Representative Name (if exists): _____ Participant Name: _____

Formulario de datos de trabajador de servicios directos (DSW)

Ayuda con el proceso de contratación. Si necesita ayuda con este paquete, comuníquese con Consumer Direct. ¡Estamos felices de ayudarlo(a)!

Información del trabajador de servicios directos

Nombre: _____ _____ _____
Primer nombre. Segundo nombre. Apellido.

Dirección postal: _____
Calle.

_____
Ciudad. Estado. Código postal.

Teléfono: Casa (____) _____ Trabajo (____) _____ Celular (____) _____

Correo electrónico: _____

Fecha de nacimiento: __/__/____ Número de seguro social

Contacto de emergencia: _____ _____ _____
Nombre. Teléfono: Relación.

Requisitos de edad y formación

¿Tiene como mínimo 18 años? ☐ Sí ☐ No.

Se requiere una licencia de enfermero(a) registrado(a) (RN) o enfermero(a) practicante autorizado(a) (LPN) para los servicios de cuidados auxiliares y de enfermería intermitente y especializada.

Adjunte una copia de su licencia si está proporcionando estos servicios. Es necesario mantenerla actualizada.

¿Ha cometido alguna vez un delito grave? ☐ Sí ☐ No.

¿Tiene antecedentes penales? ☐ Sí ☐ No. En caso afirmativo, especifique.

Léalo con atención. Este paquete inicia el proceso de contratación. El participante o tutor legal es el empleador del DSW. No Consumer Direct. Consumer Direct acepta la documentación en nombre del empleador.

Autorizo la evaluación de todo lo que declare a mi empleador. Entiendo que no puedo falsificar ni omitir ningún hecho que se me pida. Este hecho es causa de despido.

Entiendo que mi empleo es condicional. El empleo es condicional hasta que se apruebe la verificación de mis antecedentes. Entiendo que los resultados de mi verificación de antecedentes se puedan compartir. Se pueden compartir con mi empleador. Se pueden compartir con el Plan de atención médica administrada de mi empleador.

Firma del solicitante: _____ Fecha: _____

Lista de verificación de inscripción de trabajador de servicios directos (DSW)

Nombre del trabajador de servicios directos	Nombre del participante	Nombre del representante (si corresponde).

Complete todos los formularios de la siguiente lista. Guarde una copia. Envíe los **formularios originales a Consumer Direct.** El DSW no podrá comenzar a trabajar hasta que todos los formularios hayan sido revisados y aprobados por Consumer Direct. Los DSW no deben trabajar hasta que reciban un formulario de "Autorización para trabajar".

Formularios requeridos para todos los DSW nuevos:

1. ☐ Formulario de datos de DSW
2. ☐ Lista de verificación de inscripción de DSW (este formulario)
3. ☐ Declaración de relación laboral
4. ☐ I-9 - *Las instrucciones están disponibles en el sitio web de CDCN Florida en la pestaña "Recursos".*
5. ☐ W-4
6. ☐ Formulario de selección de pago - *Es posible que se requiera un anexo, consulte las instrucciones del formulario.*
7. ☐ Anexo del Acuerdo de Participante/DSW
8. ☐ Acuerdo de Participante/DSW
9. ☐ Verificación de antecedentes del proveedor de cuidados – Aceptación de la política de privacidad
10. ☐ Certificado de cumplimiento de los requisitos de verificación de antecedentes
11. ☐ Información necesaria para la toma de huellas dactilares
12. ☐ Descripción del trabajo

Suplementos:

1. ☐ Procedimientos de toma de huellas dactilares – *Solo revisión*
2. ☐ Marketplace de atención médica

Revise todos los formularios. Confirme que todos los formularios están completos y son legibles. Envíe todos los formularios a Consumer Direct. Los formularios que falten o que no se puedan leer darán lugar a un retraso en la fecha de inicio.

Hay recursos adicionales disponibles en el sitio web: www.ConsumerDirectFL.com

Divulgación de la relación laboral

Nombre del empleado (trabajador de servicio directo)	Nombre del empleador (participante)

Instrucciones para el empleado: Díganos a continuación si tiene algún parentesco con su empleador. Complete cada sección. Firme y coloque la fecha en la parte inferior del formulario.

1. Destinatario/Estado de residencia:

☐ Sí ☐ No La persona que recibe los servicios es menor de edad (menos de 18 años)
☐ Sí ☐ No Viviré en la misma dirección que mi empleador(a)

2. Divulgación de la relación:

Mi relación con mi empleador (marque una opción):

☐ Cónyuge ☐ Padre o madre ☐ Padres adoptivos o padrastro o madrastra
☐ Niño menor de 21 años ☐ Niño mayor de 21 años ☐ Hermano(a)
☐ Abuelo(a) ☐ Nieto(a) ☐ Pareja doméstica
☐ No hay relación ☐ Otro, describa: _____

3. Reconocimiento de la relación:

Es posible que esté exento de algunos impuestos. Depende de lo que haya indicado anteriormente. En la parte posterior de este formulario se explica qué impuestos debo pagar. Mi oficina local para el desempleo puede darme más información sobre los impuestos FUTA y SUTA.

Debo informar a Consumer Direct si esta relación cambia. Tengo 5 días para hacerlo. Si no lo hago, es posible que deba devolver el dinero que debería haber sido retenido de mi salario.

_____ _____
Firma del participante/representante *Fecha*

_____ _____
Firma del trabajador de servicio directo *Fecha*

Solo para uso interno: oficina central		
Iniciales del evaluador: _____	SUTA (sujeto a impuestos) ☐ Sí ☐ No	FUTA (sujeto a impuestos) ☐ Sí ☐ No

Solo para uso interno: oficina local		
Iniciales del evaluador: _____	Medicare (sujeto a impuestos) ☐ Sí ☐ No	Seguro Social (sujeto a impuestos) ☐ Sí ☐ No

10089

Divulgación de la relación laboral

Explicación de exenciones de empleados

Estatuto de Florida 443.1216 (13) 2. (d)			
Relación con el titular del EIN (empleador)	**Ley Federal de Contribuciones al Seguro (FICA)**	**Ley Federal de Contribución para el Desempleo (FUTA)**	**Ley Estatal de Impuestos al Desempleo (SUTA)**
Cónyuge	Exento	Exento	Exento
Padre o madre	*Exento **Sujeto a impuestos	Exento	Exento
Padres adoptivos o padrastro o madrastra	*Exento **Sujeto a impuestos	Exento	Exento
Hermano(a)	Sujeto a impuestos	Sujeto a impuestos	Sujeto a impuestos
Niño menor de 21 años	Exento	Exento	Exento
Niño mayor de 21 años	Sujeto a impuestos	Sujeto a impuestos	Sujeto a impuestos
Abuelo(a)	Sujeto a impuestos	Sujeto a impuestos	Sujeto a impuestos
Nieto(a)	Sujeto a impuestos	Sujeto a impuestos	Sujeto a impuestos
Pareja doméstica	Sujeto a impuestos	Sujeto a impuestos	Sujeto a impuestos

*Exento si no cumple con los 4 de los siguientes criterios:

**Sujeto a impuestos si cumple con los 4 de los siguientes criterios:

a) Un(a) padre(madre) está empleado(a) por su hijo o hija.

b) El(la) empleador(a) (hijo o hija) tiene un hijo(a) o hijastro(a) que vive en el hogar.

c) El(la) empleador(a) es:
   - viuda o viudo,
   - divorciado(a), o
   - casado(a) y vive con su cónyuge. Pero el cónyuge no puede cuidar al hijo(a) o hijastro(a) debido a una condición mental o física. El(la) cónyuge no puede proporcionar la atención durante al menos 4 semanas consecutivas en 3 meses.

d) El(la) hijo(a) o hijastro(a) del empleador es:
   - menor de 18 años, o
   - necesita atención personal de un adulto. Se necesita la atención durante al menos 4 semanas consecutivas en 3 meses debido a una condición mental o física.

