CONSUMER DIRECT CARE NETWORK

Consumer-Delegated Personal Care Services

BACKGROUND CHECK INFORMATION

Reset/clear all fields > Clear Form

Name: _____
First Middle Last

Aliases to name provided above (including maiden name or previous married names):

_____

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

Primary Phone: _____ Email Address: _____

Social Security Number: _____-_____-_____

Date of Birth: _____/_____/_____ (MM/DD/YYYY)

Place of Birth: _____ (state or country if born outside USA)

Driver's License/State ID #: _____ State: _____

Country of citizenship: _____

Sex: ☐ Male ☐ Female Weight: _____ Height: _____

Race: ☐ Asian/Pacific Islander ☐ Black ☐ American Indian/Alaskan Native ☐ White/Latino ☐ Unknown

Eye Color: ☐ Black ☐ Blue ☐ Brown ☐ Green ☐ Grey ☐ Hazel

Hair Color: ☐ Black ☐ Blonde ☐ Brown ☐ Red

Please Read Carefully

I understand the information requested above is for the purpose of obtaining a criminal background check to comply with Medicaid regulations under New Mexico's Personal Care Services program and will not be used to discriminate against me in violation of any law. I further understand that false statements or omission of facts can be grounds for not hiring me, or firing me after I begin work.

_____ _____

Signature of Applicant *Date*

CONSUMER DIRECT CARE NETWORK

Consumer-Delegated Personal Care Services

NEW EMPLOYEE CHECKLIST

Attendant Name: _____

Complete the payroll/program forms listed below. Attach proof of licensing/trainings as applicable.

Payroll/Program Related Forms (required for all new employees)

1. ☐ Background Check Information
2. ☐ New Employee Checklist (this form)
3. ☐ Equal Employment Opportunity Disclosure
4. ☐ I-9 Form – Employment Eligibility Verification – *additional I-9 instructions are available on the CDCN New Mexico Website under the Resources tab*
5. ☐ W-4 Form – Employee's Withholding Allowance Certificate
6. ☐ Pay Selection Form – *attachment may be required, see form instructions*
7. ☐ Wage Memo
8. ☐ Employee Agreement
9. ☐ Employee EVV Acknowledgement
10. ☐ Employee EVV Quiz
11. ☐ Safety Quiz
12. ☐ Driving Confirmation OR ☐ No-Driving Confirmation – *complete one of these two forms based on whether you will be providing driving-related services for a Medicaid member.*
13. ☐ Medicaid Fraud Statement
14. ☐ Authorization/Declination of Hepatitis B Vaccination
15. ☐ New Hire Expected Weekly Hours

Licensing/Training Verifications (as applicable, attach photocopy documentation)

1. ☐ Current CPR Certification. Expiration date: _____. OR ☐ Applicant does not have current CPR certification*
2. ☐ Current First Aid Certification. Expiration date: _____. OR ☐ Applicant does not have current First Aid certification*

   **may be completed within 3 months of hire date*
3. ☐ Driver's License or State ID Card – *see Driving/No Driving Confirmation forms*
4. ☐ Minimum Auto Insurance – *if applicable, only if transporting a Member*

Supplemental Materials Distributed

1. ☐ Employee Handbook
2. ☐ Payroll Calendar
3. ☐ Benefits Sheet

I have reviewed and verified the above forms for completeness and all forms are readable.

Completed on date: _____/_____/_____

CDCN Representative Name (please print): _____

10490

CONSUMER DIRECT CARE NETWORK

EQUAL EMPLOYMENT OPPORTUNITY DISCLOSURE

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

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 ☐ Undeclared

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. 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
New Mexico Consumer Direct Personal Care, LLC	1120 Pennsylvania St. NE, Albuquerque NM 87110

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.

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 (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.

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

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

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Financial control: You've got it!

