

Attendant Contact InformationName: _____
First Middle LastPhysical Address: _____
Street Apt/Unit # City State Zip CodeMailing Address: _____
(If different from above) Street/P.O. Box Apt/Unit # City State Zip Code

Email Address: _____

Phone: Home _____ Cell _____

Emergency Contact – Name & Phone #: _____

Attendant Fingerprint Background Check InformationAliases to name provided above (including maiden name or previous married names)

Social Security Number: _____ - _____ - _____

Date of Birth: ____/____/____ (8-digit numeric, e.g. 05/17/1964)

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

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

Country of citizenship: _____

Sex: ☐ Male ☐ Female Weight: _____ Height: _____Race: ☐ Asian/Pacific Islander ☐ Black ☐ American Indian/Alaskan Native ☐ White/Latino ☐ UnknownEye Color: ☐ Black ☐ Blue ☐ Brown ☐ Green ☐ Grey ☐ HazelHair Color: ☐ Black ☐ Blonde ☐ Brown ☐ Red**Employment Relationships**

Name of Member/Employer of Record: _____

Attendant's Relationship to the Member: _____

Name of Member's Representative (if exists): _____



Physical Capacity

Attendants will be expected to perform a variety of physical activities depending on the needs of the member. Because of the company's concern for the attendant's and the member's safety, attendants must complete a Health Questionnaire. This questionnaire will be reviewed by management to ensure the attendant's physical capabilities are sufficient to safely provide care to their member.

Please Read Carefully

Neither the acceptance of employee paperwork nor entry into any type of employment relationship or employment agreement with a Member for the consideration of employment shall serve to create an actual or implied contract of employment with Consumer Direct Care Network New Mexico.

I authorize investigation of all statements provided to the Member or contained in the employee paperwork. I understand that misrepresentation or omission of facts called for is cause for dismissal at any time without notice. I hereby give the Member/Managing Party permission to contact previous employers (unless otherwise indicated), references, and others, and hereby release the Member from any liability as a result of such contact.

I understand that employment remains conditional until the results of the criminal background check have been received and approved. I also understand that the results of the criminal background check or any future criminal background checks may be shared with the approving entity (MCO, county, etc.) and/or the Member I work with.

Signature of Attendant

Date



Consumer-Directed Personal Care Services
NEW EMPLOYEE CHECKLIST

Employee Name	Member Name	Representative Name (if exist)

Attendant applicants: After being selected as an attendant by a Member/LR, you must complete and submit all the forms listed below to Consumer Direct Care Network New Mexico (CDCN). Following review and approval, a program coordinator will present you with a written “Okay to Work” notification, stating when you may begin working.

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

1. ☐ Attendant Application/Data Form
2. ☐ New Employee Checklist (this form)
3. ☐ Employee-Employer Relationship Determination
4. ☐ I-9 Form – Employment Eligibility Verification – *Present original documents for the Member/LR to examine when completing section 2 of the I-9. Additional I-9 instructions are available on the CDCN New Mexico website under the Resources tab.*
5. ☐ W-4 Form – Employee’s Withholding Allowance Certificate
6. ☐ Pay Selection Form – *attachment may be required, see form instructions*
7. ☐ Wage Memo
8. ☐ Attendant Agreement
9. ☐ Attendant EVV Acknowledgement
10. ☐ Attendant EVV Quiz
11. ☐ Employee Health Questionnaire
12. ☐ Driving Confirmation OR ☐ No-Driving Confirmation – *complete one of these two forms based on whether you will be providing driving-related services for a Medicaid member.*
13. ☐ Medicaid Fraud Statement

Please review and verify that the above forms are complete and readable before submitting to CDCN. Illegible or missing forms will result in a delayed start date.

The employee is not approved to begin work until all of the above materials are received and approved by CDCN and an “Okay to Work” approval form has been issued.





EMPLOYEE-EMPLOYER RELATIONSHIP DETERMINATION

(Determine if employee is exempt from some payroll taxes)

Employee Name	Member (Employer of Record) Name

Background: Employees providing domestic services may be exempt from some payroll taxes. This is based on the Employee's age and relationship to the Employer of Record (Employer). Consumer Direct Care Network (CDCN) will apply any exemptions based on the relationships identified below. **Incorrectly filling this form out may result in inaccurate tax withholdings.**

Note: If the Employee and Employer qualify for tax exemptions, they must be taken. Exemptions cannot be waived. If the Employee's earnings are exempt from these taxes, they may not qualify for related benefits. An example is unemployment insurance.

