessitate immediate fresh air access and medical attention.**

Chemical Labeling

Reading labels and warnings will give you a certain amount of information needed when using hazardous chemicals.



	**Exploding bomb** (for explosion or reactivity hazards)		**Flame** (for fire hazards)		**Flame over circle** (for oxidizing hazards)
	**Gas cylinder** (for gases under pressure)		**Corrosion** (for corrosive damage to metals, as well as skin, eyes)		**Skull and Crossbones** (can cause death or toxicity with short exposure to small amounts)

	**Health hazard** (may cause or suspected of causing serious health effects)		**Exclamation mark** (may cause less serious health effects or damage the ozone layer*)		**Environment*** (may cause damage to the aquatic environment)

Another way to get information needed about hazardous chemicals is from their Safety Data Sheets (SDS). Use SDS to find:

- Health hazards
- First aid procedures
- PPE needed
- Safe storage and handling

Managing Chemical Exposure

If you are exposed:

- Get medical care right away, if needed.
- Call the confidential Injury Hotline immediately at **877-532-8542.**
- Email **infosafety@consumerdirectcare.com**

Quiz

The quiz for this course consists of 12 True/False Questions. You must get 10/12 (80%) of them correct to pass.

1. All PPE should be washed and disinfected so it can be used again.
- ☐ True
- ☐ False

2. All employees are expected to comply with Standard Precautions.
- ☐ True
- ☐ False

3. Used sharps should be placed in a leakproof, puncture-proof container.
- ☐ True
- ☐ False

4. If you have a sharps exposure, you can reduce your chances of infection by getting medical care right away.
- ☐ True
- ☐ False

5. You can tell by looking if someone has an infection.
- ☐ True
- ☐ False

6. You do not need to wash your hands after removing gloves.
- ☐ True
- ☐ False

7. Standard precautions should only be used with patients who are known to have a bloodborne pathogen.
- ☐ True
- ☐ False

8. A vaccine is available to protect you from the hepatitis B virus (HBV).
- ☐ True
- ☐ False

9. Your N95 mask is the one piece of PPE that can be reused after you've removed it.
- ☐ True
- ☐ False

10. Germs in droplets can contaminate the objects they land on.
- ☐ True
- ☐ False

11. Proper disposal of used PPE, sharps, and other waste supplies can reduce the spread of bloodborne pathogens.
- ☐ True
- ☐ False

12. You can get HIV if infected blood touches a break in your skin.
- ☐ True
- ☐ False

Score: _____

Training Acknowledgment and Attestation

I hereby confirm that I have read and understand the content of this Annual Safety Training provided by Consumer Direct Care Network.

First and Last Name _____

Signature _____ Date _____

PREVENTING ABUSE, NEGLECT AND EXPLOITATION

Abuse is the treatment of a person or animal with cruelty or violence. Abuse, neglect, and exploitation are common themes in the home health care field. The five types of abuse are:

1. Abuse – Purposely causing physical, mental, or verbal harm.
2. Sexual Abuse or Assault – Sexual contact with any person not able to give consent. This could be by force or through threatening behavior.
3. Neglect – Failing to provide a person with food, water, clothing, shelter, or medical attention.
4. Financial Exploitation – Using a person's money or belongings when it has not been approved. Forgery (signing someone else's name) and stealing are two examples of this. Forcing someone to sign something over to you is another example.
5. Emotional Abuse – Mental abuse such as name-calling, insults, threats, giving someone the silent treatment, and bullying.

As the Direct Care Worker, you are the one who regularly has contact with the at risk adults whom we serve. Many victims are related to their abuser. They are afraid to speak up out of fear that the abuse will get worse. They may also feel embarrassed about their situation. Many victims are also dependent on their abuser for money. They don't want to risk being left with nothing.

You will want to learn to recognize and understand the signs of abuse. Some common signs of physical abuse are bruises, broken bones, cuts, or other injuries in different stages of healing. Physical signs are easy to observe. You will want to pay close attention to your member's behavior as well. This is done in order to spot emotional abuse or neglect. The most common form of abuse is self-neglect. This is when the member is at risk because they cannot care for themselves. One warning sign to look for is loss of interest in an activity that used to be enjoyed and now is not. Another would be if your member becomes angry and wants to be alone and this is not normal behavior for them. If you ever have any concerns, you should report them to your supervisor right away. You should also contact the authorities.

It is important to know that there are community resources available to you. Adult Protective Services has a toll free, confidential hotline. This hotline is where you can report abuse, neglect, and exploitation. The phone number is 1-877-SOS-ADULT (877-767-2385). All reports are private. Each report will be looked into by an Adult Protective Services Specialist. This person will work with law enforcement to make sure that the member is safe. It is okay to report possible abuse, even if you do not have proof. It is not your job to investigate the abuse. It is your job to report it. We will all work together to make sure that each member we serve is safe in their home.