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. An alien 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

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, sex, 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, sex, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Acceptable Receipts

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

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

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

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

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

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 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

2026

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.)

Caution: To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.

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 Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(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):

(a) Multiply the number of qualifying children under age 17 by $2,200 . . . . . **3(a)** $

(b) Multiply the number of other dependents by $500 . . . **3(b)** $

Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here . . . . . **3** $

Step 4: 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. Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) Enter the result here . . **4(b)** $

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

Exempt from withholding

I claim exemption from withholding for 2026, and I certify that I meet **both** of the conditions for exemption for 2026. See *Exemption from withholding* on page 2. I understand I will need to submit a new Form W-4 for 2027 . ☐

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 2026 if you meet both of the following conditions: you had no federal income tax liability in 2025 **and** you expect to have no federal income tax liability in 2026. You had no federal income tax liability in 2025 if (1) your total tax on line 24 on your 2025 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), 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 2026 tax return. To claim exemption from withholding, certify that you meet both of the conditions by checking the box in the *Exempt from withholding* section. Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2027.

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 of tax withheld will be larger the greater the difference in pay is between the two jobs.

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

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You (and/or your spouse if married filing jointly) must have the required social security number to claim certain credits. 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.

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 15, if you expect to claim deductions other than the basic standard deduction on your 2026 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for qualified tips, overtime compensation, and passenger vehicle loan interest; student loan interest; IRAs; and seniors. You (and/or your spouse if married filing jointly) must have the required social security number to claim certain deductions. For additional eligibility requirements, see Pub. 501.

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 when you file your tax return.

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 5. 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 5 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 5 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 (plus any other additional amount you want withheld) . . . . . **4** $ _____

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

See the Instructions for Schedule 1-A (Form 1040) for more information about whether you qualify for the deductions on lines 1a, 1b, 1c, 3a, and 3b.

1 Deductions for qualified tips, overtime compensation, and passenger vehicle loan interest.

- **a** **Qualified tips.** If your total income is less than $150,000 ($300,000 if married filing jointly), enter an estimate of your qualified tips up to $25,000 . . . . . **1a** $
- **b** **Qualified overtime compensation.** If your total income is less than $150,000 ($300,000 if married filing jointly), enter an estimate of your qualified overtime compensation up to $12,500 ($25,000 if married filing jointly) of the "and-a-half" portion of time-and-a-half compensation . . . . . **1b** $
- **c** **Qualified passenger vehicle loan interest.** If your total income is less than $100,000 ($200,000 if married filing jointly), enter an estimate of your qualified passenger vehicle loan interest up to $10,000 **1c** $

2 Add lines 1a, 1b, and 1c. Enter the result here . . . . . **2** $

3 **Seniors age 65 or older.** If your total income is less than $75,000 ($150,000 if married filing jointly):

- **a** Enter $6,000 if you are age 65 or older before the end of the year . . . . . **3a** $
- **b** Enter $6,000 if your spouse is age 65 or older before the end of the year and has a social security number valid for employment . . . . . **3b** $

4 Add lines 3a and 3b. Enter the result here . . . . . **4** $

5 Enter an estimate of your student loan interest, deductible IRA contributions, educator expenses, alimony paid, and certain other adjustments from Schedule 1 (Form 1040), Part II. See Pub. 505 for more information . . . . . **5** $

6 **Itemized deductions.** Enter an estimate of your 2026 itemized deductions from Schedule A (Form 1040). Such deductions may include qualifying:

- **a** **Medical and dental expenses.** Enter expenses in excess of 7.5% (0.075) of your total income . **6a** $
- **b** **State and local taxes.** If your total income is less than $505,000 ($252,500 if married filing separately), enter state and local taxes paid up to $40,400 ($20,200 if married filing separately) . **6b** $
- **c** **Home mortgage interest.** If your home acquisition debt is less than $750,000 ($375,000 if married filing separately), enter your home mortgage interest expense (including mortgage insurance premiums) . . . . . **6c** $
- **d** **Gifts to charities.** Enter contributions in excess of 0.5% (0.005) of your total income . . . . **6d** $
- **e** **Other itemized deductions.** Enter the amount for other itemized deductions . . . . . **6e** $

7 Add lines 6a, 6b, 6c, 6d, and 6e. Enter the result here . . . . . **7** $

8 **Limitation on itemized deductions.**

- **a** Enter your total income . . . . . **8a** $
- **b** Subtract line 4 from line 8a. If line 4 is greater than line 8a, enter -0- here and on line 10. Skip line 9 **8b** $

9 Enter:
- $768,700 if you're married filing jointly or a qualifying surviving spouse
- $640,600 if you're single or head of household
- $384,350 if you're married filing separately

. . . . . **9** $

10 If line 9 is greater than line 8b, enter the amount from line 7. Otherwise, multiply line 7 by 94% (0.94) and enter the result here . . . . . **10** $

11 **Standard deduction.**

Enter:
- $32,200 if you're married filing jointly or a qualifying surviving spouse
- $24,150 if you're head of household
- $16,100 if you're single or married filing separately

. . . . . **11** $

12 **Cash gifts to charities.** If you take the standard deduction, enter cash contributions up to $1,000 ($2,000 if married filing jointly) . . . . . **12** $

13 Add lines 11 and 12. Enter the result here . . . . . **13** $

14 If line 10 is greater than line 13, subtract line 11 from line 10 and enter the result here. If line 13 is greater than line 10, enter the amount from line 12 . . . . . **14** $

15 Add lines 2, 4, 5, and 14. Enter the result here and in Step 4(b) of Form W-4 . . . . . **15** $

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.