Employee-Employer Relationship

Employee select one relationship below.

☐ I am the spouse of the Employer (Need approval from the Managed Care Organization (MCO)).
☐ I am the parent of the Employer (including adoptive and stepparent). If parent checked, check <u>any</u> of the following that apply: ☐ I provide care for the Employer's child or stepchild that lives in the home. ☐ The Employer's child or stepchild is less than 18 years old or requires personal care of an adult for at least 4 straight weeks in 3 months. ☐ The Employer is a widow, widower, divorced or married and lives with a spouse, but the spouse has a physical or medical condition that prevents them from caring for the child at least 4 straight weeks in 3 months. <i>Exempt from FUTA¹ and SUTA². Subject to FICA³ if all three boxes checked above; else FICA exempt.</i>
☐ I am the child of the Employer. If child checked, check <u>one</u> option below: ☐ I am 21 years of age or older. <i>Subject to FICA, FUTA, and SUTA.</i> ☐ I am less than 21 years old. <i>Subject to SUTA. Exempt from FICA and FUTA.</i>
☐ I am not related to the Employer or my relationship is not described above. <i>Subject to FICA, FUTA, and SUTA.</i>

Acknowledgement: The Employee and Employer agree the relationship selected above is accurate. If this information changes, the Employee must notify CDCN. If CDCN is not notified of changes, the Employee may have to pay back money that should have been withheld from pay.

Employee Signature

Date

Member/Employer Signature

Date

¹FUTA – Federal Unemployment Tax Act

²SUTA – State Unemployment

³FICA – Federal Insurance Contributions Act (Social Security and Medicare)



Instructions for Completing Form I-9 Section 1

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

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

- ① Print your full legal name: Last, First and Middle Initial. Provide any other last names used, such as maiden name. Enter "N/A" if you have never had another name.
- ② Print your physical address. A PO Box is not allowed. Enter "N/A" if you have no apartment number.
- ③ Print your Date of Birth.
- ④ Print your Social Security Number.
- ⑤ Print your Email Address or print "N/A" if you choose to not provide it.
- ⑥ Print your Telephone Number or print "N/A" if you choose to not provide it.
- ⑦ Check one box that describes your citizenship or immigration status in the United States. Enter additional information if you check box 3 or 4.
- ⑧ Sign and ⑨ date the form. **No later than first day of work for pay.**
- ⑩ Submit Supplement A (*Preparer and/or Translator Certification*) if a preparer or translator assisted you.

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

Section 1. Employee Information and Attestation: Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment , but not before accepting a job offer.					
Last Name (Family Name) ① Doe		First Name (Given Name) Jane		Middle Initial (if any) Q	Other Last Names Used (if any) N/A
Address (Street Number and Name) ② 123 Main St.		Apt. Number (if any) N/A	City or Town Anytown		State NM ZIP Code 87101
Date of Birth (mm/dd/yyyy) ③ 03/13/1964	U.S. Social Security Number ④ 1 2 3 4 5 6 7 8 9		Employee's Email Address ⑤ employee@email.com		Employee's Telephone Number ⑥ 555-123-4567
I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.		⑦ Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):			
		☒ 1. A citizen of the United States			
		☐ 2. A noncitizen national of the United States (See instructions)			
		☐ 3. A lawful permanent resident (Enter USCIS A-Number)			
		☐ 4. A noncitizen (other than Item Numbers 2. and 3. above) authorized to work until (exp. date, if any)			
		If you check Item Number 4., enter one of these:			
		USCIS A-Number		OR	Form I-94 Admission Number
				OR	Foreign Passport Number and Country of Issuance
Signature of Employee ⑧ Jane Doe			Today's Date (mm/dd/yyyy) ⑨ 09/15/2023		
If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.					

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

Instructions for Completing Form I-9 Section 2

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

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

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

- ① Examine each document. Print the details in the appropriate List column(s). Only accept unexpired, original documents (no photocopies).
You may accept one document from List A **OR** one from List B and one from List C.
- ② Print the date of the employee's first day of work.
- ③ Print your last name, first name and title. Title is "Employer."
- ④ Sign and ⑤ date the form. **Must be completed and signed within 3 days of employee's first day of work.**
- ⑥ Print your first and last name.
- ⑦ Print physical address where services are provided (the Member's home).

