



Consumer Directed Services
New Employee Packet Cover Sheet

Name of Individual Receiving Services	Employer Name
Employee Name	
Date of Hire	First Day of Work

Employer	Agency	FMSA	Document Description / Form Information
Before Hire: (1) Original or Copy for Employer's Personnel Files and (2) Original or Copy to FMSA			
<input type="checkbox"/>	HHSC	<input type="checkbox"/>	HHSC Form 1725, Criminal Conviction History and Registry Checks
<input type="checkbox"/>	HHSC	<input type="checkbox"/>	HHSC Form 1729, Applicant Verification for Employees; HHSC Form 1734, Service Provider and Employer Certification of Relationship Status for CDS
<input type="checkbox"/>	USCIS	<input type="checkbox"/>	USCIS Form I-9, Employment Eligibility Verification
<input type="checkbox"/>	HHSC	<input type="checkbox"/>	HHSC Form 1728, Liability Acknowledgment
<input type="checkbox"/>	HHSC	<input type="checkbox"/>	Professional license verification (nursing, professional therapies)
At Time of Hire: (1) Original or Copy for Employer's Personnel Files and (2) Original or Copy to FMSA			
<input type="checkbox"/>	IRS	<input type="checkbox"/>	IRS Form W-4, Employee's Withholding Allowance Certificate — Due before first payroll check is calculated; provide to the Financial Management Services Agency (FMSA) on date of hire.
<input type="checkbox"/>	OAG	<input type="checkbox"/>	Texas Employer New Hiring Reporting Form (www.employer.texasattorneygeneral.gov)
<input type="checkbox"/>	HHSC	<input type="checkbox"/>	HHSC Form 1730, Wage and Benefits Plan Employee Compensation, and any court-ordered garnishment(s); HHSC Form 1731, Employee Work Schedule and Assigned Tasks; HHSC Form 1737, Employer and Employee Service Agreement; HHSC Form 1739, Service Provider Agreement
<input type="checkbox"/>	HHSC	<input type="checkbox"/>	CLASS, DBMD and MDCP only: Cardiopulmonary resuscitation (CPR) certification — Effective at time of service delivery initiation, and maintained. <i>Verify again before expiration date.</i>
<input type="checkbox"/>	HHSC	<input type="checkbox"/>	Texas Department of Public Safety driver's license (if transporting client) — <i>Verify again before expiration date.</i>
<input type="checkbox"/>	HHSC	<input type="checkbox"/>	Proof of minimum auto insurance (if transporting client)
<input type="checkbox"/>	CDC OSHA	<input type="checkbox"/>	HHSC Form 1727, Occupational Exposure to Bloodborne Pathogens (Acknowledgement: Hepatitis B Vaccination and Universal Precautions)
<input type="checkbox"/>	TWCC	<input type="checkbox"/>	Notice to Employees Concerning Workers' Compensation in Texas (TWC Notice 5)
<input type="checkbox"/>	HHSC	<input type="checkbox"/>	If hiring a nurse: HHSC Form 1747, Acknowledgment of Nursing Requirements
<input type="checkbox"/>	CDS HHSC	<input type="checkbox"/>	If applicable: HHSC Form 1733, Employer and Employee Acknowledgement of Exemption from Nursing Licensure for Certain Services Delivered through Consumer Directed Services
<input type="checkbox"/>	HHSC	<input type="checkbox"/>	HHSC Form 1732, Management and Training of Service Provider — Initial training must be conducted within 30 days of hire.
Ongoing: (1) Original or Copy for Employer's Personnel Files and (2) Original or Copy to FMSA			
<input type="checkbox"/>	HHSC	<input type="checkbox"/>	HHSC Form 1732, Management and Training of Service Provider — Evaluation, employment status changes, documentation of training, documentation of conflict and job performance issues. (The employer must send the original or a copy to the FMSA within 30 calendar days of an initial orientation or annual evaluation and when an action affects the service provider's continued status with the employer, e.g., termination, change in payment.)
<input type="checkbox"/>	HHSC	<input type="checkbox"/>	HHSC Form 1732-EMR, Management and Training of Service Provider Addendum — Must be signed by the employee within five days of hire.
<input type="checkbox"/>	HHSC	<input type="checkbox"/>	Time sheets/service logs — HHSC Form 1745, Service Delivery Log with Written Narrative/Written Summary, or facsimile approved by the FMSA
<input type="checkbox"/>	Vendors	<input type="checkbox"/>	Receipts and invoices

Code	Action
<input checked="" type="checkbox"/>	Employer checks off each item for the personnel file and retains original or copy.
<input checked="" type="checkbox"/>	Employer checks each required item when completed and sends original or copy to the FMSA as indicated. Employer retains original or copy.
<input type="checkbox"/>	Items the employer is not required to send to the FMSA, but which the employer must maintain on file in the employee's personnel file .

Code	Agency
CDC	Centers for Disease Control and Prevention
CDS	Consumer Directed Services
HHSC	Texas Health and Human Services Commission
IRS	Internal Revenue Service
OAG	Office of the Attorney General, State of Texas
OSHA	Occupational Safety and Health Administration
TWCC	Texas Workers' Compensation Commission
USCIS	U.S. Citizenship and Immigration Services (formerly known as the INS, Immigration and Naturalization Services)



Criminal Conviction History and Registry Checks

The applicant is a person under consideration for hire as a service provider in the CDS option (employee or independent contractor [when required]). This form covers only criminal history conviction history and registry checks.

Note: An applicant may not be hired by the CDS employer, and must not start providing services for payment, until and unless the required criminal history and registry checks are conducted, in addition to other employee qualification checks. The CDS employer and Financial Management Services Agency (FMSA) review the results of all required qualification checks to determine that an applicant can be hired. This form is signed by the FMSA.

Section I - Applicant Authorization and Acknowledgment (Applicant must complete this section.)

I, (applicant's printed name) _____, give my permission to check for a criminal conviction history, to check the required registries annually, and to check the state and federal lists of people and entities excluded from participation in Medicaid (LEIE) monthly as part of my application as a service provider through the Consumer Directed Services (CDS) option. I also understand that a criminal conviction or a registry listing that prohibits a person from employment in a health care setting in the state of Texas may prohibit my employment.

I understand I may not begin delivering services until the FMSA and Employer confirm that I meet all qualifications to be hired.

Applicant Information Required by the Texas Department of Public Safety (DPS) (Applicant must complete this section.)

Individual's Name (Last, First, Middle)	Alias	Maiden Name
Date of Birth (mm/dd/yyyy)	Social Security No.	

Signature - Applicant

Date

Section II - Criminal Conviction History Check and Registry Verification Process (Employer must complete this section.)

