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This packet is designed for double sided paper printing.

CONSUMER DIRECT CARE NETWORK

Agency-Based Personal Care Services

PERSONAL CARE ATTENDANT EMPLOYMENT APPLICATION

Reset/clear all fields > Clear Form

APPLICANT INFORMATION

Name - First: _____ Middle: _____ Last: _____

Previously Held Names: _____

Mailing Address: _____

_____

City State Zip

Phone - Home: _____ Cell: _____

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

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

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

Date of Birth (mm/dd/yyyy): _____ Place of Birth (State): _____

Emergency Contact Name and Phone: _____

Primary Language: _____ Secondary Language: _____

How did you hear about working for CDCN? _____

ADDITIONAL INFORMATION/EXPERIENCE

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

CRIMINAL CONVICTIONS

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

LOCATIONS YOU CAN WORK/AVAILABILITY TO TRAVEL

Which areas are you willing to travel to for work (circle or list locations):

Southern NV: ❑ Las Vegas | ❑ N. Las Vegas | ❑ Henderson | ❑ Boulder City | ❑ Summerlin ❑ Sunrise Manor | ❑ Winchester | ❑ Spring Valley | ❑ Pahrump | ❑ Laughlin | ❑ Mesquite ❑ Logandale | ❑ Caliente | ❑ Other: _____

Northern NV: ❑ Reno| ❑ North Valleys (Sun Valley, Panther Valley, Golden Valley, Cold Springs) ❑ Washoe | ❑ Sparks | ❑ Spanish Springs | ❑ Carson City | ❑ Gardnerville | ❑ Minden | ❑ Mound House | ❑ Other: _____

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

CANDIDATE LIST/ADDITIONAL ASSIGNMENTS

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

To remain in good standing with our agency you are expected to adhere to conditions contained in your Employee Handbook – current TB test, CPR, First Aid, Continuing Education, background check and CDCN Coordinator reviews. Should your requirements lapse, you will be removed from the Candidate List. If you are not available for scheduled work after accepting an assignment, you must notify the CDCN office. A no call/no show can result in removal from the Candidate List.

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

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

☐ Be included on the Candidate List.

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

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

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

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

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

References List three references that can verify your character and work history *(Required per Nevada Administrative Code Chapter 449).*		
1.☐ **Personal** ☐ **Professional**	Reference Name:	Phone:
Reference Title:	Relationship:	
Additional Information:		
2.☐ **Personal** ☐ **Professional**	Reference Name:	Phone:
Reference Title:	Relationship:	
Additional Information:		
3.☐ **Personal** ☐ **Professional**	Reference Name:	Phone:
Reference Title:	Relationship:	
Additional Information:		

PLEASE READ CAREFULLY

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

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

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

I understand that my employment with this company shall be probationary for a period of up to **180 days**, during which my employment relation with the company is terminable at will for any reason by either party.

Signature of Applicant: _____ ❑ ❑ Date: _____

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

CONSUMER DIRECT CARE NETWORK

Agency-Based Personal Care Services

Employee Application Instructions

PERSONAL CARE ATTENDANT APPLICANTS: After being selected as a candidate for hire, you must complete, sign, and provide the following information to Consumer Direct Care Network (CDCN). After review and approval of all submitted materials, CDCN will notify you in writing when it is okay to begin working with an "Authorization to Begin Work" form.

Payroll Requirements

- Employee Data Form/Employment Application
- Equal Employment Opportunity Disclosure
- I-9 - *Employee completes Section 1, Employer completes Section 2.*
- W-4
- Pay Selection Form
- Employee Acknowledgment Form
- Wage Memo
- Statement of Good Health
- New Hire Expected Weekly Hours
- Driver's License & Auto Insurance (If applicable)

Program Requirements

- Two Step TB Skin Test - CDCN will provide you information on clinic locations
- Hepatitis B Vaccination opportunity - sign the form to accept or decline the vaccination
- Fingerprint Cards or Authorization Letter for Fingerprinting - Criminal Background Check
- Civil Applicant Waiver - Criminal Background Check
- Completed Trainings - Initial Training: 16 hours. Annual Training: 8 hours.
- Copy of CPR Certification & First Aid – CDCN will provide location information for classes. Online certification is not valid or sufficient.