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

Get paid early.[2]

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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]

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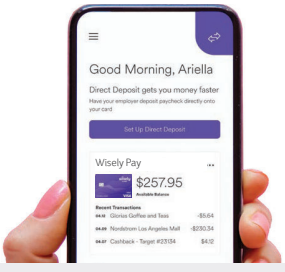
Talk to your Payroll Department.



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.

CONSUMER DIRECT CARE NETWORK

Consumer-Delegated Personal Care Services

ATTENDANT WAGE MEMORANDUM

Attendant Name	Member Name	Member CDCN ID #

Date of Hire/Effective Date: _____

Role: ☐ Dual Attendant for Medicaid and City of Albuquerque
☐ City of Albuquerque only (CDNM)
☐ Medicaid only (CDNM)

Position: ☐ Personal Care Attendant ☐ Core Personal Care Attendant

Authorized Services and Hourly Wage:

Service	Wage	Payor	Code
☐ Personal Care Services	$_____/hr	Medicaid	T1019
☐ Homemaker Services	$_____/hr	City of Albuquerque*	HMK
☐ Respite	$_____/hr	City of Albuquerque*	RES
☐ On Call	$ 50.00/day	CDNM	ONCALLWKDAY
☐ Portal-to-Portal**	$_____/hr	CDNM	PORTAL
☐ Sick Leave	$_____/hr	_____	SICK

*Attendant may not also be an employee of the City of Albuquerque nor have any contractual relationship with the City of Albuquerque. Attendant must have completed 10 hours of training prior to providing services.

**Transit time only for travel between two members' residences to deliver services. Excludes stops for errands, fuel, eating, etc.

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

_____ _____

Attendant Signature *Date*

_____ _____

CDCN Representative Signature *Date*

09493

CONSUMER DIRECT CARE NETWORK

Consumer-Delegated Personal Care Services

EMPLOYEE AGREEMENT

This agreement is between New Mexico Consumer Direct Personal Care, LLC doing business as Consumer Direct Care Network New Mexico (CDCN), and the following employee:

_____.
(Employee Print Name)

I understand CDCN is my employer. I agree to and acknowledge the following:

1. **Caregiver Handbook**
   I have received a copy of the Consumer Direct Care Network New Mexico (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. **Scheduling Commitment**
   Definite hours are not guaranteed. Service requests and service hours are defined by the Member's needs. I agree to meet commitments and the scheduled hours I accept.
   - Call-offs are only allowed for extreme emergencies. Frequent call-offs can result in disciplinary action, up to and including termination. Call-offs are defined as providing at least two-hour notice before being absent for an assigned shift.
   - No-call/no-shows will result in disciplinary action, up to and including termination. No-call/no-shows are defined as failing to show-up for an assigned shift without providing at least two-hour notice.

3. **Non-Emergent Care**
   I understand my role as a Personal Care Attendant is to assist the Member with Activities of Daily Living (ADLs) and provide nonmedical care. Under CDCN guidelines, I understand I will not perform any invasive and/or medical treatments. These treatments require a licensed professional to administer and/or provide (such as: suctioning, bowel care, insertion/removal of urinary catheter, complex wound care, medication box fills, etc.). I understand violating this condition can result in immediate termination of employment.

   If there's an emergency or risky health situation, I will contact the appropriate authorities, including the Member's doctor and/or 911.

4. **Payment**
   - I am paid at an hourly rate as defined in the wage memo. My pay is subject to applicable tax withholding.
   - CDCN offers two direct deposit pay options. I can specify a bank account or choose a pay card. If I change my options, I must submit a new Pay Selection Form.
   - CDCN issues pay every two weeks. CDCN sends pay stubs (summary of pay) and W-2s by first class mail to my address on file or electronically. A current CDCN Pay Schedule is available online at www.consumerdirectnm.com.
   - If I am eligible for portal-to-portal pay, it is paid at the county's current minimum hourly wage.