Individual's Name	Employer Name
-------------------	---------------

Criminal Conviction History Check (Check each box to certify agreement):

- ☐ I request that my FMSA obtain a **current** Criminal Conviction History Check of the applicant from DPS. I authorize the FMSA to be reimbursed for the cost of obtaining the DPS Criminal Conviction History Check and if I request the report, the cost of sending the report from my budgeted funds.
- ☐ I understand that if I request the report, the FMSA must send it to me through a secure method, DPS approved encrypted software or certified mail.
- ☐ I understand that all criminal records and reports obtained by my FMSA, and the information they contain, are confidential information.
- ☐ I understand all DPS criminal history information reports must be destroyed five days after I make the hiring decision. Paper records need to be shredded, pulped or burned. For electronic records, destroying the media or using specialized software to copy over the data are acceptable methods.
- ☐ I understand that sharing of criminal history information with any person or agency may be prosecuted as a Class A Misdemeanor.
- ☐ I understand I may not allow the applicant to begin delivering services until the FMSA and I confirm the applicant meets all qualifications to be hired.

Signature - Employer

Date

Registry Check

- ☐ I request that my FMSA obtain the applicant's status with the Employee Misconduct Registry and the Nurse Aide Registry initially and annually.
- ☐ I understand that the FMSA will screen the applicant initially and monthly using both the state and federal lists of excluded individuals and entities (LEIE).
- ☐ I also understand that the applicant cannot provide services and cannot be paid with program funds until the criminal history and registry checks are completed and my FMSA has notified me that the applicant meets the qualifications.

Signature - Employer

Date

I request that the FMSA provide the criminal history to me:

- ☐ Verbally
☐ Encrypted email
☐ Certified mail

Date of Employer Request

Section III - Criminal Conviction History and Registry Check Results (FMSA must complete this section.)

DPS Criminal Conviction Criminal History Check

Date FMSA received Form 1725 with employer selection for criminal history results:

Date of DPS Check	Time (specify a.m. or p.m.)
Obtained By	Convictions: <input type="checkbox"/> Yes <input type="checkbox"/> No
DPS approved dissemination method used to inform employer of results: <input type="checkbox"/> Verbally <input type="checkbox"/> Encrypted email <input type="checkbox"/> Certified mail <input type="checkbox"/> Did not specify method	
Date FMSA staff notified employer: _____ FMSA staff: <div style="border: 1px solid black; height: 50px; width: 100%; margin-top: 5px;"></div>	
If yes, does the conviction(s) prohibit service delivery in compliance with Health and Safety Code Chapter 250, Section 250.006(a), or Section 250.006(b)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Within five calendar days after the hiring decision, the FMSA must destroy the criminal history record information obtained from DPS whether or not hired or retained by the employer or designated representative. Date report was destroyed: _____ Date employer notified FMSA of hiring decision: _____	

Registry Checks (Conduct search at emr.dads.state.tx.us/DadsEMRWeb/)

Date of Registry Checks	Time (specify a.m. or p.m.)	Obtained By	<input type="checkbox"/> Employer <input type="checkbox"/> FMSA Representative
-------------------------	-----------------------------	-------------	---

Employee Misconduct Registry: ☐ No Record ☐ Record (must not be hired or retained)

Nurse Aide Registry: ☐ No Record ☐ Record (must not be hired or retained)

Medicaid Exclusion List: ☐ No Record ☐ Record (must not be hired)

Certification - I acknowledge that the applicant's DPS criminal conviction history and registry record were checked.

The applicant ☐ is ☐ is not eligible for hire, to be retained for service delivery based on the checks above.

Signature - FMSA Representative

Date FMSA notified the employer or
Designated Representative

FMSA and Employer Must Each Keep Original or Copy of This Form



Consumer Directed Services
Applicant Verification for Employees

Individual's Name

Employer Name

Applicant Name

Applicant Social Security No.

The employer must verify the applicant meets each criterion. The employer must ensure the following forms or copies of documentation used to verify the criteria are valid and kept in the employee's personnel file. This form and supporting documentation **must** be sent to the Financial Management Services Agency (FMSA) for verification before the employer can hire the applicant.

Employment Qualifications

- ☐ The applicant is at least 18.
- ☐ The applicant is not disqualified based on a "Yes" response on Form 1734, Service Provider and Employer Certification of Relationship Status for CDS.
- ☐ The applicant is not barred from employment based on the results of the Texas Department of Public Safety (DPS) criminal conviction history check, the Texas Health and Safety Code Chapter 250 registry checks, or the Medicaid exclusion list (Form 1725, Criminal Conviction History and Registry Checks).
- ☐ The applicant has completed Form 1728, Liability Acknowledgement.
- ☐ The applicant has read Notice Concerning Workers' Compensation in Texas (TWC Notice 5).
- ☐ The applicant has current cardiopulmonary resuscitation (CPR) and first aid certification for Medically Dependent Children Program (MDCP) flexible family support and respite services.
- ☐ The applicant has current hands-on CPR, first aid and choking prevention certification, if providing services in the Deaf Blind with Multiple Disabilities (DBMD) Program.
- ☐ The applicant has the following educational qualifications, if providing services for DBMD, Home and Community-based Services (HCS), MDCP, Texas Home Living (TxHmL) or Community First Choice (CFC):
 - has a high school diploma or a certificate recognized by a state as the equivalent of a high school diploma; or
 - documentation of a proficiency evaluation of the employee's experience and competence to perform job tasks, including an ability to provide the services needed by the individual, as demonstrated through a written competency-based assessment; and
 - at least three personal references from people not related by blood that evidence the person's ability to provide a safe and healthy environment for the individual.
- ☐ The applicant has the following qualifications, if providing services for DBMD:
 - is fluent in the communication methods used by the individual (for example, American Sign Language, tactile symbols, communication boards, pictures and gestures) or has the ability to become fluent in the communication methods used by the individual within three months after beginning to work with the individual.

FMSA Certification

The applicant ☐ **does** ☐ **does not** meet qualifications for employment.

Only applicants who meet all qualifications may be employed.

Acknowledgement

The applicant and employer acknowledge that the applicant meets the qualifications for employment and that a copy of this form must be submitted to the FMSA. The FMSA must verify the applicant's qualifications before the employer offers employment to the applicant.

Signature — Employer

Date

Signature — FMSA

Date



Consumer Directed Services (CDS)

Service Provider and Employer Certification of Relationship Status for CDS

Section 1: Basic Information

Service Provider Applicant Name	Maiden Name — if applicable
Applicant Street Address	City, State and ZIP Code
Person Receiving Services	CDS Employer Name (if different than person receiving services)
Person Receiving Services Street Address	City, State and ZIP Code
Applicant's Relationship to Person Receiving Services	Designated Representative (DR) — if applicable
Applicant's Relationship to CDS Employer	Applicant's Relationship to DR

Service Provider Applicant: Place a check mark in the column that describes your status and relationship.