TEST YOURSELF

True or False

Score _____

1. Calling someone names is an example of emotional abuse. **T** **F**
2. If you notice a bruise on your client's back, it is probably nothing to worry about. **T** **F**
3. Self-Neglect is the most common form of abuse. **T** **F**
4. You will rarely encounter abuse, neglect, or exploitation in the home health care industry. **T** **F**
5. Withholding food until your member takes a bath is not abuse. **T** **F**
6. APS has a toll free number where you can report your concerns anonymously. **T** **F**
7. If you suspect that your client is being abused, you should conduct your own investigation before reporting it to the authorities. **T** **F**
8. Forcing your client to make you a co-signer on their bank account is an example of financial exploitation. **T** **F**
9. Most victims are related to their abuser. **T** **F**
10. It is not necessary to report your concerns to your supervisor. **T** **F**

DCW Name (please print)	DCW Signature	Date
Coordinator Name (please print)	Coordinator Signature	Date

CONSUMER DIRECT CARE NETWORK

ACW/DCW FRAUD PREVENTION QUIZ

TEST YOURSELF

True or False

Score _____

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

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

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

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

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

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

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

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

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

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

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

04400

Supplemental Materials

wisely® by ADP

Financial control: You've got it!

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

Get paid early.[2]

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

Save and manage your money on your terms.

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

Shop with confidence.

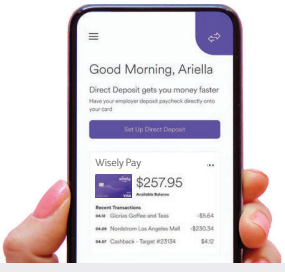
Pay online, in store, in app, or by phone everywhere Visa® debit cards are accepted or where Debit Mastercard® is accepted.

Skip ATM fees.

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

Get Wisely today!

Talk to your Payroll Department.



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

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

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

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

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

Instructions for Completing Form I-9 Section 1

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

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

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

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

③ Print your Date of Birth.

④ Print your Social Security Number.

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

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

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

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

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

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

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

Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	Other Last Names Used (if any)
① Doe	Jane	Q	N/A

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

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

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.): ⑦

- [X] 1. A citizen of the United States
- [ ] 2. A noncitizen national of the United States (See Instructions)
- [ ] 3. A lawful permanent resident (Enter USCIS or A-Number.)
- [ ] 4. A noncitizen (other than **Item Numbers 2.** and 3. above) authorized to work until (exp. date, if any)

Example

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

Signature of Employee	Today's Date (mm/dd/yyyy)
⑧ Jane Doe	⑨ 09/15/2023

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

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

Instructions for Completing Form I-9 Section 2

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

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

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

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

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

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

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

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

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

⑥ If not pre-populated, print CDCN's business name (Arizona Consumer Direct Personal Care).

⑦ If not pre-populated, print CDCN's office address (50 N. Alvernon Way, Tucson, AZ 85711).

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign **Section 2** within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1		①	Driver's License		Social Security Card
Issuing Authority			State of Residence		SSA
Document Number (if any)			0123456789abcde		123-45-6789
Expiration Date (if any)			08/17/2027		N/A
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

Example

Do not check. You must physically examine documents.

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

First Day of Employment (mm/dd/yyyy): ② 09/15/2023

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

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
⑥ **Arizona Consumer Direct Personal Care**	⑦ **50 N. Alvernon Way, Tucson AZ, 85711**

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

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

2025 Payroll Calendar

CONSUMER DIRECT CARE NETWORK

Symbol Key: (○) Pay Day (△) Postal and Bank Holiday

JANUARY

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

FEBRUARY

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

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			

2025 Bank & Post Office Holidays

*Consumer Direct Care Network office closures

- ***New Year's Day** - Wednesday, January 1
- ***Martin Luther King, Jr. Day** - Monday, January 20
- **Presidents Day** - Monday, February 17
- ***Memorial Day** - Monday, May 26
- ***Juneteenth** - Thursday, June 19
- ***Independence Day** - Friday, July 4
- ***Labor Day** - Monday, September 1
- **Columbus Day** - Monday, October 13
- ***Veterans Day** - Tuesday, November 11
- ***Thanksgiving Day** - Thursday, November 27
- ***Christmas Day** - Thursday, December 25

CONSUMER DIRECT CARE NETWORK

Work weeks are Sunday through Saturday. You must submit time daily using Electronic Visit Verification (EVV). Corrections are due by the correction deadline. Late time or time with mistakes may result in late pay. Thank you!

Two Week Pay Period		EVV Time Correction	
Start Date	End Date	Deadline	Pay Date
Sunday	Saturday	Monday	Friday
12/15/2024	12/28/2024	12/30/2024	1/10/2025
12/29/2024	1/11/2025	1/13/2025	1/24/2025
1/12/2025	1/25/2025	1/27/2025	2/7/2025
1/26/2025	2/8/2025	2/10/2025	2/21/2025
2/9/2025	2/22/2025	2/24/2025	3/7/2025
2/23/2025	3/8/2025	3/10/2025	3/21/2025
3/9/2025	3/22/2025	3/24/2025	4/4/2025
3/23/2025	4/5/2025	4/7/2025	4/18/2025
4/6/2025	4/19/2025	4/21/2025	5/2/2025
4/20/2025	5/3/2025	5/5/2025	5/16/2025
5/4/2025	5/17/2025	5/19/2025	5/30/2025
5/18/2025	5/31/2025	6/2/2025	6/13/2025
6/1/2025	6/14/2025	6/16/2025	6/27/2025
6/15/2025	6/28/2025	6/30/2025	7/11/2025
6/29/2025	7/12/2025	7/14/2025	7/25/2025
7/13/2025	7/26/2025	7/28/2025	8/8/2025
7/27/2025	8/9/2025	8/11/2025	8/22/2025
8/10/2025	8/23/2025	8/25/2025	9/5/2025
8/24/2025	9/6/2025	9/8/2025	9/19/2025
9/7/2025	9/20/2025	9/22/2025	10/3/2025
9/21/2025	10/4/2025	10/6/2025	10/17/2025
10/5/2025	10/18/2025	10/20/2025	10/31/2025
10/19/2025	11/1/2025	11/3/2025	11/14/2025
11/2/2025	11/15/2025	11/17/2025	11/26/2025*
11/16/2025	11/29/2025	12/1/2025	12/12/2025
11/30/2025	12/13/2025	12/15/2025	12/24/2025*
12/14/2025	12/27/2025	12/29/2025	1/9/2026
12/28/2025	1/10/2026	1/12/2026	1/23/2026