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS , documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.			
	List A	OR	List B AND List C
Document Title 1		①	<i>Driver's License</i> <i>Social Security Card</i>
Issuing Authority			<i>State of Residence</i> <i>SSA</i>
Document Number (if any)			<i>0123456789abode</i> <i>123-45-6789</i>
Expiration Date (if any)			<i>08/17/2027</i> <i>N/A</i>
Document Title 2 (if any)		Additional Information	
Issuing Authority		Example ⚡ Do not check. You must physically examine documents. ☐ Check here if you used an alternative procedure authorized by DHS to examine documents.	
Document Number (if any)			
Expiration Date (if any)			
Document Title 3 (if any)			
Issuing Authority			
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): ② <i>09/15/2023</i>
Last Name, First Name and Title of Employer or Authorized Representative ③ <i>Smith, Ronald Employer</i>		Signature of Employer or Authorized Representative ④ <i>Ronald Smith</i>	Today's Date (mm/dd/yyyy) ⑤ <i>09/15/2023</i>
Employer's Business or Organization Name ⑥ <i>Ronald Smith</i>	Employer's Business or Organization Address, City or Town, State, ZIP Code ⑦ <i>500 Fictional Street, Anytown NM 87018</i>		

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

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



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

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

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

List A		OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)		Additional Information			
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)		☐ Check here if you used an alternative procedure authorized by DHS to examine documents.			
Issuing Authority					
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 Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 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. 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		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 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 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority For persons under age 18 who are unable to present a document listed above: 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record	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. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 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. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 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.
Acceptable Receipts May be presented in lieu of a document listed above for a temporary period. For receipt validity dates, see the M-274.			
• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	OR	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

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





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

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

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 07/31/2026

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

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

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

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

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

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

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

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

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



Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.

Give Form W-4 to your employer.

Your withholding is subject to review by the IRS.

2024**Step 1:**
Enter
Personal
Information

(a) First name and middle initial	Last name	(b) Social security number
Address		Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov .
City or town, state, and ZIP code		
(c) ☐ Single or Married filing separately		
☐ Married filing jointly or Qualifying surviving spouse		
☐ Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

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 most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**
- (b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**
- (c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate ☐

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

Step 3: Claim Dependent and Other Credits	If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly):		
	Multiply the number of qualifying children under age 17 by \$2,000 \$ _____		
	Multiply the number of other dependents by \$500 \$ _____		
	Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here	3	\$ _____
Step 4 (optional): Other Adjustments	(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income	4(a)	\$ _____
	(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here	4(b)	\$ _____
	(c) Extra withholding. Enter any additional tax you want withheld each pay period . .	4(c)	\$ _____

Step 5:
Sign
Here

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

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

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

Section references are to the Internal Revenue Code.

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 2024 if you meet both of the following conditions: you had no federal income tax liability in 2023 **and** you expect to have no federal income tax liability in 2024. You had no federal income tax liability in 2023 if (1) your total tax on line 24 on your 2023 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2024 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2025.

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. Expect to work only part of the year;
2. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or
3. Prefer the most accurate withholding for multiple job situations.

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.

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

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



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

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

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2024 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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



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

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

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

- 1 Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 **1** \$ _____
- 2 Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.
 - a** Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a **2a** \$ _____
 - b** Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b **2b** \$ _____
 - c** Add the amounts from lines 2a and 2b and enter the result on line 2c **2c** \$ _____
- 3** Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3** _____
- 4 Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) **4** \$ _____

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

- 1** Enter an estimate of your 2024 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 7.5% of your income **1** \$ _____
- 2** Enter: $\left\{ \begin{array}{l} \bullet \$29,200 \text{ if you're married filing jointly or a qualifying surviving spouse} \\ \bullet \$21,900 \text{ if you're head of household} \\ \bullet \$14,600 \text{ if you're single or married filing separately} \end{array} \right\}$ **2** \$ _____
- 3** If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" **3** \$ _____
- 4** Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information **4** \$ _____
- 5 Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 **5** \$ _____