Section 2: All Programs

The applicant must answer the following questions.

Service Provider Status and Relationship		Yes	No	NA
1.	Are you under 18?	<input type="checkbox"/>	<input type="checkbox"/>	
2.	Are you the individual's legally authorized representative (LAR)? (That is, the individual's natural parent, legal or adopted parent, stepparent or managing conservator if the individual is under 18 [a minor], or the court-appointed guardian of an individual of any age.)	<input type="checkbox"/>	<input type="checkbox"/>	
3.	Are you the spouse* of the individual's LAR? (That is, the spouse of the individual's natural parent, legal or adopted parent, stepparent or managing conservator if the individual is under 18 [a minor], or the spouse of the court-appointed guardian of an individual of any age.)	<input type="checkbox"/>	<input type="checkbox"/>	
4.	Are you the spouse* of the individual? (Consumer Managed Personal Attendant Services (CMPAS) service providers mark this item Not Applicable (N/A).)**	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Are you the spouse* of the employer? (CMPAS service providers mark this item NA.)**	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	If the individual is a Texas Department of Family and Protective Services (DFPS) foster child or adult, are you their foster parent? (If the individual is not a DFPS foster child or adult, mark this item NA.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	If the individual is a DFPS foster child or adult, are you the spouse* of the foster parent? (If the individual is not a DFPS foster child or adult, mark this item NA.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Are you the power of attorney (attorney in fact or agent) for financial responsibilities on behalf of the individual?	<input type="checkbox"/>	<input type="checkbox"/>	
9.	Are you the DR or the CDS employer for the individual?	<input type="checkbox"/>	<input type="checkbox"/>	
10.	Are you the spouse* of the employer's DR?	<input type="checkbox"/>	<input type="checkbox"/>	

Employee's Withholding Certificate

OMB No. 1545-0074

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.****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) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> 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: $\left\{ \begin{array}{l} \bullet \$768,700 \text{ if you're married filing jointly or a qualifying surviving spouse} \\ \bullet \$640,600 \text{ if you're single or head of household} \\ \bullet \$384,350 \text{ if you're married filing separately} \end{array} \right\}$	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:	$\left\{ \begin{array}{l} \bullet \$32,200 \text{ if you're married filing jointly or a qualifying surviving spouse} \\ \bullet \$24,150 \text{ if you're head of household} \\ \bullet \$16,100 \text{ if you're single or married filing separately} \end{array} \right\}$	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

* **Spouse** is defined as either a legal marriage or a marriage without formalities (common law marriage) in accordance with the Texas Family Code.

** The spousal relationship in questions 4 and 5 is not applicable for CMPAS. (The spouse may be employed.)

Section 3: Medically Dependent Children Program (MDCP)

If providing services in the MDCP program, please answer the following additional questions. (Mark these items NA if the individual is not enrolled in MDCP.)

Service Provider Status and Relationship		Yes	No	NA
1.	Are you the parent or primary caregiver of the individual?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Are you the spouse* of the parent or primary caregiver?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 4: Home and Community-based Services (HCS) and Texas Home Living (TxHmL)

If providing Community First Choice Personal Assistance Services or Habilitation (CFC PAS/HAB), respite, adaptive aids or behavioral support services in the HCS or TxHmL program, please answer the following additional questions, as applicable. (Mark these items NA if the individual is not receiving an applicable HCS or TxHmL service.)

Applicant Status and Relationship		Yes	No	NA
1.	Are you a person living in the same household as the individual? (Applies to CFC PAS/HAB and respite services.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Are you a person related to the individual within the fourth degree of consanguinity or within the second degree of affinity? (Applies to adaptive aids and behavioral support services.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 5: Community Living Assistance and Support Services (CLASS) — Respite Service Providers Only

If providing respite services in the CLASS program and the **primary caregiver is the CFC PAS/HAB applicant**, answer the following additional question. (Mark this item NA if the individual is not receiving CLASS respite services. Also mark this item NA if the individual is receiving CLASS respite services, but the primary caregiver is not the CFC PAS/HAB service provider.)

Applicant Status and Relationship		Yes	No	NA
1.	Do you live in the same household as the individual?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 6: Primary Home Care (PHC), Community Attendant Services (CAS) and Family Care (FC)

If providing PHC, CAS or FC, please answer the following additional questions. (Mark these items NA if the individual is not enrolled in PHC, CAS or FC.)

Applicant Status and Relationship		Yes	No	NA
1.	Are you the primary caregiver for the individual?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Are you the spouse* of the primary caregiver for the individual?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Employer and Service Provider Applicant Verification

If any item above is marked Yes, the applicant is not eligible to be a paid service provider (employee, contractor or vendor) in the CDS option for this individual.

If every item above is marked No or NA, the applicant meets relationship eligibility for employment in the CDS option for this individual, unless contraindicated by requirements of the individual's program. (NA only applies where indicated.) The employer and the applicant certify that the responses are accurate.

Employer confirmation and acknowledgement: As the CDS employer, I confirm that the information provided on this form is true and correct to the best of my knowledge. I understand that an applicant cannot be paid for providing services if they are not eligible for employment.

Printed Employer Name

Signature — Employer

Date

Applicant confirmation and acknowledgement: As the applicant, I confirm that the information provided on this form is true and correct to the best of my knowledge. I understand that I cannot be paid for providing services if I am not eligible for employment.

Printed Service Provider Applicant Name

Signature — Service Provider Applicant

Date



Employment Eligibility Verification

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

USCIS
Form I-9

OMB No.1615-0047

Expires 07/31/2026

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.):					
		<input type="checkbox"/> 1. A citizen of the United States					
		<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)					
		<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)					
		<input type="checkbox"/> 4. A noncitizen (other than Item Numbers 2. and 3. above) authorized to work until (exp. date, if any)					
		If you check Item Number 4. , enter one of these:					
		USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance	
Signature of Employee					Today's Date (mm/dd/yyyy)		

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

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

List A		OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)		Additional Information			
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority		Check here if you used an alternative procedure authorized by DHS to examine documents.			
Document Number (if any)					
Expiration Date (if any)					
Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.					First Day of Employment (mm/dd/yyyy):
Last Name, First Name and Title of Employer or Authorized Representative			Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)
Employer's Business or Organization Name			Employer's Business or Organization Address, City or Town, State, ZIP Code		

For reverification or rehire, complete [Supplement B, Reverification and Rehire](#) on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.

* Documents extended by the issuing authority are considered unexpired.

Employees may present one selection from List A or a combination of one selection from List B and one selection from List C.

Examples of many of these documents appear in the Handbook for Employers (M-274).