Consumer Direct Care Network Arizona
50 N. Alvernon Way
Tucson, AZ 85711-2801

Phone: 888-398-8409
Fax: 877-398-8413
Email: infoCDAZ@ConsumerDirectCare.com
Web: www.ConsumerDirectAZ.com

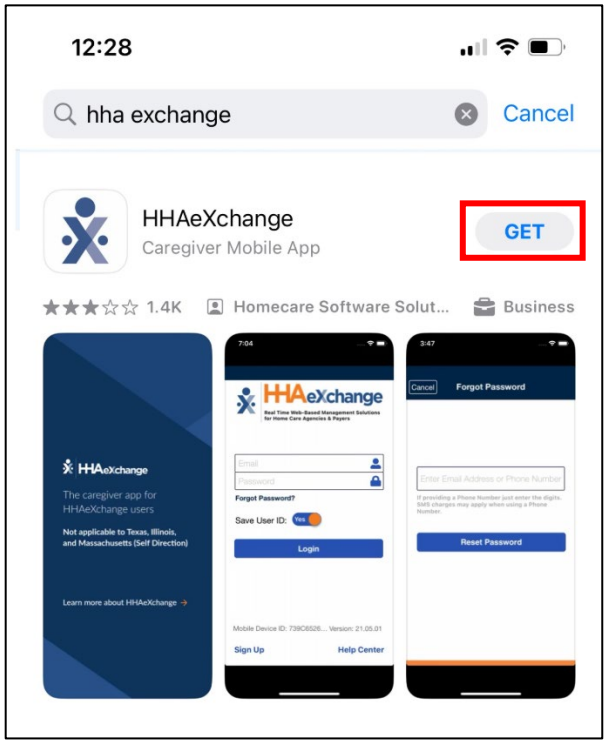
CONSUMER DIRECT CARE NETWORK ARIZONA

Getting started in the HHAeXchange Mobile App

Caregivers are responsible for downloading and installing the application on their personal mobile device. **After registering, Caregivers must provide credentials and ID numbers to Consumer Direct Arizona for further setup by calling 888-398-8409 or emailing infocdaz@consumerdirectcare.com.**

Download the App

1. Go to the **App Store** (for iPhones) or **Google Play** (for Android phones) and download the app. Use the keyword **hha exchange** to search.



2. When you first open up the app you will need to choose a language. All messages and emails will also be in the language you choose.

Sign up & Register

You will need to create an account and then register. This is a two-step process:

1. **Sign up** and create a password.
2. **Register** by entering your information.

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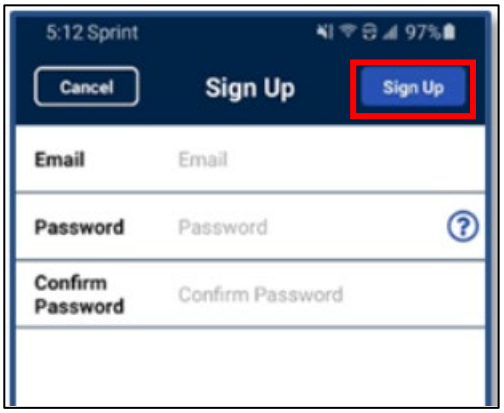
Sign up

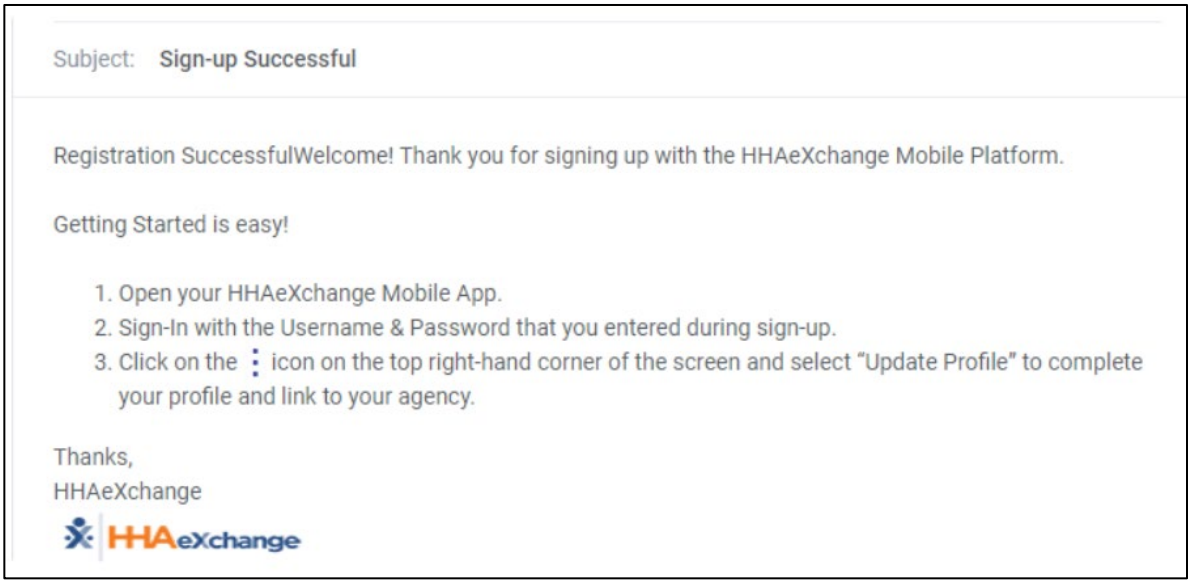


After you download the app, tap **Sign up** at the bottom of the screen.