Upon completion of all application documents, deliver or send them to our state office via mail, fax or email attachment using the contact information below.

Reminder: You may not begin working as an employee until all the items listed above are completed, submitted, approved, and an "Authorization to Begin Work" form is provided to you by CDCN. You will need to remain in compliance with Medicaid regulations and program requirements as a condition of employment through CDCN.

Reminder: CareAttend EVV instructions and payroll related forms can be downloaded from the CDCN Nevada website at: http://consumerdirectnv.com/

CONSUMER DIRECT CARE NETWORK

EQUAL EMPLOYMENT OPPORTUNITY DISCLOSURE

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

The purpose of this questionnaire is to aid in complying with required governmental record keeping and/or reporting requirements. **This information <u>will not</u> 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 (<u>not</u> 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 (<u>not</u> 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 (<u>not</u> Hispanic or Latino)	A person having origins in any of the original peoples of Africa.
☐ Asian (<u>not</u> 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 (<u>not</u> Hispanic or Latino)	A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
☐ Two or More Races (<u>not</u> 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 <u>required</u> 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)
Managing Employer		

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
Consumer Direct Services for Nevada	1005 Terminal Way, Suite 125, Reno NV 89502

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

LISTS OF ACCEPTABLE DOCUMENTS

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

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

Acceptable Receipts

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2026

Step 1: Enter Personal Information

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

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

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

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(b) is more accurate . . . . . ☐

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

Step 3: Claim Dependent and Other Credits

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

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

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

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

Step 4: Other Adjustments

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

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

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

Exempt from withholding

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

Step 5: Sign Here

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

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

Employers Only

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

General Instructions

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

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2026 if you meet both of the following conditions: you had no federal income tax liability in 2025 **and** you expect to have no federal income tax liability in 2026. You had no federal income tax liability in 2025 if (1) your total tax on line 24 on your 2025 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2026 tax return. To claim exemption from withholding, certify that you meet both of the conditions by checking the box in the *Exempt from withholding* section. Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2027.

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

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

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

2. Expect to work only part of the year;

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

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

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

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

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

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

Specific Instructions

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

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work. Submit a separate Form W-4 for each job.

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

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

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

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

Step 4.

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 15, if you expect to claim deductions other than the basic standard deduction on your 2026 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for qualified tips, overtime compensation, and passenger vehicle loan interest; student loan interest; IRAs; and seniors. You (and/or your spouse if married filing jointly) must have the required social security number to claim certain deductions. For additional eligibility requirements, see Pub. 501.

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

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

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

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

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 5. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . **1** $ _____

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

a Find the amount from the appropriate table on page 5 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . **2a** $ _____

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 5 and enter this amount on line 2b . . . . . **2b** $ _____

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 **Limitation on itemized deductions.**