- I have the right to earn and use paid sick leave. I will accrue one 1 hour of sick leave for every 30 hours worked, and may use up to 64 hours per year. Hours used and earned will be shown on my pay stub. I cannot use EVV to claim sick leave, but must submit a paper form.
- I agree to use AuthentiCare IVR phone system or the AuthentiCare App to submit time-worked. I understand:
  - I must clock in and clock out for each scheduled shift daily.
  - I am required to contact CDCN immediately if I am not able to use AuthenticCare and report the issues I am having. If I do not notify CDCN within twenty-four (24) hours of a scheduled shift, I will not be provided with a correction form.
  - Not all issues will be approved for a correction form.
- Overtime is not allowed unless approved by CDCN's Service Coordinator Supervisor. If I think overtime may happen, I must get approval before working the extra hours. I agree to monitor my work hours and abide by overtime restrictions.

5. Training & Certification Requirements:

- Complete initial in-home Personal Care Services training within three (3) months of hire and successfully pass a written competency test.
- Complete 12 hours of continuing education each year.
- Maintain current CPR and First Aid certification throughout employment.

6. My Personal Care Attendant Responsibilities Include:

- Maintain program compliance (follow all policies and procedures).
- Provide accurate documentation and record keeping (includes reporting of work no-shows).
- Maintain confidentiality.
- Not transport a member in a car unless such services are authorized on the Member's IPoC and proof of automobile insurance and valid driver's license are on file with CDCN.
- Report work-place injuries immediately to the CDCN Risk Manager on the 24-hour Injury Hotline (877-532-8542).
- Report to CDCN or appropriate authorities if concerned about fraud, abuse, neglect, exploitation, environmental hazards, law enforcement intervention, emergency services, or death.

7. Sobriety Agreement

I agree to not provide services while under the influence of drugs or alcohol. I understand my employment will be immediately terminated for providing services while under the influence of drugs or alcohol.

Employee Signature	*Date*	*CDCN Authorized Representative Signature* (Employer)	*Date*

CONSUMER DIRECT CARE NETWORK

EMPLOYEE EVV ACKNOWLEDGEMENT

_____

Print Employee (Attendant) Name

Instructions:

1. **Review each topic and ask questions if necessary. Initial by each to show your agreement and understanding.**
2. **In this acknowledgement, "I, my, me" refers to the above-named employee who will be providing services to a Personal Care Services Program member.**

_____ **Receipt of AuthentiCare training materials:** I received the IVR instruction sheet or AuthentiCare App information and I have received training on how to use the EVV system. I am responsible to ensure that services begin and end at the member's home.

_____ **Acknowledgement of the required use of the EVV system AuthentiCare and Authorized Hours:** I understand that the use of the EVV system AuthentiCare is required by the New Mexico Health Care Authority Department and the Managed Care Organizations. I understand that I am responsible for clocking in and clocking out for each scheduled shift using the AuthentiCare IVR phone system or the AuthentiCare App. I understand that I cannot be paid for hours worked that were not authorized by Consumer Direct Care Network.

_____ **Acknowledgement of the EVV system AuthentiCare time reporting methods:** I understand that I am responsible to check in and check out using the member's registered phone. I understand that if the assigned member does not have a phone, phone service or a phone is not available, or if I experience hardships using the phone system, there are alternatives available to me. An alternative is to use my own personal smartphone with the AuthentiCare application.

_____ **Acknowledgement of the requirement to submit accurate and complete information in a timely manner:** I have received a copy of the Consumer Direct Care Network (CDCN) payroll periods. I understand that all time worked must be submitted using the EVV method selected on a daily basis. I understand that I am required to contact CDCN immediately if I am not able to clock in or clock out so that they can assist me while I am having difficulties. I understand that not all issues will be approved for a correction form. I understand if I do not notify CDCN of issues within 24 hours of a scheduled shift that I will not be provided with a correction form. I understand that to ensure timely pay corrections, I must notify CDCN of any pay discrepancies within 14 days of receiving my paycheck. **I understand that in the event of an extraordinary and unavoidable situation that is out of my control that according to Medicaid timely-filing requirements, request for payment that has not been submitted within 60 days from the date the employee worked cannot be processed.**

_____ **Acknowledgement of the requirement to notify CDCN if I am unable to clock in or clock out using the EVV System:** I understand that I am responsible for contacting CDCN if I am not able to clock in or clock out to fix the problem at the time that it is occurring. I understand that if there is a power outage or a telephone service outage that I am responsible for contacting the provider and documenting with a reference number that the service interference has occurred as soon as service is restored.