00540

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	$480	$850	$850	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020
$10,000 - 19,999	0	480	1,480	1,850	2,050	2,220	2,220	2,220	2,220	2,220	2,220	2,620
$20,000 - 29,999	480	1,480	2,480	3,050	3,250	3,420	3,420	3,420	3,420	3,420	3,820	4,820
$30,000 - 39,999	850	1,850	3,050	3,620	3,820	3,990	3,990	3,990	3,990	4,390	5,390	6,390
$40,000 - 49,999	850	2,050	3,250	3,820	4,020	4,190	4,190	4,190	4,590	5,590	6,590	7,590
$50,000 - 59,999	1,020	2,220	3,420	3,990	4,190	4,360	4,360	4,760	5,760	6,760	7,760	8,760
$60,000 - 69,999	1,020	2,220	3,420	3,990	4,190	4,360	4,760	5,760	6,760	7,760	8,760	9,760
$70,000 - 79,999	1,020	2,220	3,420	3,990	4,190	4,760	5,760	6,760	7,760	8,760	9,760	10,760
$80,000 - 99,999	1,020	2,220	3,420	4,240	5,440	6,610	7,610	8,610	9,610	10,610	11,610	12,610
$100,000 - 149,999	1,870	4,070	6,270	7,840	9,040	10,210	11,210	12,210	13,210	14,210	15,360	16,560
$150,000 - 239,999	1,870	4,100	6,500	8,270	9,670	11,040	12,240	13,440	14,640	15,840	17,040	18,240
$240,000 - 319,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,780	14,980	16,180	17,380	18,580
$320,000 - 364,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,860	15,860	17,860	19,860	21,860
$365,000 - 524,999	2,720	5,920	9,390	12,260	14,760	17,230	19,530	21,830	24,130	26,430	28,730	31,030
$525,000 and over	3,140	6,840	10,540	13,610	16,310	18,980	21,480	23,980	26,480	28,980	31,480	33,990

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	$90	$850	$1,020	$1,020	$1,020	$1,070	$1,870	$1,870	$1,870	$1,870	$1,870	$1,970
$10,000 - 19,999	850	1,780	1,980	1,980	2,030	3,030	3,830	3,830	3,830	3,830	3,930	4,130
$20,000 - 29,999	1,020	1,980	2,180	2,230	3,230	4,230	5,030	5,030	5,030	5,130	5,330	5,530
$30,000 - 39,999	1,020	1,980	2,230	3,230	4,230	5,230	6,030	6,030	6,130	6,330	6,530	6,730
$40,000 - 59,999	1,020	2,880	4,080	5,080	6,080	7,080	7,950	8,150	8,350	8,550	8,750	8,950
$60,000 - 79,999	1,870	3,830	5,030	6,030	7,100	8,300	9,300	9,500	9,700	9,900	10,100	10,300
$80,000 - 99,999	1,870	3,830	5,100	6,300	7,500	8,700	9,700	9,900	10,100	10,300	10,500	10,700
$100,000 - 124,999	2,030	4,190	5,590	6,790	7,990	9,190	10,190	10,390	10,590	10,940	11,940	12,940
$125,000 - 149,999	2,040	4,200	5,600	6,800	8,000	9,200	10,200	10,950	11,950	12,950	13,950	14,950
$150,000 - 174,999	2,040	4,200	5,600	6,800	8,150	10,150	11,950	12,950	13,950	14,950	16,170	17,470
$175,000 - 199,999	2,040	4,200	6,150	8,150	10,150	12,150	13,950	15,020	16,320	17,620	18,920	20,220
$200,000 - 249,999	2,720	5,680	7,880	10,140	12,440	14,740	16,840	18,140	19,440	20,740	22,040	23,340
$250,000 - 449,999	2,970	6,230	8,730	11,030	13,330	15,630	17,730	19,030	20,330	21,630	22,930	24,240
$450,000 and over	3,140	6,600	9,300	11,800	14,300	16,800	19,100	20,600	22,100	23,600	25,100	26,610

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	$280	$850	$950	$1,020	$1,020	$1,020	$1,020	$1,560	$1,870	$1,870	$1,870
$10,000 - 19,999	280	1,280	1,950	2,150	2,220	2,220	2,220	2,760	3,760	4,070	4,070	4,210
$20,000 - 29,999	850	1,950	2,720	2,920	2,980	2,980	3,520	4,520	5,520	5,830	5,980	6,180
$30,000 - 39,999	950	2,150	2,920	3,120	3,180	3,720	4,720	5,720	6,720	7,180	7,380	7,580
$40,000 - 59,999	1,020	2,220	2,980	3,570	4,640	5,640	6,640	7,750	8,950	9,460	9,660	9,860
$60,000 - 79,999	1,020	2,610	4,370	5,570	6,640	7,750	8,950	10,150	11,350	11,860	12,060	12,260
$80,000 - 99,999	1,870	4,070	5,830	7,150	8,410	9,610	10,810	12,010	13,210	13,720	13,920	14,120
$100,000 - 124,999	1,870	4,270	6,230	7,630	8,900	10,100	11,300	12,500	13,700	14,210	14,720	15,720
$125,000 - 149,999	2,040	4,440	6,400	7,800	9,070	10,270	11,470	12,670	14,580	15,890	16,890	17,890
$150,000 - 174,999	2,040	4,440	6,400	7,800	9,070	10,580	12,580	14,580	16,580	17,890	18,890	20,170
$175,000 - 199,999	2,040	4,440	6,400	8,510	10,580	12,580	14,580	16,580	18,710	20,320	21,620	22,920
$200,000 - 249,999	2,720	5,920	8,680	10,900	13,270	15,570	17,870	20,170	22,470	24,080	25,380	26,680
$250,000 - 449,999	2,970	6,470	9,540	12,040	14,410	16,710	19,010	21,310	23,610	25,220	26,520	27,820
$450,000 and over	3,140	6,840	10,110	12,810	15,380	17,880	20,380	22,880	25,380	27,190	28,690	30,190

CONSUMER DIRECT CARE NETWORK

PAY SELECTION FORM

Name: _____
(please print)

Consumer Direct recommends every employee select direct deposit, either to a prepaid debit card or to another account you specify. Direct deposits avoid all possible delays associated with delivery of mail - and that helps you access your pay on pay day. Pay stubs (summary of your pay) are available online through our secure web portal: www.DirectMyCare.com.

Consumer Direct offers the following pay options. Please select <u>one</u> option below.

☐ **Wisely Pay Card Direct Deposit** – I authorize Consumer Direct to issue me a Wisely Pay Card using my Social Security Number and other identification on file and to initiate payroll deposits to my card account. You should receive your debit card in approximately two weeks.

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

Account Type (check one): ☐ Checking ☐ Savings

For Checking Accounts:

Attach (tape) a voided check here

Do not attach a deposit slip.

For Savings Accounts: provide a document from your bank with exact numbers to process direct deposits to your account. If the document is larger than a standard-sized check, please provide a separate document. Do not attach a deposit slip because it does not have all the necessary numbers.

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

_____ _____

Signature Date

02593

wisely by ADP

Control financiero: ¡Ahora es posible!

Controle su dinero con una cuenta digital de Wisely®[1].

Reciba pagos con anticipación[2].

Ya sea que quiera pagar una factura u obtener dinero para planes de último momento, Wisely le permite obtener el dinero con hasta 2 días de anticipación[2].

Ahorre y organice su dinero como quiera.

Realice un seguimiento de su saldo y sus gastos las 24 horas del día, los 7 días de la semana, y obtenga importantes ahorros[3].

Realice compras con confianza.

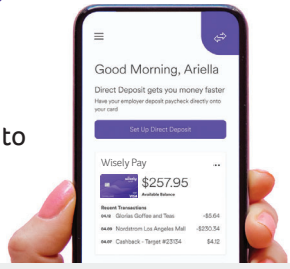
Pague en línea, en la tienda, en la aplicación o por teléfono dondequiera que se acepten tarjetas de débito Visa® o Mastercard®.