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

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

. . . . . **9** $

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

11 **Standard deduction.**

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

. . . . . **11** $

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

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

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

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

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

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

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

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

00540

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$480	$850	$850	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020
$10,000 - 19,999	0	480	1,480	1,850	2,050	2,220	2,220	2,220	2,220	2,220	2,220	2,620
$20,000 - 29,999	480	1,480	2,480	3,050	3,250	3,420	3,420	3,420	3,420	3,420	3,820	4,820
$30,000 - 39,999	850	1,850	3,050	3,620	3,820	3,990	3,990	3,990	3,990	4,390	5,390	6,390
$40,000 - 49,999	850	2,050	3,250	3,820	4,020	4,190	4,190	4,190	4,590	5,590	6,590	7,590
$50,000 - 59,999	1,020	2,220	3,420	3,990	4,190	4,360	4,360	4,760	5,760	6,760	7,760	8,760
$60,000 - 69,999	1,020	2,220	3,420	3,990	4,190	4,360	4,760	5,760	6,760	7,760	8,760	9,760
$70,000 - 79,999	1,020	2,220	3,420	3,990	4,190	4,760	5,760	6,760	7,760	8,760	9,760	10,760
$80,000 - 99,999	1,020	2,220	3,420	4,240	5,440	6,610	7,610	8,610	9,610	10,610	11,610	12,610
$100,000 - 149,999	1,870	4,070	6,270	7,840	9,040	10,210	11,210	12,210	13,210	14,210	15,360	16,560
$150,000 - 239,999	1,870	4,100	6,500	8,270	9,670	11,040	12,240	13,440	14,640	15,840	17,040	18,240
$240,000 - 319,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,780	14,980	16,180	17,380	18,580
$320,000 - 364,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,860	15,860	17,860	19,860	21,860
$365,000 - 524,999	2,720	5,920	9,390	12,260	14,760	17,230	19,530	21,830	24,130	26,430	28,730	31,030
$525,000 and over	3,140	6,840	10,540	13,610	16,310	18,980	21,480	23,980	26,480	28,980	31,480	33,990

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$90	$850	$1,020	$1,020	$1,020	$1,070	$1,870	$1,870	$1,870	$1,870	$1,870	$1,970
$10,000 - 19,999	850	1,780	1,980	1,980	2,030	3,030	3,830	3,830	3,830	3,830	3,930	4,130
$20,000 - 29,999	1,020	1,980	2,180	2,230	3,230	4,230	5,030	5,030	5,030	5,130	5,330	5,530
$30,000 - 39,999	1,020	1,980	2,230	3,230	4,230	5,230	6,030	6,030	6,130	6,330	6,530	6,730
$40,000 - 59,999	1,020	2,880	4,080	5,080	6,080	7,080	7,950	8,150	8,350	8,550	8,750	8,950
$60,000 - 79,999	1,870	3,830	5,030	6,030	7,100	8,300	9,300	9,500	9,700	9,900	10,100	10,300
$80,000 - 99,999	1,870	3,830	5,100	6,300	7,500	8,700	9,700	9,900	10,100	10,300	10,500	10,700
$100,000 - 124,999	2,030	4,190	5,590	6,790	7,990	9,190	10,190	10,390	10,590	10,940	11,940	12,940
$125,000 - 149,999	2,040	4,200	5,600	6,800	8,000	9,200	10,200	10,950	11,950	12,950	13,950	14,950
$150,000 - 174,999	2,040	4,200	5,600	6,800	8,150	10,150	11,950	12,950	13,950	14,950	16,170	17,470
$175,000 - 199,999	2,040	4,200	6,150	8,150	10,150	12,150	13,950	15,020	16,320	17,620	18,920	20,220
$200,000 - 249,999	2,720	5,680	7,880	10,140	12,440	14,740	16,840	18,140	19,440	20,740	22,040	23,340
$250,000 - 449,999	2,970	6,230	8,730	11,030	13,330	15,630	17,730	19,030	20,330	21,630	22,930	24,240
$450,000 and over	3,140	6,600	9,300	11,800	14,300	16,800	19,100	20,600	22,100	23,600	25,100	26,610