1. You will need to type in:
- Your **Email Address**
- A **Password** you can remember
    - (at least 8 letters, 1 capital, and 1 number)
- Confirm Password – retype password

2. When you are finished, tap **Sign Up** to log in to the app.

Once you've created an account, you will get a welcome email (check your junk mail).



Subject: **Sign-up Successful**

Registration SuccessfulWelcome! Thank you for signing up with the HHAeXchange Mobile Platform.

Getting Started is easy!

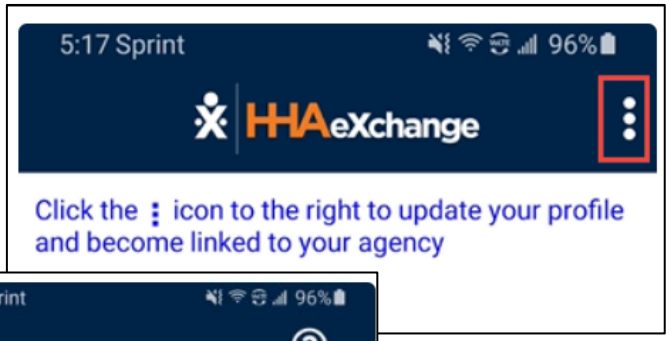
1. Open your HHAeXchange Mobile App.
2. Sign-In with the Username & Password that you entered during sign-up.
3. Click on the ⋮ icon on the top right-hand corner of the screen and select "Update Profile" to complete your profile and link to your agency.

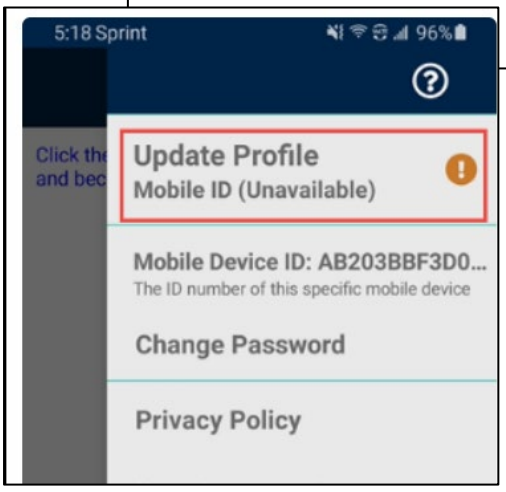
Thanks,
HHAeXchange

Register

Follow the steps below to register on the app.

1. Log in to the app after you get the email.
2. Read the **Terms of User Agreement** and tap **Agree**.
3. When the Main Screen opens, click the **three-dots icon** and tap **Update Profile**.





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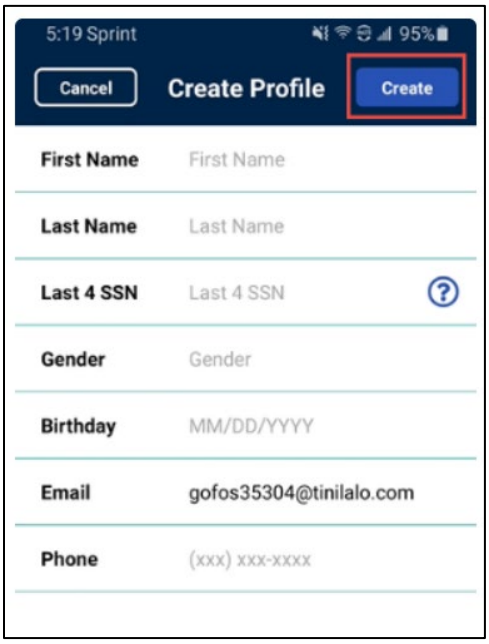
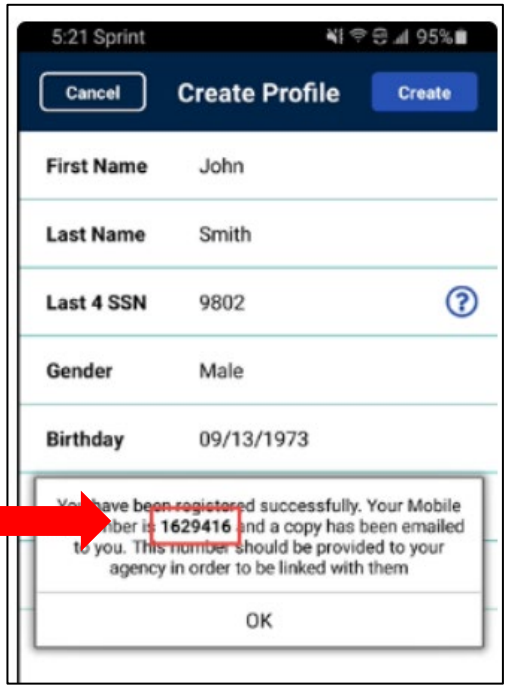
4. Fill out everything on the **Create Profile** page. Tap **Create** to create the Profile.