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

*Refer to the Employment Authorization Extensions page on [I-9 Central](#) for more information.

Consumer Directed Services
Liability Acknowledgement**Liability Acknowledgement Between the Employer and the Applicant for Employment**

The individual receiving services or the individual's legally authorized representative (LAR) is the employer in the Consumer Directed Services (CDS) option.

The **employer** employs (hires, manages and terminates) employees. The **employer** is solely responsible and liable for any negligent acts or omissions by the employer; the employee; other employee(s) or service provider(s); the individual receiving services; or, if applicable, the employer's designated representative.

Employees or service providers are **not** employed or retained by the Texas Health and Human Services Commission (HHSC); any other state or federal governmental agency; or by the Financial Management Services Agency (FMSA).

As an applicant for employment through the CDS option, I acknowledge that I have read and that I understand the above information regarding the employer and employee liability.

Signature – Employer
(Must be signed by the employer)

Date

Signature – Applicant for Employment

Date

Liability Notice to Applicants for Employment**Section I:**

The employer:

- ☐ **is** a subscriber of Texas Workers' Compensation through the Texas Department of Insurance, Division of Workers' Compensation.
- ☐ **is not** a subscriber of Texas Workers' Compensation through the Texas Department of Insurance, Division of Workers' Compensation.
(Employer completes Section II below if this option applies.)

Section II:

Employer indicates the correct option in this section if the employer **is not** a subscriber to Texas Workers' Compensation.

☐ I have made the following arrangement(s) for employee work-related injuries/illnesses:

- ☐ self-insurance;
- ☐ homeowner's personal liability insurance;
- ☐ renter's personal liability insurance;
- ☐ medical coverage insurance;
- ☐ risk pool insurance;
- ☐ other: _____

☐ I have **no** insurance or other protection against employee work-related injuries/illnesses for my employee(s).

Acknowledgement by Employer and Applicant for Employment

I acknowledge that I have read and that I understand the above information in Section I and in Section II.

Signature – Employer
(Must be signed by the employer)

Date

Signature – Applicant for Employment

Date

Consumer Directed Services
Wage and Benefits Plan
Employee Compensation

Employee Name (Last, First, Middle Initial)		Social Security No.
Date of Hire	First Date of Work	<input type="checkbox"/> Initial Wage and Benefit Plan <input type="checkbox"/> Plan Change – Effective Date:

Name of Program Service Being Provided: _____

Compensation:

Regular Hourly Wage

☐ Employee = \$ _____

☐ Respite = \$ _____

Calculation of Overtime Hourly Wage

Hourly	\$ _____	+	\$ 0	(50%) =	\$ 0
Hourly	\$ _____	+	\$ 0	(50%) =	\$ 0

Benefits: *Optional*

☐ **Hepatitis B Vaccination** (Attach completed Form 1727 if vaccination is requested by the employee.)

Employer: List other optional benefits here. (Attach additional sheet, if required.)

Withholdings:

☐ **W-4 Employee's Withholding Allowance Certificate** (Attach completed Form W-4.)

☐ **Required Garnishments**

Type:	Amount:
Frequency:	Payment To:

☐ **Voluntary Withholdings** (not related to W-4)

Type:	Amount:
Frequency:	Payment To:

☐ **Other** (specify): _____

Acknowledgement/Agreement:

Time Sheets/Service Delivery Logs must be completed accurately each work shift/day. Payment for services delivered is made from state and/or federal funds. Falsification of a time sheet is considered fraud and is punishable under the law.

Accurate, signed time sheets are due: _____

Paychecks are distributed by (method): _____ at least twice a month on _____
or every other week starting _____.

Employee and employer mutually agree to the compensation, benefits, withholdings and all information above and agree that any changes or revisions must be documented and provided to the employee, the employer and the Financial Management Services Agency.

_____ Signature - Employer or Designated Representative	_____ Date	_____ Signature - Employee	_____ Date
---	---------------	-------------------------------	---------------



Consumer Directed Services
Employee Work Schedule and Assigned Tasks

Employee Name: _____

Purpose of Form:

☐ Initial

☐ Change

Activity Involved:

☐ Tasks

☐ Schedule

Effective Date: _____

Schedule I

Day	Time In	Time Out	Time In	Time Out	Time In	Time Out	Total Hours
Sunday							
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							
Weekly Total Hours							

Schedule I - Tasks

Schedule II

Day	Time In	Time Out	Time In	Time Out	Time In	Time Out	Total Hours
Sunday							
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							
Weekly Total Hours							

Schedule II - Tasks

Acknowledgment of Work Schedule and Assigned Tasks - Sign and Date:

Signature — Employer

Date

Signature — Employee

Date



Employer and Employee Service Agreement

The name of individual receiving services, hereafter referred to as the "**Individual**," is:

The Individual's program, _____, hereafter referred to as the "**program**," is funded and administered by the Texas Health and Human Services Commission (HHSC).

The name of the employer, hereafter referred to as "**Employer**" is: _____.

The Employer is the ☐ Individual, ☐ parent of a minor or ☐ court-appointed guardian of the Individual.

This agreement is between the Employer and _____ hereafter referred to as "**Employee**."

The Employer Agrees:

1. To give notice to the Employee as soon as possible of any change(s) in the work schedule, the tasks to be performed or the number of hours the Employee will work.
2. To adhere to all federal, state, and local employment-related laws and regulations.
3. To assume responsibility for:
 - a. liability for any negligent acts or omissions by the Employer, his/her Employee(s) and service provider(s), the Designated Representative (if applicable), the Individual or others in the work place; and
 - b. managing the risk and liability of any incidence(s) of Employee work-related injury/injuries or illnesses.
4. To provide orientation and training to the Employee of tasks and activities to be performed.
5. To provide the Employee with written notice of compensation for services delivered.

The Employee Agrees:

1. I, _____ the Employee, am willing and able to perform the tasks as outlined by, and at the direction of, the Employer, the Individual or the Designated Representative, if applicable.
2. To provide information and documents to the Employer, as required, to maintain current, up-to-date personnel records. The information and documents include at least changes in address and/or telephone numbers, criminal convictions and evidence of employment status and qualifications.
3. To not use the personal property of the Employer or the Individual without prior approval. The Employee will reimburse the Employer for any expense incurred related to his/her personal use of the personal property.
4. To respect the rights and dignity of the Individual and to follow safety procedures for the benefit of the Individual and the Employee.
5. To notify the Employer as soon as possible when the Employee will be late for work or is not able to work, as well as not report to work when illness or another condition may jeopardize the health and safety of the Individual.