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$280	$850	$950	$1,020	$1,020	$1,020	$1,020	$1,560	$1,870	$1,870	$1,870
$10,000 - 19,999	280	1,280	1,950	2,150	2,220	2,220	2,220	2,760	3,760	4,070	4,070	4,210
$20,000 - 29,999	850	1,950	2,720	2,920	2,980	2,980	3,520	4,520	5,520	5,830	5,980	6,180
$30,000 - 39,999	950	2,150	2,920	3,120	3,180	3,720	4,720	5,720	6,720	7,180	7,380	7,580
$40,000 - 59,999	1,020	2,220	2,980	3,570	4,640	5,640	6,640	7,750	8,950	9,460	9,660	9,860
$60,000 - 79,999	1,020	2,610	4,370	5,570	6,640	7,750	8,950	10,150	11,350	11,860	12,060	12,260
$80,000 - 99,999	1,870	4,070	5,830	7,150	8,410	9,610	10,810	12,010	13,210	13,720	13,920	14,120
$100,000 - 124,999	1,870	4,270	6,230	7,630	8,900	10,100	11,300	12,500	13,700	14,210	14,720	15,720
$125,000 - 149,999	2,040	4,440	6,400	7,800	9,070	10,270	11,470	12,670	14,580	15,890	16,890	17,890
$150,000 - 174,999	2,040	4,440	6,400	7,800	9,070	10,580	12,580	14,580	16,580	17,890	18,890	20,170
$175,000 - 199,999	2,040	4,440	6,400	8,510	10,580	12,580	14,580	16,580	18,710	20,320	21,620	22,920
$200,000 - 249,999	2,720	5,920	8,680	10,900	13,270	15,570	17,870	20,170	22,470	24,080	25,380	26,680
$250,000 - 449,999	2,970	6,470	9,540	12,040	14,410	16,710	19,010	21,310	23,610	25,220	26,520	27,820
$450,000 and over	3,140	6,840	10,110	12,810	15,380	17,880	20,380	22,880	25,380	27,190	28,690	30,190

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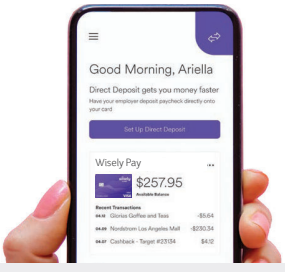

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CONSUMER DIRECT CARE NETWORK

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

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

Consumer Direct Care Network Nevada
1005 Terminal Way, Suite 125
Reno, NV 89502-2179

Phone: 877-786-4999
Fax: 877-786-4998
Email: infoCDNV@ConsumerDirectCare.com
Web: www.ConsumerDirectNV.com

CONSUMER DIRECT CARE NETWORK

Agency-Based Personal Care Services

EMPLOYEE ACKNOWLEDGEMENT

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

1. **Employee Handbook**
   I have received a copy of the Consumer Direct Care Network Nevada (CDCN) Employee 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 change or update policies, procedures or any information in the Handbook at any time.

2. **Review each Consumer's Service Plan**
   I must review the Service Plan for each Consumer I work with. I understand I will provide services as scheduled by CDCN.

3. **Status Change Form**
   I have received a Status Change Form. I agree to notify CDCN within ten (10) days of any change in name, address, telephone number, licenses and certifications. This includes criminal convictions and charges being brought against me. I will notify CDCN immediately if I resign.

4. **Effective Date**
   I can begin work when CDCN approves my enrollment materials and I receive an Okay to Work letter from CDCN.

5. **Training**
   I will complete:
   - Sixteen (16) hours of initial training when hired, and
   - Eight (8) hours of continuing education per year.

6. **Direct Deposit**
   - CDCN offers two direct deposit pay options. I can specify a bank account or choose a pay card. If I change my direct deposit option, 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.
   - CDCN can withhold wages for overpayments.

7. **Overtime**
   Overtime is not allowed without prior written approval by CDCN. I understand overtime is defined as working either more than eight (8) hours in a day or forty (40) hours in a week.

8. **Electronic Visit Verification (EVV)**
   I have received CareAttend EVV user information. Requirements include:
   - Signing in and out for each shift worked using the CareAttend EVV system.
   - If the system is unavailable or I forget to clock in or clock out, submitting a paper correction form with Consumer signature. Payment of wages may be delayed.

   Not following EVV rules may result in corrective action by CDCN, up to and including termination.

9. Program Requirements

The State of Nevada requires current First Aid/CPR certification, TB screening, caregiver training hours, and fingerprint background check. I must comply with requirements, or my employment will be suspended.