_____ _____

Employee Signature *Date*

09676

CONSUMER DIRECT CARE NETWORK

ELECTRONIC VISIT VERIFICATION QUIZ

Score _____

TEST YOURSELF

True or False

1.	You must notify Consumer Direct Care Network within 24 hours of a missing or pending claim.	**T F**
2.	I can contact Consumer Direct Care Network to request a correction form without a valid reason.	**T F**
3.	Any missed visits not reported immediately cannot be processed.	**T F**
4.	The use of the EVV system is required by the New Mexico Health Care Authority department and the Managed Care Organizations.	**T F**
5.	If my phone/tablet is stolen/lost, I will need to report immediately to Consumer Direct Care Network.	**T F**
6.	I am not required to use the EVV system at all times.	**T F**
7.	Consumer Direct Care Network is responsible to monitor my clock-ins and clock-outs.	**T F**
8.	I am required to follow the work schedule as instructed by Consumer Direct Care Network.	**T F**
9.	I can clock in and clock out from other location besides the member's home.	**T F**
10.	The member can clock in and clock out on my behalf.	**T F**
11.	I may only work the hours that Consumer Direct Care Network has authorized me to work.	**T F**
12.	My payroll may be affected if I do not clock in and clock out correctly daily.	**T F**

Employee (Attendant) Name _____ Attendant Signature _____ Date _____

09806

2026 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.

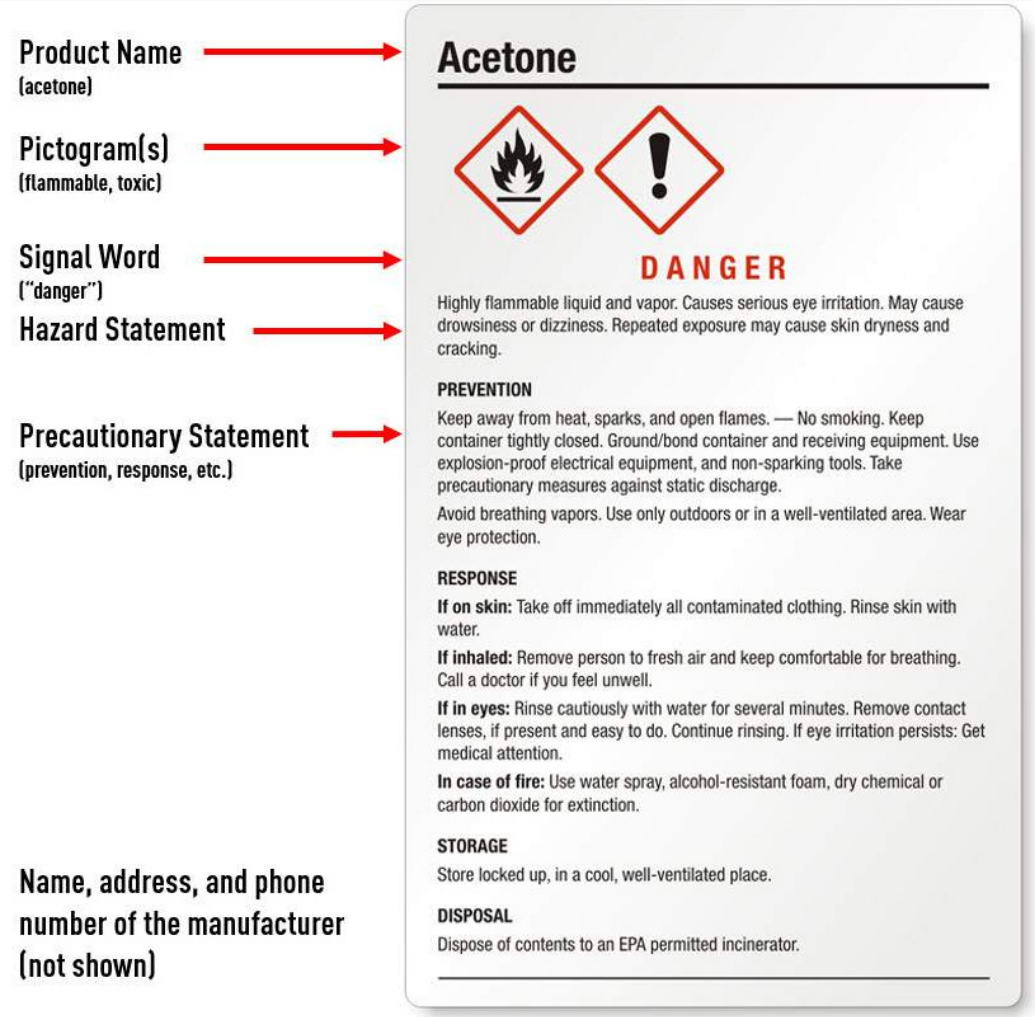
Ingestion (swallowing): Chemicals that are swallowed can be absorbed into the digestive tract. Always wash your hands before touching any food, especially after using cleaning products.