NOTE: all the information must match was Consumer Direct Arizona has on file.



5. A message will appear containing the **Mobile ID**.

Take a picture or write down this number.
Call 888-398-8409 or email infoCDAZ@ConsumerDirectCare.com to give your info to Consumer Direct Arizona.



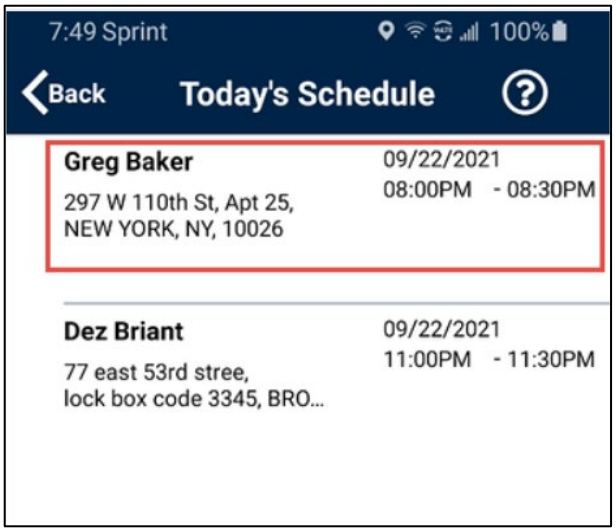
6. You will get a second email after you register. It will have your **Mobile ID** and instructions on how to log in and use the app.

CONSUMER DIRECT CARE NETWORK ARIZONA

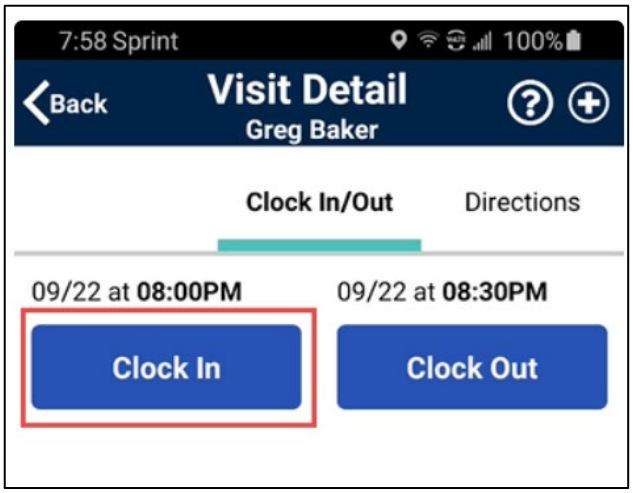
How to Clock in & out Using the HHAeXchange Mobile App

Clocking in

1. Open the app and tap **Today's Schedule**. Pick the visit for today (example: Greg Baker).



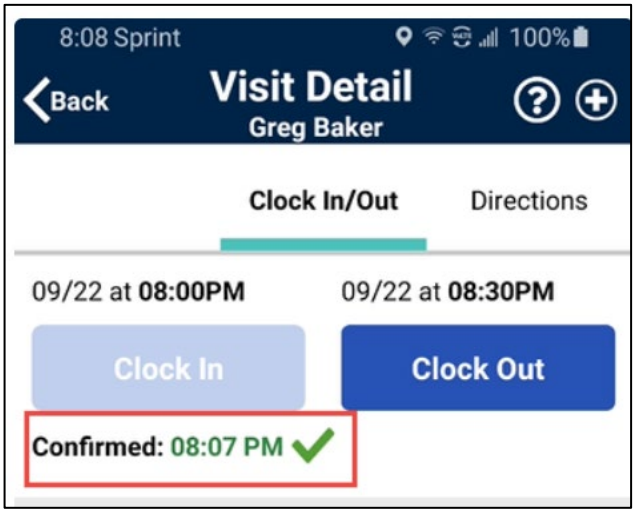
2. Tap the **Clock In** button on the Visit Detail page.



3. Choose how to clock in:

- **GPS** (uses your phone's location), or
- **Security Token** (this means a FOB).

4. If it works, the time will show in **green**. If it didn't work, the time will show in **red**.



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There is also other information on the **Visit Detail** page:

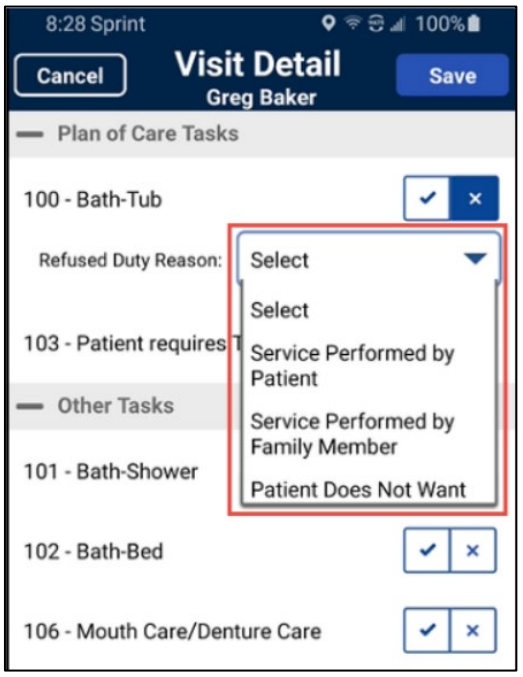
Options (Tab)	Description
Directions tab	Provides directions to the patient's home.
Patient Info tab	patient name, phone numbers, address, and emergency contacts.
Care Plan tab	List of tasks, how often to do them, and additional instructions.
Notes tab	Shows notes made by you or the agency.