I understand I cannot be paid for any services provided if:

- The Consumer is in the hospital or at a medical appointment.
- Authorized tasks on the Service Plan cannot be performed with the Consumer.

10. Automobile Notice

Driving for Consumer tasks is only allowed if authorized in the Consumer's Service Plan. I will ensure any car used to provide services has auto insurance that meets the State's minimum guidelines. I will not perform driving tasks for the Consumer without a valid driver's license. I agree to notify CDCN if my driving status changes.

11. Personal Care Attendant Responsibilities

As a CDCN caregiver I am responsible for:

- Program compliance.
- Documents and Record Keeping.
- Confidentiality.
- Following each Consumer's Service Plan.
- Reporting a Serious Occurrence within 24 hours, including, but not limited to: injuries on the job, falls (with or without injury), unplanned hospitalizations, emergency room/urgent care visits, and assault/abuse/neglect/exploitation.
- Reviewing and understanding the provisions of Nevada Administrative Code 449.396 to 449.3982, titled Agencies to Provide Personal Care Services In The Home before I provide services. I acknowledge CDCN provided me a copy or electronic access to these administrative codes.
    - https://www.leg.state.nv.us/nac/nac-449.html
- Reviewing and understanding the provisions of Nevada Revised Statute 449, concerning Medical Facilities and other related entities before I provide services. I acknowledge CDCN provided me a copy or electronic access to these statutes.
    - https://www.leg.state.nv.us/nrs/nrs-449.html

12. Non-Emergent Care/Responding to Emergencies

Services provided under this program are not meant to be emergency or acute medical services. Any potential risky health situations must be reported to the Consumer's attending physician and/or to local emergency services, such as 911, as appropriate.

I will receive training about responding to emergencies, including fire and medical emergencies, etc. CDCN will also review the Consumer's Back Up and Emergency Plan with me.

Employee Signature _____ Date _____

CONSUMER DIRECT CARE NETWORK

Agency-Based Personal Care Services

WAGE MEMORANDUM

Employee Name	Consumer Name	Consumer CDCN ID #

Position: ☐ Personal Care Attendant ☐ Lead Personal Care Attendant

Effective Date: _____

Wage:

Service	Wage
Personal Care (PCS); PAS Program - Personal Care; Cope Program - Personal Care; Waiver - Social Supervision	$17.00/hour
Personal Care (Private Pay)	
Respite (Waiver)	$17.00/hour
Homemaker and Chore (Waiver)	$17.00/hour
Administrative Services (ADMIN)	
Training	$17.00/hour
Portal-to-Portal (travel time)	$17.00/hour
Mileage	$0.28/mile
On-Call - Weekday On-Call - Weekend On-Call – Holiday	$15.00/day $20.00/day $20.00/day

Overtime: Overtime is generally not allowed. Any exception must be approved in advance of time worked and in writing by the Consumer Direct Care Network (CDCN) office. Overtime is defined as either more than 8 hours in a day or 40 hours in a week. Prior to working an overtime schedule, you will need to have CDCN approval and sign a Modified Wage Agreement.

Holiday Pay: 1.5 X regular wage for holidays worked as established in the CDCN employee handbook.

☐ New Attendant/Initial Wage Memo: _____ _____

Attendant Signature Date

_____ _____

CDCN Representative Signature Date

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

_____ _____

CDCN Representative Signature Date/Time of phone call

Statement of Good Health

This person is in a state of good health, is free from active tuberculosis and any other communicable disease in a contagious stage.