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

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

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

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



Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$0	\$780	\$850	\$940	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,370
\$10,000 - 19,999	0	780	1,780	1,940	2,140	2,220	2,220	2,220	2,220	2,220	2,570	3,570
\$20,000 - 29,999	780	1,780	2,870	3,140	3,340	3,420	3,420	3,420	3,420	3,770	4,770	5,770
\$30,000 - 39,999	850	1,940	3,140	3,410	3,610	3,690	3,690	3,690	4,040	5,040	6,040	7,040
\$40,000 - 49,999	940	2,140	3,340	3,610	3,810	3,890	3,890	4,240	5,240	6,240	7,240	8,240
\$50,000 - 59,999	1,020	2,220	3,420	3,690	3,890	3,970	4,320	5,320	6,320	7,320	8,320	9,320
\$60,000 - 69,999	1,020	2,220	3,420	3,690	3,890	4,320	5,320	6,320	7,320	8,320	9,320	10,320
\$70,000 - 79,999	1,020	2,220	3,420	3,690	4,240	5,320	6,320	7,320	8,320	9,320	10,320	11,320
\$80,000 - 99,999	1,020	2,220	3,620	4,890	6,090	7,170	8,170	9,170	10,170	11,170	12,170	13,170
\$100,000 - 149,999	1,870	4,070	6,270	7,540	8,740	9,820	10,820	11,820	12,830	14,030	15,230	16,430
\$150,000 - 239,999	1,960	4,360	6,760	8,230	9,630	10,910	12,110	13,310	14,510	15,710	16,910	18,110
\$240,000 - 259,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
\$260,000 - 279,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
\$280,000 - 299,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,380
\$300,000 - 319,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,980	17,980	19,980
\$320,000 - 364,999	2,040	4,440	6,840	8,310	9,710	11,280	13,280	15,280	17,280	19,280	21,280	23,280
\$365,000 - 524,999	2,720	6,010	9,510	12,080	14,580	16,950	19,250	21,550	23,850	26,150	28,450	30,750
\$525,000 and over	3,140	6,840	10,540	13,310	16,010	18,590	21,090	23,590	26,090	28,590	31,090	33,590

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	\$240	\$870	\$1,020	\$1,020	\$1,020	\$1,540	\$1,870	\$1,870	\$1,870	\$1,870	\$1,910	\$2,040
\$10,000 - 19,999	870	1,680	1,830	1,830	2,350	3,350	3,680	3,680	3,680	3,720	3,920	4,050
\$20,000 - 29,999	1,020	1,830	1,980	2,510	3,510	4,510	4,830	4,830	4,870	5,070	5,270	5,400
\$30,000 - 39,999	1,020	1,830	2,510	3,510	4,510	5,510	5,830	5,870	6,070	6,270	6,470	6,600
\$40,000 - 59,999	1,390	3,200	4,360	5,360	6,360	7,370	7,890	8,090	8,290	8,490	8,690	8,820
\$60,000 - 79,999	1,870	3,680	4,830	5,840	7,040	8,240	8,770	8,970	9,170	9,370	9,570	9,700
\$80,000 - 99,999	1,870	3,690	5,040	6,240	7,440	8,640	9,170	9,370	9,570	9,770	9,970	10,810
\$100,000 - 124,999	2,040	4,050	5,400	6,600	7,800	9,000	9,530	9,730	10,180	11,180	12,180	13,120
\$125,000 - 149,999	2,040	4,050	5,400	6,600	7,800	9,000	10,180	11,180	12,180	13,180	14,180	15,310
\$150,000 - 174,999	2,040	4,050	5,400	6,860	8,860	10,860	12,180	13,180	14,230	15,530	16,830	18,060
\$175,000 - 199,999	2,040	4,710	6,860	8,860	10,860	12,860	14,380	15,680	16,980	18,280	19,580	20,810
\$200,000 - 249,999	2,720	5,610	8,060	10,360	12,660	14,960	16,590	17,890	19,190	20,490	21,790	23,020
\$250,000 - 399,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
\$400,000 - 449,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
\$450,000 and over	3,140	6,450	9,110	11,610	14,110	16,610	18,430	19,930	21,430	22,930	24,430	25,870