Clocking out

1. When the Visit is done, tap **Clock Out** on the Visit Detail page.

If the Visit included tasks:

- Select the **check** if you did them, or the **X** if they were refused.
- Select the **Refused Duty Reason** when a duty is marked refused.



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CONSUMER DIRECT CARE NETWORK ARIZONA

How to Clock in & out Using the HHAeXchange FOB device

The **FOB** is a small device that gives you an 8-digit code. You'll use it to clock in and out.

Using the **FOB for an EVV** visit requires a **Device ID** and two codes, one for **Clock In**; another for **Clock Out**.

Caregivers may start or end a visit from any phone by calling 833-380-5799.

These steps show how you use the FOB device to clock in and out.

Step	Action
1	At the start and end of your visit, press the FOB button and write down the **8-digit code**.
2	Call **833-380-5799** from any phone.
3	Press **3** for "FOB Device."
4	Press **3** again for "Clock In and Out."
5	The system will ask you to enter: • Time & Attendance Pin • 6-digit Device ID (on the FOB) • 8-digit Clock in code • 8-digit Clout out code • Any tasks you did (one at a time)
6	After entering tasks, dial "000" to end the call.

What to do if there is a Problem
Complete the following troubleshooting steps if you are unable to complete an EVV.

- Ensure you are dialing the correct number.
- If the number is correct, redial and attempt to complete an EVV.
- If you are still unable to successfully complete an EVV, contact your Manager or Agency Representative. Failure to complete an EVV for the Clock In and/or Out of a visit will result in non-payment for the visit or the retrieval of a signed, physical, timesheet.

Task #	Description
110	Shopping
120	Meal/Snack Preparation and Clean Up
130	Errand
140	Medical Appointment
150	Self-Administration of Medication
160	Bathing
170	Eating
180	Assisting with Mail
190	Dressing and Grooming

Task #	Description	Task #	Description
200	Housekeeping – Bedroom	310	Emergency and Safety Skills
210	Housekeeping – Bathroom	320	Health/Medical
220	Housekeeping – Kitchen	330	Independent Living Skills
230	Housekeeping – Common Living Areas	340	Leisure Time Recreation Skills
240	Laundry	350	Medication Administration
250	General Supervision	360	Mobility
260	Turning, Positioning or Transferring	370	Personal Health Care
270	Toileting	380	Range of motion/exercise
280	Cognitive/ Academic	390	Sensorimotor
290	Communication	400	Socialization
300	Continence Support and Hygiene (bowel, bladder, catheter)	410	Vital Signs

Supervisor	Phone Number

HHAeXchange

Placing Phone EVV Calls: Instructions

Phone number - English
833-380-5799

Calling Instructions

To Clock In:

Step	Action
1	To place EVV, dial the number provided on the front of this pamphlet from the Member's home phone. ***Note:*** *If you are unable to use the Member's home phone, contact your Manager for other approved EVV phone numbers on record for the Member.*
2	Press **1** to **Clock In** when prompted.
3	Enter the **Assignment ID** (provided by your Agency).
4	Confirm the entry. ***Note:*** *If you enter your* ***Assignment ID*** *incorrectly, the system prompts you to reenter your credentials. If you fail to enter your* ***Assignment ID*** *after several attempts, the system stops you from placing an EVV and you must contact your Manager.*
5	If the EVV is placed successfully, then the following automated message is heard: **"Your call has been successfully registered"**

Assignment ID

Calling Instructions

To Clock Out:

Step	Action
1	To place EVV, dial the number provided on the front of this pamphlet from the Member's home phone.
2	Press **2** to **Clock Out** when prompted.
3	Enter your **Assignment ID**.
4	Confirm the entry. ***Note:*** *Refer to the* ***Clock In*** *instructions if you are having trouble placing an EVV or entering the* ***Assignment ID****.*
5	If the EVV is successfully placed, then the following automated message is heard: **"Enter the 2-digit ID number for the first duty performed on the patient."** ***Note:*** *A* ***Duty ID*** *may be either 2 or 3 digits, depending on the Agency,*
6	Enter each **Duty ID**. • If an invalid **Duty ID** is entered, then you are alerted and asked to enter the next **Duty ID.** • If a valid **Duty ID** is entered, then you are asked to enter the next **Duty ID**. • If the Member refused a Duty, then enter star (*) followed by the **Duty ID** to log a **Refused Duty**.
7	When all Duties have been entered, dial **00** (or **000**) to complete the EVV. Upon completion, the following is heard: **"Your Call-Out has been registered successfully. Goodbye."**

Special Scenarios

Mutual Cases:

For a successful EVV, complete the following steps when providing service for two Members at once.

Step	Action
1	Follow the call instructions outlined in the **Clock In/Out** sections.
2	Clock In and Out only **ONCE** for the Visit.
3	When **Clocking Out**, enter the **Primary** Member's Duties first, and then dial **00** (or **000**).
4	Repeat step 3 for the **Secondary** Member.
5	Dial **00** (or **000**) a second time for the system to complete the EVV and Clock out. ***Note:*** *Please contact your Manager if you are unsure of who the* ***Primary*** *Member is. Entering the wrong Member first results in a bad EVV.*

Live-in Cases:

Step	Action
1	Follow the call instructions outlined in the **Clock In/Out** sections.
2	**Clock In** when you first arrive at the Member's residence.
3	Each morning, **Clock Out** at the time designated by the Agency.
4	When **Clocking Out**, you are prompted to enter the Duties for the day. Once completed, the system automatically places a new EVV for the following shift.