_____ _____

Physician's Signature *Date*

_____ _____

Physician's Name (please print) Caregiver's Name (please print)

_____ _____

Office Address Address of Caregiver

_____ _____

Office Phone Number Phone Number of Caregiver

Please return the completed form to Consumer Direct Care Network:

1005 Terminal Way, Suite #125
Reno, NV 89502-2179

Toll Free Fax: 1-877-786-4998
Email: InfoCDNV@consumerdirectcare.com

02180

CONSUMER DIRECT CARE NETWORK

AUTHORIZATION/DECLINATION
HEPATITIS B VACCINATION

_____
Employee Name

The above-named employee is authorized to receive or complete the **Hepatitis B vaccination series** through a Public Health Nurse, Local Clinic, or Concentra and have the charges billed to the Consumer Direct Care Network (CDCN) at:

Consumer Direct Care Network
1005 Terminal Way, Suite #125
Reno, NV 89502-2179

Phone: 1-877-786-4999
Fax: 1-877-786-4998

***** CLINIC OR HEALTH PERSONNEL *****

THIS AUTHORIZATION IS NOT VALID UNLESS SIGNED

_____ _____
Authorization Approval: CDCN Representative DATE

HEPATITIS B VACCINATION ACCEPT/DECLINE

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

I choose to: ☐ be vaccinated ☐ decline vaccination

_____ _____
Employee Signature *Date*

00366

FINGERPRINT BACKGROUND WAIVER

NOTICE OF NONCRIMINAL JUSTICE APPLICANT'S RIGHTS, CONSENTS AND SELF DISCLOSURE OF CRIMINAL HISTORY

As an applicant who is the subject of a Federal Bureau of Investigation (FBI) fingerprint-based criminal history record check for a noncriminal justice purpose you have certain rights which are discussed below.

1. You must be notified by (enter name of requesting agency) Consumer Direct Care Network NV that your fingerprints will be used to check the criminal history records of the FBI and the State of Nevada.

2. If you have a criminal history record, the officials making a determination of your suitability for the job, license or other benefit for which you are applying must provide you with the opportunity to complete or challenge the accuracy of the information in the record. You may review and challenge the accuracy of all criminal history records which are returned to the submitting agency. The proper forms and procedures will be furnished to you by the Nevada Department of Public Safety, Records Division upon request. If you decide to challenge the accuracy or completeness of your criminal history record, Title 28 of the Code of Federal Regulations, Section 16.34, provides for the proper procedure to do so.

3. Based on 28 CFR § 50.12 (b), officials making such determinations should not deny the license or employment based on information in the record until the applicant has been afforded a reasonable time to correct or complete the record or has declined to do so.

4. You have the right to expect that officials receiving the results of the fingerprint-based criminal history record check will use it only for authorized purposes and will not retain or disseminate it in violation of federal or state statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council.

5. I hereby authorize (enter name of requesting agency) Consumer Direct Care Network NV, to submit a set of my fingerprints to the Nevada Department Public Safety, Records Bureau for the purpose of accessing and reviewing State of Nevada and FBI criminal history records that may pertain to me.

   In giving this authorization, I expressly understand that the records may include information pertaining to notations of arrest, detainments, indictments, information or other charges for which the final court disposition is pending or is unknown to the above referenced agency. For records containing final court disposition information, I understand that the release may include information pertaining to dismissals, acquittals, convictions, sentences, correctional supervision information and information concerning the status of my parole or probation when applicable.

6. I hereby release from liability and promise to hold harmless under any and all causes of legal action, the State of Nevada, its officer(s), agent(s) and/or employee(s) who conducted my criminal history records search and provided information to the submitting agency for any statement(s), omission(s), or infringement(s) upon my current legal rights. I further release and promise to hold harmless and covenant not to sue any persons, firms, institutions or agencies providing such information to the State of Nevada on the basis of their disclosures. I have signed this release voluntarily and of my own free will.

CONSENT TO CHECK OF REGISTRIES

I consent to have a check of registries, including, but not limited to, any government abuse registries, licensing registries, sexual abuse registries, the Office of Inspector General List of Excluded individuals and Entities registry, and any other registry screenings that are part of the website established pursuant to NRS 439.942. I authorize the Health Care Purchasing and Compliance Division and a facility, hospital, agency, program, or home, as defined in NRS 449.119, in which I am an employee, independent contractor or working as an employee of a temporary employment service, to conduct such registry screenings and receive any information that may be available from such registries. In addition, I authorize the release of any information that may be available from the Statewide Central Registry and any equivalent registry maintained by a governmental entity in a jurisdiction in which I have resided within the immediately preceding 5 years to the Health Care Purchasing and Compliance Division and a facility, hospital, agency, program or home.