Evite los cargos del cajero automático.

Acceda a una red de 90 000 cajeros automáticos sin cargo a nivel nacional[4].

¡Aproveche todos los beneficios de Wisely hoy mismo!

Hable con su departamento de Nóminas.



Administre su dinero como quiera.

Afford yourself every advantage™.

[1] La tarjeta Wisely es una tarjeta prepagada. La cuenta digital se requiere para la administración y el mantenimiento de su tarjeta prepaga en línea de forma digital o mediante una aplicación móvil. La tarjeta Wisely no es una tarjeta de crédito, por cual no otorga crédito.

[2] Debe iniciar sesión en la aplicación myWisely o en su cuenta de mywisely.com para inscribirse en el depósito directo anticipado. No se garantiza el depósito directo anticipado de los fondos y queda sujeto a los plazos de la orden de pago del pagador. La referencia acerca del plazo de financiación más rápido se establece al comparar nuestra política de extender los fondos al recibir la orden de pago con la práctica bancaria habitual de otorgar los fondos al momento de la liquidación. Consulte las reglas completas en mywisely.com o en la aplicación myWisely. Si tiene una tarjeta Wisely Pay o Wisely Cash (vea el reverso), se requiere una actualización que es posible que no esté disponible para todos los tarjetahabientes. Permita que pase un plazo de hasta 3 semanas después de la configuración inicial del depósito directo para que su pago se cargue a su tarjeta.

[3] Los montos transferidos a su sobre de ahorros ya no aparecerán en su saldo disponible. Puede restituirlos a su saldo disponible en cualquier momento con la aplicación myWisely o desde su cuenta de mywisely.com.

[4] El número de transacciones en cajero automático sin cargo podría estar limitado. Inicie sesión en la aplicación myWisely o en mywisely.com para consultar el acuerdo del tarjetahabiente y la lista de todos los cargos a fin de obtener más información.

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00540

Acuerdo entre el participante y el trabajador de servicio directo (DSW)

Nombre del DSW en letra de imprenta

Nombre del participante en letra de imprenta

INSTRUCCIONES

- Analice cada tema. Haga preguntas según sea necesario. Firme a continuación para demostrar que está de acuerdo.

CONDICIONES

- En este contrato:
  a. "CDCN" se refiere a Consumer Direct para Florida, LLC. haciendo negocios como Consumer Direct Care Network Florida
  b. "AHCA" se refiere a la Agencia para la Administración de Servicios de Atención Médica de Florida
  c. "MCP" se refiere al Plan de Atención Administrada del Participante
  d. "PDO" significa opción dirigida por el participante
  e. "LG" significa el tutor legal del participante

El DSW es el empleado del participante. **CDCN no es el empleador del DSW.** CDCN es el agente del fiscal empleador; ayudamos al participante con algunas tareas del empleador. Este acuerdo se celebra entre el DSW y el participante. Complete todos los formularios que se encuentran en el Paquete de inscripción de DSW. Llenar estos formularios establecerá su relación laboral con el participante/LG.

1. Los roles y responsabilidades del participante/LG incluyen, entre otros:

- Entrenar al DSW.
- Supervisar al DSW.
- Tratar al DSW con respeto; esto incluye sus creencias, cultura, religión y privacidad.
- Complete y envíe las hojas de horas correctas; de este modo se garantizará que el DSW reciba la remuneración acordada.
- Asegurarse de que el DSW no trabaje más horas de las aprobadas en este acuerdo.

2. El participante/LG deberá:

A. Recibir una copia del Manual del Empleador. Revisarán el manual con el DSW. El manual traza las pautas dentro de la PDO; incluye políticas y procedimientos. El manual también se puede encontrar en el sitio web del CDCN.

B. Recibir una copia del calendario de pagos.

C. Entrenar al DSW.

i. El CDCN proporciona las siguientes capacitaciones **opcionales** para usar a discreción del participante:

- Control de infecciones (precauciones universales)
- Ley de Responsabilidad y Transferibilidad de Seguro Médico (HIPAA) y confidencialidad.
- Abuso, negligencia y explotación (ANE)
- Fraude de Medicaid
- Levantamiento y movimiento de pacientes

ii. Se recomienda que el DSW esté capacitado en primeros auxilios/CPR. La capacitación en primeros auxilios/CPR no se requiere en el programa PDO; el participante debe decidir si desea que se capacite a su DSW.

D. Revise el Plan de Cuidado con el DSW. Ambas partes entienden que el CDCN no es financieramente responsable del pago de los servicios en situaciones en las que:

i. El participante no es elegible para Medicaid.
ii. El participante/LG permite que el DSW trabaje horas extras que no han sido aprobadas. Las horas extras son cuando un DSW trabaja más de 40 horas por semana.
iii. El participante/LG le permite al DSW:
    a. Trabajar más tiempo del que está aprobado en el plan de atención; o
    b. Realizar tareas que no están aprobadas en el plan de atención.

E. Dígale al DSW que mantenga al CDCN al día con los cambios. El DSW debe informar a CDCN dentro de los 5 días de los cambios. Cambios que se deben informar a CDCN:

- Cambio en el nombre del DSW.
- Cambio de dirección del DSW.
- Cambio en el número de teléfono del DSW.
- Cualquier condena penal que ocurra después de la fecha de contratación.

3. El DSW entiende que:

a. El DSW no debe tergiversar ni omitir datos. Si el DSW lo hace, el DSW puede ser despedido sin previo aviso.

b. El empleo es condicional hasta que se hayan aprobado los resultados de la verificación de antecedentes penales.

c. Los resultados de la verificación de antecedentes penales o cualquier verificación de antecedentes penales futura se pueden compartir con:

i. La entidad aprobadora (MCP, condado, etc.); y
ii. El participante/LG con quien trabaja el DSW.

4. Requisitos de información del participante y/o del DSW

I. El DSW debe informar lo siguiente si involucra al DSW y/o al participante:

a. Todos los incidentes, accidentes y lesiones en el lugar de trabajo. El DSW debe informar al participante/LG sobre todos los incidentes y accidentes de inmediato. Las lesiones en el lugar de trabajo se **deben** informar a la Línea Directa de Lesiones del CDCN.

i. **Línea Directa de Lesiones del CDCN:** 1-888-541-1701

b. Todas los posibles ANE a la línea directa de abuso de adultos o ancianos del condado.

i. **Línea directa de abuso:** 1-800-962-2873

II. El participante y el DSW deben informar:

a. Toda sospecha de fraude de Medicaid. Los informes se pueden hacer al CDCN o la AHCA. El CDCN puede ayudarlo en el proceso.

Acuerdo entre el participante y el trabajador de servicio directo (DSW)

i. **Línea directa de fraude de CDCN:** 1-877-532-8530

ii. **Línea directa de fraude contra Medicaid de la AHCA:** 1-866-966-7226

5. Funciones y responsabilidades del CDCN:

- Enviar los formularios requeridos.
- Ayuda para completar los formularios requeridos.
- Pagar al DSW.
- Asegurarse de que al DSW no se le pague por trabajar más horas de las aprobadas en este acuerdo.
- Presentar y pagar todos los impuestos estatales y federales del DSW.
- Proporcionar un número de servicio al cliente gratuito al que pueda llamar si tiene preguntas sobre la PDO.