Both the Employer and the Employee Agree:

1. That this document serves as an agreement, not an employment contract.
2. That the Employer employs the Employee. The Employee is not an independent contractor. The Employer controls the training and management, evaluation and firing/termination of the Employee.
3. That the Employee is not barred by relationship to the Individual, Employer or Designated Representative, if applicable, from being an Employee.
4. That a Financial Management Services Agency (FMSA) is responsible for the administration of program funds on behalf of the Employer, including payroll functions.
5. That funds for services to pay the Employee is from public sources, and financial accountability and liability applies to the use of the funds. Both the Employer and the Employee have an individual and joint responsibility to be accountable for the public funds spent through the Consumer Directed Services (CDS) option and understand that submitting false or fraudulent time sheets, submitting a time sheet of an unqualified service provider, submitting a time sheet for tasks other than those approved on the service plan or implementation plan will be reported to the appropriate authorities for investigation and possible prosecution as Medicaid fraud.

6. To provide an accurate accounting of services delivered by the Employee, and to submit accurate time sheets and documentation for reimbursement to the FMSA.
7. To bill only for actual time worked, allowable benefits and CDS-related expenses (billing for services and items not allowed or budgeted results in non-payment by the FMSA).
8. The Employer must not charge any fee to the Employee. The Employee must not make any payment to the Employer related to the Employee's employment. Any corrections to payroll are made by the FMSA.
9. That neither the FMSA or HHSC is responsible or liable for any negligent acts, work-related injuries or omissions by the Employer, Individual, Employee, other Employees and service providers and/or the Designated Representative, if applicable.
10. That personal medical and personal information and data about the Individual and the Employee is confidential. This information is not to be discussed, directly or indirectly, with others outside of the work environment at any time, currently or in the future.

Duration and Modification of Service Agreement

1. This service agreement will be in effect as of the date this agreement is signed by the Employer and Employee. This service agreement must not precede the date the Individual is eligible to participate in the program or in CDS
2. This service agreement can be modified by agreement of both parties, unless prohibited by HHSC rules or policy, or by applicable state, federal and/or local regulations.
3. This service agreement will terminate when:
 - a. the Individual's participation in CDS ends voluntarily or involuntarily;
 - b. the individual is no longer eligible for the HHSC program or for CDS participation;
 - c. the Employee is convicted of a crime or listed on a registry that forbids employment by law;
 - d. a relationship change occurs and continued employment is prohibited; or
 - e. the Employee fails to maintain and provide documentation of eligibility or qualifications for continued employment.
4. This service agreement may be terminated, without cause, by either party with 14-calendar days written notice. A different time frame may be used if both parties agree in writing.

The following required documents are incorporated by reference:

Document	Date of Signature
HHSC Form 1725, Criminal Conviction History and Registry Checks	
HHSC Form 1729, Applicant Verification for Employees	
HHSC Form 1733, Employer and Employee Acknowledgement of Exemption from Nursing Licensure for Certain Services Delivered through Consumer Directed Services, if applicable	
HHSC Form 1734, Applicant and Employer Certification of Relationship for Employment	

Acknowledgement of service agreement, including documents incorporated by reference:

Employer:

Printed Name

Signature

Date

Employee:

Printed Name

Signature

Date



Consumer Directed Services
Service Provider Agreement

Form 1739
October 2013-E

This agreement is between the **Texas Health and Human Services Commission (HHSC)**, the state Medicaid agency; a **Financial Management Services Agency (FMSA)**; and a **service provider** providing services to one or more individuals through the Consumer Directed Services (CDS) Option.

The **service provider**, _____ ☐ an individual or
☐ an entity, located at (Address) _____,
_____; Telephone _____ Fax _____

The service provider agrees to:

- provide services, items or goods that are authorized prior to purchase to individuals in home and community support programs in accordance with program rules and policy;
- keep records of purchased services, items and goods in accordance with program rules and policy;
- accept checks from the FMSA as full and complete payment for authorized services, items or goods purchased for individuals served through home and community-based programs;
- neither impose on or accept from individuals any additional charges for the services, items or goods paid for by the check; and
- provide records and other information upon request to the individual, the FMSA, HHSC, or their representative.

The FMSA and HHSC agree:

- that the FMSA will pay the service provider for services, items or goods provided to the individual in accordance with this agreement and program rules and policy; and
- to allow the service provider to charge the individual for approved upgrades or purchases not authorized or paid for in accordance with this agreement, program rules and policy.

The service provider, FMSA and HHSC mutually agree that:

- the FMSA _____,
doing business in _____, provides
financial management services (FMS) to the individual receiving services for purchases from the service provider;
- the FMSA is responsible for acquiring the completed agreement and retaining the original on behalf of HHSC;
- payment from the FMSA will not be issued prior to the receipt of this agreement by the FMSA;
- payment from the FMSA is funded by HHSC with government funds; and
- the FMSA is not a Texas or federal government agency.

This agreement is effective _____, and terminates when the service provider is no longer providing services to individuals through the FMSA.

Service Provider or Representative* (Print)

Service Provider or Representative* (Signature)

Date

FMSA Representative* (Print)

FMSA Representative* (Signature)

Date

** If the service provider is an entity, a representative from the entity with authorization to negotiate this agreement on behalf of the entity must sign.*

Consumer Directed Services
Occupational Exposure to Bloodborne Pathogens**Universal Precautions**

Blood has long been recognized as a potential source of pathogenic microorganisms that may present a risk to individuals who are exposed during the performance of their duties. Universal precautions is the method of control required by the Occupational Safety and Health Administration (OSHA) to protect employees from exposure to all human blood and body fluids. **Universal precautions** refers to a concept of bloodborne disease control, which requires that all human blood and certain human body fluids be treated as if known to be infectious for HIV (the virus that causes AIDS), the Hepatitis B virus and other bloodborne pathogens.

Protective barriers reduce the risk of exposure to blood, body fluids containing visible blood and other fluids to which universal precautions apply. Examples of protective barriers include gloves, gowns, masks and protective eyewear. Universal precautions are intended to supplement rather than replace recommendations for routine infection control, such as hand-washing and using gloves to prevent gross microbial contamination of hands. Universal precautions will be used during the provision of services as applicable and appropriate.

Employee Initials: _____ Date: _____

Hepatitis B

Hepatitis B is a serious infection involving the liver. Hepatitis B virus (HBV) can cause lifelong infection, cirrhosis (scarring) of the liver, liver cancer, liver failure and death. Hepatitis B is spread when blood or body fluids from an infected person enters the body of a person who is not infected. HBV is a major infectious occupational hazard for health care. Any health-care worker may be at risk for HBV exposure depending on the tasks that he or she performs. Workers should be vaccinated if their tasks involve contact with blood or blood-contaminated body fluids.

Employee Initials: _____ Date: _____

Hepatitis B Vaccination

OSHA standards effective June 4, 1992, require that employers make available the Hepatitis B vaccine and vaccination series to all employees who have occupational exposure. The Hepatitis B vaccine is available at no cost to the employee. The cost to provide vaccinations is an administrative expense to the employer and is reimbursable through the individuals's program budget.