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 _____

CONSUMER DIRECT CARE NETWORK

Consumer-Delegated Personal Care Services

DRIVING CONFIRMATION

Print Attendant's Name

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

For an attendant to be paid for driving-related services, program rules require:

1. Support Services must be authorized on the member's Individual Plan of Care.
2. The attendant's driver's license and proof of insurance for the vehicle driven must be on file at Consumer Direct Care Network (CDCN). If these are not provided and updated when necessary, the attendant cannot claim driving services.

Driving is only authorized for Support Services that are on the member's plan of care. The attendant will not be paid for driving services when going to doctor's appointments, driving out of state, or driving while on vacation. 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:

Attendant'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

I understand that it is my responsibility to provide CDCN with updates of any changes or insurance renewals and that I will not submit hours for driving services unless the requirements above have been met.

_____ _____

Attendant Signature *Date*

03111

CONSUMER DIRECT CARE NETWORK

Consumer-Delegated Personal Care Services

NO DRIVING CONFIRMATION

_____

Print Attendant's Name

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

State regulations require a copy of the attendant's driver's license or state identification card be on file even driving-related services are not provided by the attendant.

Attachment Required

Please attach a photocopy of <u>one of the following</u> documents:

☐ **Attendant's Driver's License**

State: _____ Number: _____ Expiration Date: _____

☐ **Attendant's State ID Card**

State: _____ Number: _____ Expiration Date: _____

Acknowledgement

The attendant hereby agrees they will not provide driving services at any time while providing program services.

_____ _____

Attendant Signature *Date*

03112

ATTENDANT MEDICAID FRAUD STATEMENT

Because you provide services to a Medicaid recipient, it is important to know what fraud means. Professionals, friends, and even family members can commit fraud. It is your responsibility to recognize the signs of fraud so you can avoid this problem. Fraud is: "the intentional twisting of the truth to trick someone into giving up something of value or to surrender a legal right."

Consumer Direct Care Network (CDCN) is a mandatory reporter of any issues involving Medicaid fraud. Any member, legal representative, or attendant participating in the following acts will be reported to the New Mexico Health Care Authority Department:

1. Claiming hours or services on a timesheet or Electronic Visit Verification (EVV) system that were not worked.
2. Failing to provide and maintain quality services as written on the Individual Plan of Care.
3. Engaging in a behavior that is considered abusive and/or improper by the Medicaid program.
4. Pretending to need services which are not medically necessary.
5. Encouraging a member to receive services not required or requested by the member or legal representative.