6. El DSW da su consentimiento para examinar todas las declaraciones proporcionadas al participante/LG. Esto incluye las declaraciones contenidas en la documentación del DSW.

La firma del DSW y del participante indica que están de acuerdo con los términos anteriores.

_____	_____	_____	_____
Firma del participante/LG	*Fecha*	*Firma del trabajador de servicio directo*	*Fecha*

_____	_____
Firma del administrador de caso	*Fecha*

PRIVACY POLICY ACKNOWLEDGEMENT FORM

I acknowledge that I have received a copy of the privacy policies from the Florida Department of Law Enforcement and the Federal Bureau of Investigation, which describe the exchange of information where criminal record results will become part of the Care Provider Background Screening Clearinghouse.

I understand and agree that I will read and comply with the guidelines contained in the privacy policies.

_____

Employee/Contractor Name (Printed)

_____

Employee/Contractor Signature

_____

Date

DSW

ATTESTATION OF COMPLIANCE
with Background Screening Requirements

Authority: This form shall be used by **all employees** to comply with:

- the attestation requirements of **section 435.05(2), Florida Statutes**, which state that every employee required to undergo Level 2 background screening must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer; **AND**

- the proof of screening within the previous 5 years in **section 408.809(2), Florida Statutes,** which requires proof of compliance with level 2 screening standards that have been screened through the Care Provider Background Screening Clearinghouse created under Section 435.12, F.S., or screened within the previous 5 years by the Agency, Department of Health, Department of Elder Affairs, the Agency for Persons with Disabilities, Department of Children and Families, or the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S., and in accordance with the standards in Section 408.809(2), F.S., if that agency is not currently implemented in the Care Provider Background Screening Clearinghouse.

This form must be maintained in the employee's personnel file. If this form is used as proof of screening for an administrator or chief financial officer to satisfy the requirements of an **application for a health care provider license**, please attach a copy of the screening results and submit with the licensure application.

Employee/Contractor Name:
Health Care Provider/ Employer Name:
Address of Health Care Provider:

You must attest to meeting the requirements for employment and you may not have been arrested for and awaiting final disposition of, have been found guilty of, regardless of adjudication, or have entered a plea of nolo contendere (no contest) or guilty to, or have been adjudicated delinquent and the record has not been sealed or expunged for, any offense prohibited under *any* of the following provisions of state law or similar law of another jurisdiction:

Criminal offenses found in section 435.04, F.S.

(a) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.

(b) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.

(c) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.

(d) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(e) Section 782.04, relating to murder.

(g) Section 782.071, relating to vehicular homicide

(h) Section 782.09, relating to killing of an unborn child by injury to the mother.

(i) Chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.

(j) Section 784.011, relating to assault, if the victim of the offense was a minor.

(k) Section 784.03, relating to battery, if the victim of the offense was a minor.

(l) Section 787.01, relating to kidnapping.

04039

(m) Section 787.02, relating to false imprisonment.

(n) Section 787.025, relating to luring or enticing a child.

(o) Section 787.04(2), relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings.

(p) Section 787.04(3), relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person.

(q) Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.

(r) Section 790.115(2)(b), relating to possessing an electric weapon or device, destructive device, or other weapon on school property.

(s) Section 794.011, relating to sexual battery.

(t) Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.

(u) Section 794.05, relating to unlawful sexual activity with certain minors.

(v) Chapter 796, relating to prostitution.

(w) Section 798.02, relating to lewd and lascivious behavior.

(x) Chapter 800, relating to lewdness and indecent exposure.

(y) Section 806.01, relating to arson.

(z) Section 810.02, relating to burglary.

(aa) Section 810.14, relating to voyeurism, if the offense is a felony.

(bb) Section 810.145, relating to video voyeurism, if the offense is a felony.

(cc) Chapter 812, relating to theft, robbery, and related crimes, if the offense is a felony.

(dd) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.

(ee) Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.

(ff) Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.

(gg) Section 825.103, relating to exploitation of an elderly person or disabled adult, if the offense was a felony.

(hh) Section 826.04, relating to incest.

(ii) Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child

(jj) Section 827.04, relating to contributing to the delinquency or dependency of a child.

(kk) Former s. 827.05, relating to negligent treatment of children.

(ll) Section 827.071, relating to sexual performance by a child.

(mm) Section 843.01, relating to resisting arrest with violence.

(nn) Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication.

(oo) Section 843.12, relating to aiding in an escape.

(pp) Section 843.13, relating to aiding in the escape of juvenile inmates in correctional institutions.

(qq) Chapter 847, relating to obscene literature.

(rr) Section 874.05(1), relating to encouraging or recruiting another to join a criminal gang.

(ss) Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.

(tt) Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.

(uu) Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.

(vv) Section 944.40, relating to escape.

(ww) Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.

(xx) Section 944.47, relating to introduction of contraband into a correctional facility.

(yy) Section 985.701, relating to sexual misconduct in juvenile justice programs.

(zz) Section 985.711, relating to contraband introduced into detention facilities.

(3) The security background investigations under this section must ensure that no person subject to this section has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense that constitutes domestic violence as defined in s. 741.28, whether such act was committed in this state or in another jurisdiction.

Criminal offenses found in section 408.809(4), F.S.

(a) Any authorizing statutes, if the offense was a felony.

(b) This chapter, if the offense was a felony.

(c) Section 409.920, relating to Medicaid provider fraud.

(d) Section 409.9201, relating to Medicaid fraud.

(e) Section 741.28, relating to domestic violence.

(f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(g) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.

(h) Section 817.234, relating to false and fraudulent insurance claims.

(i) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.

(j) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider.

(k) Section 817.505, relating to patient brokering.

(l) Section 817.568, relating to criminal use of personal identification information.

(m) Section 817.60, relating to obtaining a credit card through fraudulent means.

(n) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.

(o) Section 831.01, relating to forgery.

(p) Section 831.02, relating to uttering forged instruments.

(q) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.

(r) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.

(s) Section 831.30, relating to fraud in obtaining medicinal drugs.

(t) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony

(u) Section 895.03, relating to racketeering and collection of unlawful debts.

(v) Section 896.101, relating to the Florida Money Laundering Act.

☐ **I have been granted an Exemption from Disqualification through the Agency for Healthcare Administration (AHCA).**

Date of Decision: _____

☐ **I have been granted an Exemption from Disqualification through the Florida Department of Health.**

Date of Decision: _____

*****A copy of the Exemption from Disqualification decision letter must be attached*****

If you are also using this form to provide evidence of prior Level 2 screening (fingerprinting) in the last 5 years and have not been unemployed for more than 90 days, please provide the following information. **A copy of the prior screening results must be attached**.