The vaccine is administered in a prescribed series of three injections over a six-month period:

Dose 2 is administered 30 days after Dose 1.

Dose 3 is administered five months following Dose 2.

The employee is responsible for requesting from the healthcare provider administering the vaccination additional information specific to the efficiency, safety, benefits, method of administration and potential side effects of the Hepatitis B vaccination.

The employee may elect to **receive** or **decline** the Hepatitis B vaccination.

Employee Initials: _____ Date: _____

Informed Choice Related to Hepatitis B Vaccination

Employee Statement – Check one statement below.

- ☐ I **agree** to receive the Hepatitis B vaccination and will be reimbursed by my employer within 30 days of presenting a paid receipt for each dose. I understand that I will only be reimbursed for doses received while employed by the employer.
- ☐ I **agree** to receive the Hepatitis B vaccination and the employer and I have agreed to the following arrangement(s) related to covering the cost of the vaccination:
- ☐ I **decline** the Hepatitis B vaccination at this time because I have previously received the Hepatitis B vaccination.
- ☐ 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 Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine at this time. However, I decline the Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.**

Federal Register: 61 FR 5507, February 13, 1996

*OSHA 1910.1030 App A - *Mandatory Declination Statement*

Certification by Employee

I, _____, the **employee**, acknowledge and certify that I have received information on occupational exposure to bloodborne pathogens, universal precautions, Hepatitis B and Hepatitis B vaccination. I have been provided the opportunity to ask questions and to seek additional information. I have made my choice (as documented above) related to the Hepatitis B vaccination based on informed choice.

* I may decide in the future to request and accept the vaccination at no charge to me.

Employee:

Employer:

Printed Name

Printed Name

Signature

Signature

Date

Date



**Employer and Employee Acknowledgement of
Exemption from Nursing Licensure for Certain Services
Delivered through Consumer Directed Services**

The employer in the Consumer Directed Services (CDS) option is the individual receiving services or the individual's legally authorized representative (LAR). The employer may choose to have certain nursing services provided by an unlicensed person employed in the CDS option. The individual or the LAR must be capable of training the unlicensed employee in the performance of the task(s) and train and supervise the employee performing the task(s). The employee who delivers the service must not have been denied a license under Chapter 301, Occupations Code or have a license under Chapter 301, Occupations Code that is revoked or suspended.

When the employee is trained and supervised by the LAR, the employee delivers the service when the LAR is present or is immediately accessible to the employee. If the employee will perform the service when the LAR is not present, the LAR must observe the person performing the service at least once to assure the LAR that the employee performs the service correctly.

Government Code, Title 4, Subtitle I, Chapter 531, Subchapter B, §531.051, Consumer Direction for certain services for persons with disabilities, states the employee must not perform those service that are expressly prohibited from delegation by the **Texas Board of Nursing (Texas Administrative Code, §225.13, Tasks Prohibited From Delegation), including:**

- (1) physical, psychological, and social assessment, which requires professional nursing judgment, intervention, referral, or follow-up;
- (2) formulation of the nursing care plan and evaluation of the client's response to the care rendered;
- (3) specific tasks involved in the implementation of the care plan that require professional nursing judgment or intervention;
- (4) the responsibility and accountability for client or client's responsible adult health teaching and health counseling which promotes client or client's responsible adult education and involves the client's responsible adult in accomplishing health goals; and
- (5) the following tasks related to medication administration:
 - (A) calculation of any medication doses except for measuring a prescribed amount of liquid medication and breaking a tablet for administration, provided the RN has calculated the dose;
 - (B) administration of medications by an injectable route except for subcutaneous injectable insulin as permitted by §225.11(b) of this title (relating to Delegation of Administration of Medications From Pill Reminder Container and Administration of Insulin);
 - (C) administration of medications by way of a tube inserted in a cavity of the body except as permitted by §225.10(10) of this title (relating to Task That May Be Delegated);
 - (D) responsibility for receiving or requesting verbal or telephone orders from a physician, dentist, or podiatrist; and
 - (E) administration of the initial dose of a medication that has not been previously administered to the client.

Examples of services that may be exempt from nursing licensure and can be included in the Individual Service Plan for the CDS option if all the qualifying conditions are met include:

- (1) bathing, including feminine hygiene;
- (2) grooming, including nail care, except for individuals with medical conditions like diabetes;
- (3) feeding, including feeding through a permanently placed feeding tube;
- (4) routine skin care, including decubitus Stage 1;
- (5) transferring, ambulation or positioning;
- (6) exercising and range of motion; and digital stimulation;
- (7) the administering of a bowel and bladder program, including suppositories, catheterization, enemas, manual evacuation and digital stimulation;

- (8) administering oral medications that are normally self-administered, including administration through a gastrostomy tube;
and
(9) non-invasive and non-sterile treatments with low risk of infection.

Employee:

Employer:

Printed Name

Printed Name

Signature

Signature

Date

Date

Certification - We, the employee and the employer, certify that the employer has trained and supervised the employee in the delivery of the services listed below. We understand that those services that cannot be provided by anybody except a licensed nurse, according to Texas Administrative Code, §225.13, **Tasks Prohibited From Delegation**, must not be provided by the employee. Checked tasks indicate the employee may perform those tasks when the LAR is not present to supervise.

<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____



Consumer Directed Services
Management and Training of Service Provider

Service Provider Name (Employee)	First Day of Work	Annual Evaluation Due Date
Name of Individual Receiving Services	Program	Services Delivered
Name of Consumer Directed Services Employer		

I. Purpose

☐ Initial Orientation ☐ Ongoing Training

☐ Evaluation

☐ 30-Day ☐ 3-Month ☐ 6-Month ☐ Annual ☐ Other _____

☐ Supervision

☐ Verbal Warning: ☐ First ☐ Second ☐ Third ☐ Other _____

☐ Written Warning: ☐ First ☐ Second ☐ Third ☐ Other _____

☐ Conflict Resolution ☐ Other _____

II. Documentation of Topics Covered at Initial Orientation or Ongoing Training: *(Initial orientation must include training related to the individual's condition and the tasks the service provider will perform as well as any required training described in an applicable addendum to Form 1735, Employer and Financial Management Services Agency Service Agreement.)*

III. Documentation of Abuse, Neglect and Exploitation Training: *(Initial orientation must include training on acts that constitute abuse, neglect or exploitation of an individual.)*

IV. Evaluation/Performance Review:

V. Corrective Action Plan (if applicable):

Date for follow-up on corrective action plan: _____

VI. Service Provider Comments:

Signature of Service Provider Date

This document has been reviewed with the service provider listed above.