Allowed Services

The following services **can be provided** under the attendant care service program:

Bathing / Grooming	Assistance with basic personal hygiene and grooming. This includes: • Bathing. • Dressing. • Oral care. • Skin checks for sores. • Hair care. • Nail care. • Skin care. • Skin checks for infection
Toileting	Assistance with toileting routines. This includes: • Helping the Member to and from the bathroom. • Bedpan or other toileting procedures. • Routine care of an incontinent Member including use of diapers and protective sheets.
Medication Reminders	Assistance may include: • Reminding the Member to take medication. • Placing the medication within the Member's reach. • Getting the Member a glass of water.
Meal Preparation and Eating	• Assistance with eating, including meal preparation essential to meeting the Member's health needs. • Assistance with activities such as menu planning, storing, preparing, and serving food. • Assistance with cutting up meat or other set-up activities. • Feeding the individual or assisting with eating.
Housekeeping	Assistance with light housekeeping tasks essential to the Member's health, including: • Changing bed linens. • Laundering a Member's clothing. • Dusting. • Cleaning floors. • Cleaning the kitchen. • Cleaning the stove (if necessary to prepare food safely). • Cleaning windows (if necessary to attain safe or sanitary living conditions). • Washing dishes.
Medical Escort	Escort services are available to Members that require approved DCW services on the way to or at a destination to obtain Arizona Medicaid reimbursable services. ***Note: the DCW may not be paid for time spent at the Physician's office unless authorized in the care plan.***

Transfers / Mobility	Assistance transferring the Member in and out of a: • Bed. • Chair. • Wheelchair. and helping the Member walk with the support of a: • Walker. • Cane. • Crutches.
Exercise / Range of Motion	Assistance with simple, recommended physical activities and exercises. This includes active and passive range-of-motion exercises, taught to the DCW by the Member or Personal Representative. A physician's order is needed to do this task.
Positioning	Assistance with positioning or turning of non-ambulatory Members in bed or a chair. This means a Member who does not walk or is confined to bed.
Shopping	Shopping in the vicinity of the Member's residence for: • Prescribed medicine. • Medical supplies. • Groceries. • Household items required specifically for the health and maintenance of the Member.
Assistive Devices	Putting on and removing assistive devices.
Assistance with Caring for Basic Material Needs	Assistance with basic material needs such as: • Hauling water for household use. • Gathering and hauling firewood for household heating or cooking. • Caring for livestock used for consumption. This includes feeding, watering and milking.
Training in Activities of Daily Living	Training the Member in Activities of Daily Living (ADL) such as: • Teaching the Member how to cook. • Helping the Member learn to take the bus.
General Supervision	• Monitoring the Member's medical condition and functional level and reporting any change to Consumer Direct. • Providing supervision to make sure the Member is safe. • Providing companionship to the Member during scheduled hours in accordance with the plan.
Coordination	Making sure activities and other necessary services are provided to the Member consistent with their individualized care plan.

Excluded Services

The following services, as per regulation, **are not authorized** tasks to be performed by the DCW for the Member under Arizona Attendant Care Services:

Invasive Body Procedures

- Injections.
- Tracheotomy care.
- Care and maintenance of intravenous equipment.
- Bowel routines.
- Medication administration.

Chore Services in the Home

- Cleaning of floors and furniture not used directly by the Member.
- Laundry not incidental to Member care.
- Washing dishes that are not the Members.

Member Performable Tasks

Any task that can reasonably be done by the Member as determined by the functional assessment performed by the MCO.

Unapproved Tasks

Any task NOT approved in the Member's care plan.

Member Transport

The DCW is NOT allowed to transport the Member in any vehicle.

Other Household Members

Care CANNOT be provided to any other member in the household unless the person is an MCO member with approved attendant care hours.

Cleaning Areas Not Used by the Member

Cleaning an area not used directly by the Member.

Specific Program Exclusions

The following items are excluded under this program:

- Babysitting.
- General home maintenance.
- Pet care, except for a service animal.