Purpose of Prior Screening:_____

Screening conducted by: Date of Prior Screening: _____

☐ Agency for Healthcare Administration
☐ Department of Health
☐ Agency for Persons with Disabilities
☐ Department of Elder Affairs
☐ Department of Financial Services
☐ Department of Children and Families

04041

Attestation

Under penalty of perjury, I, _____, hereby swear or affirm that I meet the requirements for qualifying for employment in regards to the background screening standards set forth in Chapter 435 and section 408.809, F.S. In addition, I agree to immediately inform my employer if arrested or convicted of any of the disqualifying offenses while employed by any health care provider licensed pursuant to Chapter 408, Part II F.S.

Employee/Contractor Signature	Title	Date
_____	_____	_____

CONSUMER DIRECT CARE NETWORK

INFORMATION NEEDED FOR FINGERPRINTING

Instructions: *Complete <u>each and every</u> field below with your demographic information. Please print clearly. This information is required to register you for a fingerprint background check.*

* Last Name _____
* First Name _____
* Middle Name _____
* Date of birth ____/____/____
* State/Country of birth _____
* City of birth _____
* Social security number _____
* Sex _____
* Race _____
* Eye color _____
* Hair color _____
* Height (feet/inches) _____
* Weight _____
* Country of citizenship _____
* Address - Street _____
* Address - City, State, Zip Code _____
* Phone number _____
* Email address _____

To be completed by Consumer Direct

CD Representative Name: _____

Participant Name: _____

Health Care Plan: _____

Date of Enrollment Meeting: _____

Relationship to Participant (check one): ☑ Direct Service Worker ☐ Representative

03917

Anexo 2 del Acuerdo de trabajador de servicio directo (DSW): descripción del trabajo

Nombre del DSW	Nombre del participante

Instrucciones: Utilice las listas a continuación. Busque y marque los servicios que se proporcionarán y las tareas que realizará el DSW. ***Rellene cada página. Marque todas las opciones que correspondan.***

Servicios de acompañamiento para adultos (ACCS)
¿El DSW proporcionará este servicio? ☐ **Sí** ☐ **No** (*Marque sí o no. En caso afirmativo, rellene a continuación*).

Resumen del trabajo. Los ACCS incluyen las actividades necesarias para ayudar al participante. El DSW puede ayudar con las tareas domésticas o personales. Los ACCS también consisten en proporcionar estimulación social para aliviar los efectos adversos de la soledad y el aislamiento.

- ☐ **Preparación de comidas**
  - ☐ Limpieza después de cocinar.
  - ☐ Guardar la comida.
- ☐ **Tareas domésticas ligeras.**
  - ☐ Aspirar.
  - ☐ Quitar el polvo.
  - ☐ Barrer.
- ☐ **Lavar la ropa.**
- ☐ **Hacer las compras.**
  - ☐ Preparar la lista de compras.
  - ☐ Recoger los comestibles y artículos personales.
  - ☐ Recoger los medicamentos.

Enumerar otras necesidades: _____

_____

_____

_____

Servicios de ama de llaves
¿El DSW proporcionará este servicio? ☐ **Sí** ☐ **No** (*Marque sí o no. En caso afirmativo, rellene a continuación*).

Resumen del trabajo. Ayudar en las actividades de la vida diaria. Ayudar con las tareas domésticas necesarias para el participante en un entorno doméstico. Los servicios pueden incluir el mantenimiento de pertenencias personales, la realización de tareas domésticas ligeras, la lavandería, el cuidado del césped y el control de plagas.

- ☐ **Limpiar la casa.**
  - ☐ Aspirar.
  - ☐ Quitar el polvo.
  - ☐ Barrer.
  - ☐ Limpiar el baño.
  - ☐ Lavar la ropa.
  - ☐ Cuidado del césped.
  - ☐ Control de plagas
- ☐ **Preparación de comidas**
  - ☐ Limpieza después de cocinar.

Enumerar otras necesidades: _____

_____

Servicios de cuidado personal (PCS)
¿El DSW proporcionará este servicio? ☐ **Sí** ☐ **No** (*Marque sí o no. En caso afirmativo, rellene a continuación*).

Resumen del trabajo. Ayudar o supervisar las actividades de la vida diaria. El PCS ofrece un sustituto de los servicios de auxiliar de atención domiciliaria cuando el estado de un participante ya no requiere la atención de una enfermera o auxiliar que actúe bajo supervisión regular. Las tareas de un PCS pueden incluir ayudar al beneficiario a comer, bañarse, vestirse y usar el baño. Otras tareas pueden ser preparar la cama, quitar el polvo y pasar la aspiradora.

Vestirse y desvestirse
- ☐ Vestirse.

Higiene y aseo
- ☐ Cuidado de los dientes. (Cepillo, hilo dental, enjuague bucal).
- ☐ Afeitado.
- ☐ Colocar productos faciales y corporales. (Loción, maquillaje).
- ☐ Cuidado de las uñas. (Si es diabético, dé instrucciones).
- ☐ Cuidado del cabello. (Cepillar, trenzar).

Amplitud de movimiento y movilidad corporal
- ☐ Realizar ejercicio.
- ☐ Sacar al participante de la cama. Colocar al participante en la cama o en una silla.

Ayuda con los medicamentos
- ☐ Abrir un frasco de medicamentos o pastillero.
- ☐ Conseguir que el participante tome un trago de agua para tomar los medicamentos.
- ☐ Leer las etiquetas de los medicamentos.
- ☐ Ayudar al participante a recordar qué medicamentos está tomando.
- ☐ Ayudar al participante a resurtir las recetas.
- ☐ Ayudar con la colocación de los tubos de oxígeno.
- ☐ Ayudar al participante o colocar gotas para los ojos y ungüentos para la piel que tenga a su alcance.

Baño y ducha
- ☐ Baño de esponja.
- ☐ Baño de cama.
- ☐ Entrar en el baño o la ducha. (Lavar el cuerpo o el cabello).
- ☐ Salir del baño o la ducha. (Secado).
- ☐ Vestirse.

Movilidad y caminar
- ☐ Ayudar a salir a caminar fuera de casa.
- ☐ Ayudar a trasladarse a las habitaciones. Ayudar a pasar a diferentes niveles en una casa.

Ir al baño y la continencia.
- ☐ Ayudar a ir al baño.
- ☐ Cuidado de la continencia.

Servicio de limpieza.
- ☐ Tareas domésticas ligeras.
  - ☐ Aspirar.
  - ☐ Quitar el polvo.
  - ☐ Barrer.
  - ☐ Hacer la cama.

Preparación de comidas y ayuda para la alimentación.
- ☐ Preparación de comidas y limpieza.
- ☐ Ayuda para comer. (Cortar alimentos).

Enumerar otras necesidades: _____

_____

_____

_____

Servicios de atención auxiliar de enfermería

¿El DSW proporcionará este servicio? ☐ **Sí** ☐ **No** (*Marque sí o no. En caso afirmativo, rellene a continuación*).

Resumen del trabajo. La atención puede ser proporcionada por un LPN o RN. La atención suele ser por periodos más prolongados durante el día. Los periodos suelen ser de más de dos horas. El/la enfermero(a) ayuda con las necesidades médicas.

Enumere las necesidades médicas específicas: _____

_____

_____

_____

Enfermería especializada e intermitente

¿El DSW proporcionará este servicio? ☐ **Sí** ☐ **No** (*Marque sí o no. En caso afirmativo, rellene a continuación*).