Signature of Employer Date Signature of Witness Date

Date sent to FMSA: _____

Date received by FMSA: _____

Consumer Directed Services (CDS)
Management and Training of Service Provider Addendum**Employee Misconduct Registry Notification**

Employee Name: _____ Date of Hire: _____

Position: _____ Employer Name: _____

Long-term care employers, including Consumer Directed Service (CDS) employers, in Texas are required under 40, Texas Administrative Code (TAC), Part 1, Chapter 93, and Texas Health and Safety Code, Chapter 253 and to inform new unlicensed employees about the Employee Misconduct Registry (EMR).

The purpose of the EMR is to ensure that an unlicensed person who commits an act of abuse, neglect, or exploitation that meets the definition of reportable conduct against a consumer receiving services from a facility or against an individual receiving services in the CDS option is not employed in the Texas Health and Human Services Commission (HHSC) regulated facilities and in certain programs including CDS. The EMR applies to employees who provide personal care services, treatment, or any other personal services and are not licensed by the state to perform the services.

A person listed in the EMR is not employable by a facility, agency, or individual employer. The EMR is governed by 40, Texas Administrative Code, Part 1, Chapter 93, and Texas Health and Safety Code, Chapter 253. Regarding a CDS employee, the Department of Family and Protective Services (DFPS) conducts EMR investigations and makes findings in accordance with DFPS rules at 40 TAC, Part 19, Chapter 711, Subchapter O.

Rules regarding the EMR can be found on the Secretary of State's website at:

[http://texreg.sos.state.tx.us/public/readtac\\$ext.ViewTAC?tac_view=5&ti=40&pt=19&ch=711&sch=O&rl=Y](http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=40&pt=19&ch=711&sch=O&rl=Y).

Questions may be directed to HHSC Professional Credentialing Enforcement Unit at 512-438-5495.

The employer must provide the employee with a copy of this notice.

I, _____, have read and understand the above notification.

Signature_____
Date

THIS FORM IS NOT TO BE USED AS A CONSENT / AUTHORIZATION FORM.

Agency to retain this CCH Verification Form for DPS auditing purposes.

DPS Computerized Criminal History (CCH) Verification Form

Section 1: Applicant must acknowledge the information in Section 1. Signature & date required.

Applicant Name (Print):

I acknowledge that a Computerized Criminal History (CCH) check may be performed by accessing the Texas Department of Public Safety Secure Website and may be based on name and DOB identifiers. Authority for this agency to access an individual's criminal history data may be found in Texas Government Code 411, Subchapter F <https://statutes.capitol.texas.gov/>.

Name-based information is not an exact search and only fingerprint record searches represent true identification to criminal history record information (CHRI), therefore the organization conducting the criminal history check is not allowed to discuss with me any CHRI obtained using the name and DOB method. The agency may request that I also have a fingerprint search performed to clear any misidentification based on the result of the name and DOB search.

In order to complete the fingerprint process, I must make an appointment with the Fingerprint Applicant Services of Texas (FAST) as instructed online [Crime Records General Information | Department of Public Safety \(texas.gov\)](#) Review of Personal Criminal History or by calling the DPS Program Vendor at 1-888-467-2080, submit a full and complete set of fingerprints, request a copy be sent to the agency listed below, and pay a fee of \$25.00 to the fingerprinting services company.

Once this process is completed the information on my fingerprint criminal history record may be discussed with me. **Acknowledge by signing below.**

Applicant Signature:	Date:
----------------------	-------

Section 2: Agency use only. Must be completed by authorized personnel conducting search.

Agency Name:

Authorized User:

Signature of Authorized User:

Date of Name-Based CCH Search:

Section 3: Agency use only. CHRI Name Based Tracking information. Check all that apply.

Purpose for CHRI Search.	<input type="checkbox"/> Applicant <input type="checkbox"/> Volunteer <input type="checkbox"/> Contractor <input type="checkbox"/> Other:
Is any part of the Criminal History Record Information (CHRI) stored by agency?	Reminder: DPS does not recommend storing any part of CHRI. <input type="checkbox"/> NO, CHRI is not stored by agency. <input type="checkbox"/> YES, CHRI is stored by agency.
CHRI Retention Period	<input type="checkbox"/> Temporarily Only <input type="checkbox"/> Annual <input type="checkbox"/> None Stored/Saved <input type="checkbox"/> Other:
CHRI Storage Method	<input type="checkbox"/> Physical/Printed (paper copy) <input type="checkbox"/> Digital/Electronic (saved anywhere on device/computer)
CHRI Retention Purpose	Explain:
Date CHRI Destroyed	
Destruction Method	Explain:

[CHRI + Audit Resources Link](#)

EMPLOYEE DIRECT DEPOSIT AUTHORIZATION FORM

Use this form to setup direct deposit with Astrocare. This form must be completely filled out and have attached avoided check copy or letter from your bank on company letterhead displaying the routing number, account number, and signature of the authorized bank representative in order for the direct deposit to be entered into the payroll system. Please note the following:

1. New direct deposits may take up to 3 pay periods to become active. New direct deposits are placed into prenote status. This means that the information that you provided Astrocare must be verified by your bank before the direct deposit activates. Most banks respond quickly while others may take a while longer. Once a positive notification is received, your account will be moved to active status. Until then you will receive a paper check by mail to the address listed on your W4 unless arrangements are made prior to payroll for pickup.
2. If you are using this form to change your direct deposit to a different account, you will receive a paper check until the new account is in active status. Your checks will be mailed to the address that you provided on your W4 unless arrangements are made prior to payroll for pickup.
3. Astrocare will not be held liable for any non-sufficient funds fees (NSFs) that you may receive in your account. Please verify that funds are in your account **BEFORE** writing checks, having an automatic deduction take place, withdrawing money, or using your debit/check card. Astrocare will not reimburse these fees.
4. Direct deposits are scheduled to arrive at your bank on payday. Please speak with a bank representative before calling Astrocare to verify receipt of your direct deposit.
5. It is the employee's responsibility to make sure that Astrocare has the correct and updated information for your bank account. If the information is not correct and current, there may be a delay in receiving your funds. The delay could extend to the next pay period and a small fee may be assessed.
6. Astrocare will attempt to reverse funds that are deposited into your account in error. If the attempt is unsuccessful the employee is liable for all monies received in error and must either a.) repay the monies by money order or cashier's check only or b.) the monies will be treated as an advance and will be applied to future pay.