CONSUMER DIRECT CARE NETWORK

2025 Benefits
Summary Caregivers

Benefit	Eligibility Requirements	Enrollment	Important Details
Health Insurance	30+ Hours per week	First of the month following 30 days of employment	Free preventative care. In-network co-pays: $15 doctor visit, $25 specialist, $400 emergency room, $400 outpatient imaging.
TransChoice Advance (Medical Buy Up)	30+ Hours per week and enrolled in company Medical Insurance Plan	First of the month following 30 days of employment	Add to your Medical Plan a hospital/surgical benefit. Pays $250/day in-hospital and/or surgery payments per calendar year maximums. Note: Minimum participation requirement of 10 enrollees.
Telemedicine by 98point6	30+ Hours per week and enrolled in company Medical Insurance Plan	First of the month following 30 days of employment	App allows you to text directly with a doctor about non-emergency medical issues. Doctors are available 24/7 by text messaging and can prescribe some medications. Prescription and lab fees are at your own expense.
Health Care Flexible Spending Account (FSA)	30+ Hours per week	First of the month following 30 days of employment	Employees can defer up to $3,300 per calendar year in pre-tax dollars to use for eligible medical expenses. Unused funds (up to $660) are rolled over to the following year's FSA.
Dependent Care Flexible Spending Account (FSA)	10+ Hours per week	First of the month following 30 days of employment	Employees can defer up to $5,000 per calendar year in pre-tax dollars to use for daycare or disabled adult dependent care expenses. Unused funds are forfeited at the end of the year.
Vision Insurance	10+ Hours per week	First of the month following 30 days of employment	Plan participants receive a free annual eye exam with in-network providers, and can choose between new lenses or frames with $20 copay OR free contacts (within allowance). Additional discounts available.
Voluntary Dental Insurance	10+ Hours per week	First month following 30 days of employment	FREE preventative care (cleanings). Additional services subject to $50 deductible and $1,000 maximum benefit per year.
Basic Life/AD&D Insurance	10+ Hours per week	**Automatic:** First of the month following 30 days of employment	In the event of an employee's death, this **company paid** plan pays their beneficiary a benefit equal to $10,000. Life and AD&D Benefits reduce to 65% at age 65 and to 45% at age 80.
Voluntary Supplemental Life Insurance	10+ Hours per week	First of the month following 30 days of employment	Employees can elect amounts in $10,000 increments, up to the lesser of $300,000 or 5 times your annual earnings. Verification may be required in certain circumstances. Life Benefits reduce to 65% at age 65 and to 45% at age 80.
Unum Supplemental Insurances	10+ Hours per week	First of the month following 30 days of employment	Coverages Available: Critical Illness, Accident and Hospital Insurance
Employee Assistance Program (EAP)	No hours requirement	**Automatic:** All employees and eligible family members	The EAP offers free and confidential counseling and assistance resolving situations that may inpact your personal or professional life. Employees are given 5 counseling sessions per issue.
401(k) Retirement Plan	No hours requirement Must be age 18 or older	First of the month following 90 days of employment	Employees can defer pre-tax dollars into the company's 401(k) plan.
Pet Insurance	No hours requirement	No waiting period	MetLife Pet Insurance offers assistance to pay for your pet's medical care, including check-ups, testing, surgery, and hospitalization. Contact MetLife at www.metlife.com/getpetquote or 800-438-6388.

For additional assistance, please contact MyAdvocate at MyAdvocateServices.com or by calling 855-507-0301

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

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[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact the Human Resources Department _____.

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

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)
Arizona Consumer Direct	20-1610330
5. Employer address	**6. Employer phone number**
100 Consumer Direct Way	844-360-4747

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

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

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

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☑ Some employees. Eligible employees are:

    Regular status employees working at least 30 hours/week

- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:

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

  - ☐ We do not offer coverage.

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

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

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

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

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

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

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

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

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

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

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

This Organization Participates in E-Verify

This employer will provide the Social Security Administration (SSA) and, if necessary, the Department of Homeland Security (DHS), with information from each new employee's Form I-9 to confirm work authorization.

IMPORTANT: If the Government cannot confirm that you are authorized to work, this employer is required to give you written instructions and an opportunity to contact DHS and/or the SSA before taking adverse action against you, including terminating your employment.

Employers may not use E-Verify to pre-screen job applicants and may not limit or influence the choice of documents you present for use on the Form I-9.

To determine whether Form I-9 documentation is valid, this employer uses E-Verify's photo matching tool to match the photograph appearing on some permanent resident cards, employment authorization cards, and U.S. passports with the official U.S. government photograph. E-Verify also checks data from driver's licenses and identification cards issued by some states.

If you believe that your employer has violated its responsibilities under this program or has discriminated against you during the employment eligibility verification process based upon your national origin or citizenship status, please call the Office of Special Counsel at 800-255-7688, 800-237-2515 (TDD) or at www.justice.gov/crt/osc.

E-Verify Works for Everyone

For more information on E-Verify, please contact DHS:

888-897-7781

www.dhs.gov/E-Verify

NOTICE:
Federal law requires all employers to verify the identity and employment eligibility of all persons hired to work in the United States.

E-VERIFY IS A SERVICE OF DHS AND SSA

IF YOU HAVE THE RIGHT TO WORK,
Don’t let anyone take it away.

If you have the legal right to work in the United States, there are laws to protect you against discrimination in the workplace.

You should know that –

- In most cases, employers cannot deny you a job or fire you because of your national origin or citizenship status or refuse to accept your legally acceptable documents.

- Employers cannot reject documents because they have a future expiration date.

- Employers cannot terminate you because of E-Verify without giving you an opportunity to resolve the problem.

- In most cases, employers cannot require you to be a U.S. citizen or a lawful permanent resident.

If any of these things have happened to you, contact the Office of Special Counsel (OSC).

For assistance in your own language:
Phone: 1-800-255-7688 or
(202) 616-5594
For the hearing impaired:
TTY 1-800-237-2515 or
(202) 616-5525

E-mail: osccrt@usdoj.gov

Or write to:
U.S. Department of Justice – CRT
Office of Special Counsel – NYA
950 Pennsylvania Ave., NW
Washington, DC 20530

U.S. Department of Justice
Civil Rights Division

Office of Special Counsel for Immigration-Related Unfair Employment Practices

www.justice.gov/crt/about/osc

Work Opportunity Tax Credits - Consumer Direct Care Network

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

Applicant Instructions

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

- Please answer each question to complete the voluntary screening.

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

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

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

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

IVR CODE: 410849