Resumen del trabajo. Servicios de enfermería especializada proporcionados para garantizar la seguridad del participante y lograr los objetivos del plan de tratamiento autorizado por el médico. Estos servicios especializados pueden ser realizados en el hogar del cliente por un LPN o RN. La atención tiende a ser durante breves periodos del día, por lo general, no más de dos horas. El/la enfermero(a) ayuda con las necesidades médicas. Las necesidades pueden ser inyecciones. Las necesidades también pueden incluir el cuidado de heridas.

Enumere las necesidades médicas específicas: _____

_____

_____

_____

Las responsabilidades del DSW para con el participante:

- Tratar al participante con dignidad y respeto. Respetar sus creencias personales, cultura y religión. También, respetar su privacidad y propiedad personal.
- Informar al plan de atención administrada sobre sospechas de abuso, negligencia o explotación.
- Llamar al 911 en caso de emergencia.
- Respetar y utilizar los métodos de comunicación preferidos por el participante.
- Mantener la privacidad de la información personal del participante.
- Informar al plan de atención administrada de un cambio en el estado de salud.
- En caso de renuncia, avisar con al menos dos semanas de antelación.
- Proporcionar una atención segura.
- Avisar con antelación si se retrasa o no podrá llegar al trabajo.

_____ _____ _____ _____

Firma del participante o DR *Fecha* *Firma del DSW* *Fecha*

_____ _____

Firma del administrador de casos *Fecha*

Calendario de Nómina 2026

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

ENERO

Dom	Lun	Mar	Mié	Jue	Vie	Sáb
				1 △	2	3
4	5	6	7	8	9 ◯	10
11	12	13	14	15	16	17
18	19 △	20	21	22	23 ◯	24
25	26	27	28	29	30	31

FEBRERO

Dom	Lun	Mar	Mié	Jue	Vie	Sáb
1	2	3	4	5	6 ◯	7
8	9	10	11	12	13	14
15	16 △	17	18	19	20 ◯	21
22	23	24	25	26	27	28

MARZO

Dom	Lun	Mar	Mié	Jue	Vie	Sáb
1	2	3	4	5	6 ◯	7
8	9	10	11	12	13	14
15	16	17	18	19	20 ◯	21
22	23	24	25	26	27	28
29	30	31				

ABRIL

Dom	Lun	Mar	Mié	Jue	Vie	Sáb
			1	2	3 ◯	4
5	6	7	8	9	10	11
12	13	14	15	16	17 ◯	18
19	20	21	22	23	24	25
26	27	28	29	30		

MAYO

Dom	Lun	Mar	Mié	Jue	Vie	Sáb
					1 ◯	2
3	4	5	6	7	8	9
10	11	12	13	14	15 ◯	16
17	18	19	20	21	22	23
24	25 △	26	27	28	29 ◯	30
31						

JUNIO

Dom	Lun	Mar	Mié	Jue	Vie	Sáb
	1	2	3	4	5	6
7	8	9	10	11	12 ◯	13
14	15	16	17	18	19 △	20
21	22	23	24	25	26 ◯	27
28	29	30				

JULIO

Dom	Lun	Mar	Mié	Jue	Vie	Sáb
			1	2	3 △	4
5	6	7	8	9	10 ◯	11
12	13	14	15	16	17	18
19	20	21	22	23	24 ◯	25
26	27	28	29	30	31	

AGOSTO

Dom	Lun	Mar	Mié	Jue	Vie	Sáb
						1
2	3	4	5	6	7 ◯	8
9	10	11	12	13	14	15
16	17	18	19	20	21 ◯	22
23	24	25	26	27	28	29
30	31					

SEPTIEMBRE

Dom	Lun	Mar	Mié	Jue	Vie	Sáb
		1	2	3	4 ◯	5
6	7 △	8	9	10	11	12
13	14	15	16	17	18 ◯	19
20	21	22	23	24	25	26
27	28	29	30			

OCTUBRE

Dom	Lun	Mar	Mié	Jue	Vie	Sáb
				1	2 ◯	3
4	5	6	7	8	9	10
11	12 △	13	14	15	16 ◯	17
18	19	20	21	22	23	24
25	26	27	28	29	30 ◯	31

NOVIEMBRE

Dom	Lun	Mar	Mié	Jue	Vie	Sáb
1	2	3	4	5	6	7
8	9	10	11 △	12	13 ◯	14
15	16	17	18	19	20	21
22	23	24	25 ◯	26 △	27	28
29	30					

DICIEMBRE

Dom	Lun	Mar	Mié	Jue	Vie	Sáb
		1	2	3	4	5
6	7	8	9	10	11 ◯	12
13	14	15	16	17	18	19
20	21	22	23	24 ◯	25 △	26
27	28	29	30	31		

Asuetos bancarios y de las oficinas postales en 2026

*Cierre de oficinas de Consumer Direct Care Network

- ***Día de Año Nuevo** - Jueves 1 de Enero
- ***Día de Martin Luther King, Jr.** - Lunes 19 de Enero
- **Día de los Presidentes** - Lunes 16 de Febrero
- ***Día de los Caídos** - Lunes 25 de Mayo
- ***Juneteenth** - Viernes 19 de Junio
- ***Día de la Independencia** - Viernes 3 de Julio
- ***Día del Trabajo** - Lunes 7 de Septiembre
- **Día de Colón** - Lunes 12 de Octubre
- ***Día de los Veteranos** - Miércoles 11 de Noviembre
- ***Día de Acción de Gracias** - Jueves 26 de Noviembre
- ***Día de Navidad** - Viernes 25 de Diciembre

00540

Las semanas laborales van de domingo a sábado. Debes enviar tiempo diariamente. Las correcciones deben ser entregadas antes de la fecha límite. El retraso en el tiempo o el tiempo con errores puede resultar en un pago atrasado. Comuníquese con CDFL si tiene problemas para ingresar o aprovar el tiempo trabajado.

Periodo de paga de dos semanas		**Fecha limite de correcciones a tiempo EVV**	**Fecha de pago**
Fecha de inicio	**Fecha de finalización**		
Domingo	**Sábado**	**Lunes**	**Viernes**
12/14/2025	12/27/2025	12/29/2025	1/9/2026
12/28/2025	1/10/2026	1/12/2026	1/23/2026
1/11/2026	1/24/2026	1/26/2026	2/6/2026
1/25/2026	2/7/2026	2/9/2026	2/20/2026
2/8/2026	2/21/2026	2/23/2026	3/6/2026
2/22/2026	3/7/2026	3/9/2026	3/20/2026
3/8/2026	3/21/2026	3/23/2026	4/3/2026
3/22/2026	4/4/2026	4/6/2026	4/17/2026
4/5/2026	4/18/2026	4/20/2026	5/1/2026
4/19/2026	5/2/2026	5/4/2026	5/15/2026
5/3/2026	5/16/2026	5/18/2026	5/29/2026
5/17/2026	5/30/2026	6/1/2026	6/12/2026
5/31/2026	6/13/2026	6/15/2026	6/26/2026
6/14/2026	6/27/2026	6/29/2026	7/10/2026
6/28/2026	7/11/2026	7/13/2026	7/24/2026
7/12/2026	7/25/2026	7/27/2026	8/7/2026
7/26/2026	8/8/2026	8/10/2026	8/21/2026
8/9/2026	8/22/2026	8/24/2026	9/4/2026
8/23/2026	9/5/2026	9/7/2026	9/18/2026
9/6/2026	9/19/2026	9/21/2026	10/2/2026
9/20/2026	10/3/2026	10/5/2026	10/16/2026
10/4/2026	10/17/2026	10/19/2026	10/30/2026
10/18/2026	10/31/2026	11/2/2026	11/13/2026
11/1/2026	11/14/2026	11/16/2026	11/25/2026*
11/15/2026	11/28/2026	11/30/2026	12/11/2026
11/29/2026	12/12/2026	12/14/2026	12/24/2026*
12/13/2026	12/26/2026	12/28/2026	1/8/2027
12/27/2026	1/9/2027	1/11/2027	1/22/2027