CDCN is charged by federal and state law with the responsibility of identifying, investigating, and referring to appropriate entities cases of suspected fraud or abuse of the Medicaid program by the **member**, **attendant,** or **Provider Agency**.

If you believe that a person or agency (neighbor, doctor's clinic, personal care provider, etc.) has done any of the things listed, you should contact the Human Services Department. (Number listed below)

<u>Medicaid fraud is a crime against all taxpayers and is a State and Federal crime.</u>

All cases of possible Medicaid fraud and program abuse should be reported immediately to New Mexico's Health Care Authority Department. The call you make would be confidential and anonymous. To make a report, call or email the New Mexico Health Care Authority Department, Medical Assistance Division at 1-800-228-4802 or HSD-OIG.Fraud@state.nm.us. See our website's Fraud Resources page for more information.

CDCN takes Medicaid fraud very seriously. CDCN is required to report suspected Medicaid fraud to the State of New Mexico. If it is discovered, the company will turn it over to the authorities and the person or persons committing fraud will be prosecuted to the full extent of the law.

Attendant Name	Attendant Signature	Date

02941

CONSUMER DIRECT CARE NETWORK

Consumer-Delegated Personal Care Services

HEPATITIS B VACCINATION AUTHORIZATION/DECLINATION

Print Attendant's Name

Instruction to attendant: Please choose either to decline or receive the Hepatitis B vaccination by marking one of the boxes below and signing at the bottom. Consumer Direct Care Network New Mexico (CDCN) will return the form to you with an authorization date and signature so that you may complete the vaccination, if you choose to receive it.

☐ I decline the Hepatitis B vaccination

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring the Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. However, I decline 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. In the future, if I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with the Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

☐ I choose to receive the Hepatitis B vaccination

This Authorization is valid through the authorization date shown below. If you are not able to use this Authorization by the authorization deadline, you must contact the office and have it reissued.

The above-named employee is authorized to receive or complete the Hepatitis B vaccination series at a local clinic, doctor's office or other authorized provider.

THIS AUTHORIZATION IS NOT VALID UNLESS SIGNED BELOW BY CDCN.

Provider Instruction: Please do not honor this Authorization if presented after the expiration date shown below. Notify CDCN of any requests made after that date.

Please bill the following address: Consumer Direct Care Network
1120 Pennsylvania Street NE
Albuquerque, NM 87110
Phone 866-344-2371

This Authorization expires on: _____/_____/_____
[to be completed by a CDCN representative]

Attendant (Employee) Signature *Date*

CDCN Signature *Date*

Authorized Provider/Facility

Authorized Provider Signature *Date*

01091

CONSUMER DIRECT CARE NETWORK

EXPECTED WEEKLY HOURS - NEW HIRE

CAREGIVER/NURSE
(Non-FEA)

Employee Name: _____

Entity: CDNM

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

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)
New Mexico Consumer Direct	20-1380008
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)

CONSUMER DIRECT CARE NETWORK

2026 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 $3,400 per calendar year in pre-tax dollars to use for eligible medical expenses. Unused funds (up to $680) 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 $7,500 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. Buy-up plan offered with a $2,000 annual maximum and includes orthodontia care for dependents up to age 26.
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. The company offers a match of up to 25% of your contribution amount (maximum of 1%).
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

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

2026 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		

2026 Bank & Post Office Holidays

*Consumer Direct Care Network office closures

- ***New Year's Day** - Thursday, January 1
- ***Martin Luther King, Jr. Day** - Monday, January 19
- **Presidents Day** - Monday, February 16
- ***Memorial Day** - Monday, May 25
- ***Juneteenth** - Friday, June 19
- ***Independence Day** - Friday, July 3
- ***Labor Day** - Monday, September 7
- **Columbus Day** - Monday, October 12
- ***Veterans Day** - Wednesday, November 11
- ***Thanksgiving Day** - Thursday, November 26
- ***Christmas Day** - Friday, 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
12/14/2025	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

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