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	\$510	\$850	\$1,020	\$1,020	\$1,020	\$1,020	\$1,220	\$1,870	\$1,870	\$1,870	\$1,960
\$10,000 - 19,999	510	1,510	2,020	2,220	2,220	2,220	2,420	3,420	4,070	4,070	4,160	4,360
\$20,000 - 29,999	850	2,020	2,560	2,760	2,760	2,960	3,960	4,960	5,610	5,700	5,900	6,100
\$30,000 - 39,999	1,020	2,220	2,760	2,960	3,160	4,160	5,160	6,160	6,900	7,100	7,300	7,500
\$40,000 - 59,999	1,020	2,220	2,810	4,010	5,010	6,010	7,070	8,270	9,120	9,320	9,520	9,720
\$60,000 - 79,999	1,070	3,270	4,810	6,010	7,070	8,270	9,470	10,670	11,520	11,720	11,920	12,120
\$80,000 - 99,999	1,870	4,070	5,670	7,070	8,270	9,470	10,670	11,870	12,720	12,920	13,120	13,450
\$100,000 - 124,999	2,020	4,420	6,160	7,560	8,760	9,960	11,160	12,360	13,210	13,880	14,880	15,880
\$125,000 - 149,999	2,040	4,440	6,180	7,580	8,780	9,980	11,250	13,250	14,900	15,900	16,900	17,900
\$150,000 - 174,999	2,040	4,440	6,180	7,580	9,250	11,250	13,250	15,250	16,900	18,030	19,330	20,630
\$175,000 - 199,999	2,040	4,510	7,050	9,250	11,250	13,250	15,250	17,530	19,480	20,780	22,080	23,380
\$200,000 - 249,999	2,720	5,920	8,620	11,120	13,420	15,720	18,020	20,320	22,270	23,570	24,870	26,170
\$250,000 - 449,999	2,970	6,470	9,310	11,810	14,110	16,410	18,710	21,010	22,960	24,260	25,560	26,860
\$450,000 and over	3,140	6,840	9,880	12,580	15,080	17,580	20,080	22,580	24,730	26,230	27,730	29,230





PAY SELECTION FORM

Employee Name: _____

Date of Birth: _____

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

Please check one pay option below.

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

- ☐ **Direct Deposit to a Wisely Pay Card Account.** I authorize CDCN to issue me a Wisely Pay card. The card will be tied to my identification on file. CDCN will make payroll deposits to my card account. I will receive the card in 7 to 10 business days after initial processing.
- ☐ **Direct Deposit to an Existing Checking, Savings or Pay Card Account.** I authorize CDCN to initiate payroll deposits to my bank or financial institution.

The Name of my bank is: _____

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

AN ATTACHMENT IS REQUIRED.

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

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

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

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

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

Employee Signature

Date





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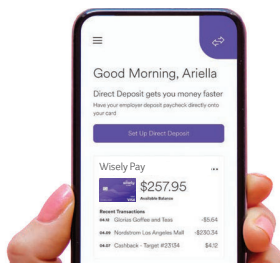


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² You must log in to the myWisely app or mywisely.com to opt-in to early direct deposit. Early direct deposit of funds is not guaranteed and is subject to the timing of payor's payment instruction. Faster funding claim is based on a comparison of our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

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

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

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Attendant Name	Member/Employer of Record Name	Member CDCN ID #

Along with their other duties and privileges of self-directed care, the member sets their attendant's wage rate.

A member must set an attendant's wage consistent with employment law and may consider such factors as experience, training, how well they do the job, willingness to work at night or odd hours, or how long the attendant has worked for the member. If a member has a question about setting wages, they may contact Consumer Direct Care Network (CDCN) or refer to their Member Training Manual.

To ensure compliance with employment law CDCN offers members an attendant wage range from a minimum of \$12.00 an hour (\$12.36 in Las Cruces) up to a maximum wage of \$13.10 an hour.

Select and mark one wage rate below or write in a wage under "Other"

Wage Rate: ☐ \$12.00/hour ☐ \$12.60/hour ☐ \$13.10/hour

Other: ☐ \$_____/hour (minimum \$12.00/hr, or \$12.36 in Las Cruces, maximum \$13.10/hour)*

Overtime (working more than 40 hours per week) is not allowed without CDCN authorization.