Consumer Direct Care Network Florida
1401 NW 136th Ave, Suite 402
Sunrise, FL 33323

Teléfono: 877-270-9580
Fax: 877-344-0999
Correo electrónico: infoCDFL@ConsumerDirectCare.com
Página web: www.ConsumerDirectFL.com

Please note: If you have a disability and need more help, we can help you. If you need someone that speaks your language, we can also help. You may call our Member Services Department at (866) 472-4585 for more help from 8:00 am to 7:00 pm. If you are blind or have trouble hearing or communicating, please call 711 for TTY/TTD services. We can help you get the information you need in large print, audio (sound), and braille. We provide you with these services for free.

Tenga en cuenta lo siguiente: si tiene una discapacidad y necesita más ayuda, podemos ayudarlo. También podemos ayudarlo si necesita a alguien que hable en su idioma. Para obtener más ayuda, puede llamar a nuestro Departamento de Servicios para Miembros al (866) 472-4585, de 8:00 a. m. a 7:00 p. m. Si es ciego o tiene problemas de audición o comunicación, llame al 711 para acceder a servicios de TTY/TDD. Podemos ayudarlo a obtener la información que necesita en letra de molde grande, audio (sonido) y en sistema Braille. Estos servicios son gratuitos.

Remake: Si ou gen yon andikap epi ou bezwen plis èd, nou kapab ede w. Si ou bezwen yon moun ki pale lang ou an, nou kapab ede w tou. Ou gendwa rele Depatman Sèvis Manm nou an nan (866) 472-4585 pou jwenn plis èd soti 8è:00 a.m. rive 7è:00 p.m. Si ou avèg oswa ou gen difikilte pou tande oswa pou kominike, tanpri rele 711 pou sèvis TTY/TTD yo. Nou kapab ede w jwenn enfòmasyon oubezwen an gwo karaktè, odyo (son) ak an Bray. N ap ba w sèvis sa yo pou gratis.

Xin lưu ý: Nếu quý vị là người khuyết tật và cần thêm trợ giúp, chúng tôi có thể giúp quý vị. Nếu quý vị cần người có thể nói ngôn ngữ của quý vị, chúng tôi cũng có thể giúp. Quý vị có thể gọi cho Bộ phận Dịch vụ thành viên của chúng tôi theo số (866) 472-4585 để được trợ giúp thêm từ 8:00 am đến 7:00 pm. Nếu quý vị bị mù hoặc có vấn đề về thính giác hoặc giao tiếp, vui lòng gọi 711 cho dịch vụ TTY/TTD. Chúng tôi có thể giúp quý vị nhận thông tin quý vị cần bằng bảng chữ in lớn, âm thanh và chữ nổi Braille. Chúng tôi cung cấp miễn phí các dịch vụ này cho quý vị.

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Non-Discrimination Notification

Molina Healthcare of Florida, Inc.

Medicaid

Discrimination is against the law. Molina Healthcare of Florida, Inc. (Molina) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Molina does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Molina:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Molina Member Services at (866) 472-4585 (TTY: 711).

If you believe that Molina has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator
200 Oceangate, Ste 100
Long Beach, CA 90802
Phone: (866) 472-4585 (TTY: 711)
Fax: (877) 508-5738
Email: **civil.rights@molinahealthcare.com**

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Molina Member Services is available to help you. You may obtain our grievance procedure by visiting our website at: **https://www.molinahealthcare.com/members/common/en-US/Notice-of-Nondiscrimination.aspx**.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
Phone: (800) 368-1019 (TDD: (800) 537-7697)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Non-Discrimination Tag Line – Section 1557

Molina Healthcare of Florida, Inc.

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call (866) 472-4585 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (866) 472-4585 (TTY: 711).
French Creole (Haitian Creole)	ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (866) 472-4585 (TTY: 711).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (866) 472-4585 (TTY: 711).
Portuguese	ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para (866) 472-4585 (TTY: 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (866) 472-4585（TTY：711）。
French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (866) 472-4585 (TTY : 711).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (866) 472-4585 (TTY: 711).
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (866) 472-4585 (телетайп: 711).
Arabic	ةظوملحا: اذإ تكن ركذا ثدحتت غةللا، نإف تامدخ ةدعاسملا ةيوغللا رفاوتت نمجلاب لكل. لتصا مقرب (866) 472-4585 (مقر فتاه مصلا مكبلاو: 711).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (866) 472-4585 (TTY: 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (866) 472-4585 (TTY: 711).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (866) 472-4585 (TTY: 711) 번으로 전화해 주십시오.
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (866) 472-4585 (TTY: 711).
Gujarati	સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો (866) 472-4585 (TTY: 711).
Thai	เรยน: ถาคณพดภาษาไทยคณสามารถใชบรการชวยเหลอทางภาษาไดฟร โทร (866) 472-4585 (TTY: 711).

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MOLINA HEALTHCARE

MOLINA HEALTHCARE

Your Extended Family.

Non-Discrimination Notification
Molina Healthcare of Florida
Medicaid

Molina Healthcare of Florida (Molina) complies with all Federal civil rights laws that relate to healthcare services. Molina offers healthcare services to all members without regard to race, color, national origin, age, disability, or sex. Molina does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. This includes gender identity, pregnancy and sex stereotyping.

To help you talk with us, Molina provides services free of charge:

- Aids and services to people with disabilities
    - Skilled sign language interpreters
    - Written material in other formats (large print, audio, accessible electronic formats, Braille)
- Language services to people who speak another language or have limited English skills
    - Skilled interpreters
    - Written material translated in your language
    - Material that is simply written in plain language

If you need these services, contact Molina Member Services at (866) 472-4585.

If you think that Molina failed to provide these services or treated you differently based on your race, color, national origin, age, disability, or sex, you can file a complaint. You can file a complaint in person, by mail, fax, or email. If you need help writing your complaint, we will help you. Call our Civil Rights Coordinator at (866) 606-3889, or TTY, 711. Mail your complaint to:

Civil Rights Coordinator
200 Oceangate
Long Beach, CA 90802

You can also email your complaint to civil.rights@molinahealthcare.com. Or, fax your complaint to (877) 508-5738.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can mail it to:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

You can also send it to a website through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

If you need help, call 1-800-368-1019; TTY 800-537-7697.