SELF DISCLOSURE STATEMENT OF CRIMINAL HISTORY

I attest that I have never been convicted of any of the following crimes:

- Murder, voluntary manslaughter or mayhem.
- Assault or battery with intent to kill or to commit sexual assault or mayhem.
- Sexual assault, statutory sexual seduction, incest, lewdness, indecent exposure or any other sexually related crime.
- Abuse or neglect of a child or contributory delinquency.
- Abuse, neglect, exploitation or isolation of any older persons or vulnerable persons, including, a violation of any provision of NRS 200.50955 or 200.5099, inclusive, or a law of any other jurisdiction that prohibits the same or similar conduct.
- A violation of any provision of NRS 422.450 to 422.590, inclusive, relating to Nevada's State Plan for Medicaid.
- Any violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in Chapter 454 of NRS, within the immediately preceding 7 years.
- Prostitution, solicitation, lewdness or indecent exposure, or any other sexually related crime that is punished as a misdemeanor, within the immediately preceding 7 years.
- A crime involving domestic violence that is punished as a felony.
- A crime involving domestic violence that is punished as a misdemeanor, within the immediately preceding 7 years.
- A violation of any provision of law relating to the State Plan for Medicaid or a law of any other jurisdiction that prohibits the same or similar conduct.
- A criminal offense under the laws governing Medicaid or Medicare.
- Any offense involving fraud, theft, embezzlement, burglary, robbery, fraudulent conversion or misappropriation of property.
- Any other felony involving the use or threatened use of force or violence against the victim or the use of a firearm or other deadly weapon.
- An attempt or conspiracy to commit any of the offenses listed in this Self Disclosure Statement of Criminal History section.

CONSENT TO BE ENROLLED IN A RAP BACK SYSTEM (Optional – check only if you consent)

☐ I understand that if I check this box, the licensed entity I am under employment/contract/service with or the Nevada Health Authority may enroll me in a RAP BACK SYSTEM (Record of Arrests and Prosecutions) which would allow the Nevada Department of Public Safety to notify my employer and the Nevada Health Authority of any criminal offenses that I may be convicted of in the future.

AUTHORIZATION OF SUBMISSION OF FINGERPRINTS

I authorize the submission of my fingerprints to the Nevada Department of Public Safety for submission to the Federal Bureau of Investigation for its background check report.

A reproduction of this authorization for release of information by photocopy, facsimile or similar process, shall for all purposes be as valid as the original.

In consideration for processing my application I, the undersigned, whose name and signature voluntarily appears below; do hereby and irrevocably agree to the above.

I understand that a person who willfully provides a false statement or information connected with a background investigation that would disqualify the person from employment, including without limitation, a conviction of a crime listed in NRS 449.174, is guilty of a misdemeanor.

I declare under penalty of perjury that the foregoing is true and correct.

Applicant's Name: _____
(PLEASE PRINT LAST, FIRST, MIDDLE)

Address: _____

Applicant's Signature: _____Date: _____

Submitting Agency: Consumer Direct Care Network of Nevada

Address: 1005 Terminal Way STE 125 Reno NV 89502

Agency representative: _____
(PLEASE PRINT LAST, FIRST, MIDDLE)

Agency representative's Signature: _____ Date: _____

CONSUMER DIRECT CARE NETWORK

EXPECTED WEEKLY HOURS - NEW HIRE

CAREGIVER/NURSE
(Non-FEA)

Employee Name: _____

Entity: CDNV

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)
Consumer Direct Services for Nevada	30-0122521
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 option offered with a $2,000 annual maximum, and includes orthodontia care.
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

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