Account 1 Amount to Deposit- \$ _____ % _____

Financial Institution _____

Please Circle One ☐ Checking ☐ Savings

Routing (ABA) Number _____

Account Number _____

Account 2 Amount to Deposit- Remainder _____ \$ _____ % _____

Financial Institution _____

Please Circle One ☐ Checking ☐ Savings

Routing (ABA) Number _____

Account Number _____

I hereby authorize Astrocare CLASS/CDS/AVHP, Inc. to initiate electronic debit and/or credit entries to the bank account(s) shown above for an allotted amount. I understand this will remain in effect until my written authorization is received by Astrocare CLASS, Inc. to terminate this authorization or until Astrocare CLASS, Inc. terminates this authorization.

Signature: _____

Printed Name: _____ Date: _____

Email Address: _____

Texas Financial Management Services Agencies (FMSAs) are responsible for keeping current with IRS and TWC regulations and updating this resource as needed.

Fiscal/Employer Agent Household Employee Tax Exemption Information

Developed by the National Resource Center for Participant-Directed Services, November 2011

Texas Financial Management Services Agencies (FMSAs) are responsible for keeping current with IRS and TWC regulations and updating this resource as needed.

DADS is providing this document as a resource for Financial Management Services Agencies and CDS employers to use to determine if family members are exempt from paying certain federal and state taxes. Use this document in combination with DADS Form 1734, Service Provider and Employer Certification of Relationship Status for CDS to determine exemption status.

The taxable wages page of **FY014 CDS budget workbooks** includes, for each employee, a drop down box, entitled **Meets Family Exemption Criteria**, with the categories:

- No
- Exempt all (SUTA, FUTA, FICA)
- Exempt SUTA FUTA

Remember to select the appropriate category.

Fiscal/Employer Agent Household Employee Tax Exemption Information

Employees providing domestic or household services, like those employees hired directly by participants or their representatives in programs using a Fiscal/Employer Agent, may be exempt from paying certain federal and state taxes that are normally paid by employers and employees. Employers and employees may be exempt from certain federal and state taxes based on the employee's student status, age, or family relationship with the employer. These exemptions are not optional. If employees and employers qualify for these exemptions, the exemptions must be honored.

The questions below are intended to be asked of a participant's employee to determine tax exemption status.

Tax Exemptions for a Child Employed by his/her own Parent

Are you the child of the employer?

Yes	I am an employee in the participant direction program and my employer is my parent. Employee Date of Birth: _____/_____/_____
No	My employer is not my parent.

If the answer is yes and the child employee is under 21 during the entire tax year, then the employer and employee are both exempt from paying FICA (Social Security and Medicare) and the employer is exempt from paying FUTA (Federal Unemployment Tax) on wages paid to this employee. The payments are subject to both FICA and FUTA tax when the employee reaches age 21. The employer may also be exempt from paying State Unemployment Insurance Tax, depending on the rules in the state.

Tax Exemptions for a Spouse Employed by his/her own Spouse

Is the employer your spouse?

Yes	I am an employee in the participant direction program and my employer is my spouse.
No	My employer is not my spouse.

If the answer is yes, then the employer and employee are both exempt from paying FICA (Social Security and Medicare) and the employer is exempt from paying FUTA (Federal Unemployment Tax) on wages paid to this employee. The employer may also be exempt from paying State Unemployment Insurance Tax, depending on the rules in the state.

Tax Exemptions for a Parent Employed by his/her own Child

Are you the parent of the employer?

Yes	I am an employee in the participant direction program and my employer is my child.
No	My employer is not my child.

If the answer is yes, then the employer does not owe FUTA taxes. The employer may also be exempt from paying State Unemployment Insurance Tax, depending on the rules in the state. The employer and employee may be exempt from FICA taxes, depending on the answers to the "Additional Questions for Parent Employed by this/her own Child" below.

Additional Questions for Parent Employed by his/her own Child

Answer the questions in this section if you answered "Yes" to the question above.

Do you care for your grandchild or step-grandchild who is living in your son or daughter's home?

Yes	I provide care for my grandchild in my child's home.
No	I do not provide care for my grandchild.

If you answered no, you and your employer are exempt from paying FICA (Social Security and Medicare tax). If you answered yes, go on to the next question.

Is your grandchild or step-grandchild under age 18 OR does he/she have a physical or mental condition that requires the personal care of an adult for at least 4 continuous weeks during the calendar quarter in which services are performed?

Yes	That description fits my grandchild or step-grandchild.
No	That description does not fit my grandchild or step-grandchild.

If you answered no, you and your employer are exempt from paying FICA (Social Security and Medicare tax). If you answered yes, go on to the next question.

Is your son or daughter (your employer) widowed or divorced (and not remarried), or living with a spouse who has a mental or physical condition which prohibits the spouse from caring for your grandchild for at least 4 continuous weeks during the calendar quarter in which services are performed?

Yes
No

That description fits my son or daughter (my employer).

That description does not fit my son or daughter (my employer).

If you answered no, you and your employer are exempt from paying FICA (Social Security and Medicare tax). If you answered yes, FICA must be paid by you and your employer.

If the employee answered "no" to any of the above "Additional Questions for Parent Employed by their own Child", then the employer and employee are both exempt from paying FICA (Social Security and Medicare

If the employee answered "yes" to all of the above "Additional Questions for Parent Employed by their own Child", FICA (Social Security and Medicare) is due for both the employer and employee for wages paid to this employee. However the employer is still exempt from FUTA taxes, and may also be exempt from paying State Unemployment Insurance Tax, depending on the rules in the state.

Tax Exemptions for Foreign Students in the US for the Purpose of Providing Domestic Services

Are you a non-resident alien temporarily in the United States on an F-1, J-1, M-1, or Q-1 visa admitted to the US for the purpose of providing domestic services?

Yes
No

If the answer is yes, then the employer and employee are both exempt from paying FICA (Social Security and Medicare) and the employer is exempt from paying FUTA (Federal Unemployment Tax) on wages paid to this employee. The employer may also be exempt from paying State Unemployment Insurance Tax, depending on the rules in the state.

Tax Exemption for Employees under the Age of 18

Are you under the age of 18, or will turn 18 in this calendar/tax year?

Yes
No

I am under the age of 18 or will turn 18 this year.

Employee Date of Birth: ____/____/____

No. I am not a under the age of 18.

If you answered yes, go on to the next question.

If the answer is no, then the employer and employee are not exempt from paying FICA (Social Security and Medicare). If yes, go to the next question.

Is this job or performing household services your principal occupation? If you are a student, check "No".

Yes
No

This job or performing household services is my principal occupation and I am NOT a student.

No. I am a student or this is not my principal occupation.

If the answer is no, then the employer and employee are both exempt from paying FICA (Social Security and Medicare). The employer may also be exempt from paying State Unemployment Insurance Tax, depending on the rules in the state.

Developed by the National Resource Center for Participant-Directed Services, November 2011

Texas Financial Management Services Agencies (FMSAs) are responsible for keeping current with IRS and TWC regulations and updating this resource as needed.