Attendant Signature

Date

Member/LR Signature

Date

Office Use Only- Completed by Consumer Direct

Effective Date: _____





ATTENDANT AGREEMENT

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

_____, has elected to hire me for the position of Attendant.
(Member or Legal Representative (LR) Print Name)

I will perform personal care services for the Member, according to New Mexico's Personal Care Services Program (PCSP). I understand New Mexico Consumer Direct Personal Care, LLC doing business as Consumer Direct Care Network New Mexico (CDCN) is the Fiscal and Employer Agency. CDCN assists the Member/LR with employer related tasks. CDCN is not my employer. The Member/LR is my employer.

1. I have received:

- A blank Status Change Form. I agree to notify CDCN within ten (10) days of any change in name, addresses, and telephone number. I must also disclose any criminal charges that may affect my employment within ten (10) days.
- A current CDCN Pay Schedule.

2. CPR and TB Screening

Current CPR and TB screening are recommended, but not required by CDCN. The Member/LR may require them. If required, I am responsible for any costs associated with meeting these requirements.

3. Effective Date

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

4. Training

CDCN provides the Member/LR with Attendant training materials and related information upon request.

5. Payment

- I am paid at an hourly rate for approved services I provide to the Member. Hourly rate is identified in the CDCN wage memo.
- CDCN offers two direct deposit pay options. I can specify a bank account or choose a pay card. If I change my direct deposit option, I must submit a new Pay Selection Form. I understand it may take one or two pay cycles for the changes to take effect.
- CDCN issues pay every two weeks. CDCN sends pay stubs (summary of pay) and W-2s by first class mail to my address on file or electronically.
- I understand I can choose to receive checks by mail. Receiving checks by mail is dependent upon federal holidays, other U.S. mail disruptions and payroll corrections.
- Overtime is not authorized. Overtime is defined as more than 40 hours in a workweek. I understand it is my responsibility to monitor hours worked and avoid overtime situations.
- I have the right to earn and use paid sick leave. I will accrue 1 hour of sick leave for every 30 hours worked, per employer. I may use up to 64 hours of earned sick leave per year, per employer. Hours used and earned will be shown on my pay stub. I cannot use EVV to claim sick leave, but must submit a paper form. Unused sick leave hours are not paid to employee upon termination of employment.



- CDCN will file amended payroll tax returns in instances of over-collected Social Security and Medicare taxes from my pay (occurs when earnings are less than the IRS threshold published in Circular E). If this happens, I will receive a refund from CDCN in January. I agree to not file a claim for refund of over-collected Medicare or Social Security taxes with the IRS.
- CDCN is not responsible to pay me if:
 - The Member loses program eligibility.
 - The Member is in the hospital, nursing home, an institution, or incarcerated and out of GEO fence claims.
 - The Member/LR allows me to work overtime (more than 40 hours per week).
 - The Member/LR allows me to work time outside the approved Individual Plan of Care (IPoC). CDCN will only pay up to the authorized amount and will make adjustments to ensure the authorized amount is processed.
 - Time corrections are not submitted within thirty (30) days of time worked.
 - There is alleged misrepresentation of time worked. CDCN has the right to withhold payments until the issue is resolved.

Attendant agrees to pursue payment from the member for any above issues that may result in unpaid hours worked.

6. Automobile Insurance

Current automobile liability insurance is required if I'm authorized to drive for work. Verification of insurance must be filed with CDCN and updated as required. If insurance is not provided, I understand I will not be able to provide these types of support services to the Member.

7. My Attendant Responsibilities Include:

- Program Compliance.
- Maintaining current valid state photo ID or driver's license.
- Documentation and record keeping.
- Confidentiality.
- Address and telephone number change notification.
- Refusal of prohibited payments.
- Disclosing abuse, neglect, and exploitation to law enforcement and appropriate authorities.
- Disclosing to CDCN any additional employment while working as an Attendant to the Member.

8. CDCN Responsibilities:

In the consumer-directed service model, CDCN serves as the Member/LR's Fiscal Employer Agent (FEA), providing payroll and reporting services. There are additional PCSP program requirements CDCN must follow. Responsibilities include:

- Maintain a signed agreement with the Member/LR.
- Explain PCSP provisions to the Member/LR.
- Provide Member/LR with assistance and training upon request, including:
 - Employer tasks (recruiting, hiring, supervising and dismissing Attendants), and



- Attendant training information and materials (CPR, first aid, diabetes, Alzheimer's disease, lifting and moving patients, TB, Hepatitis B, mental health, etc.).
- Verify the Member qualifies for Medicaid coverage each month.
- Make referrals to appropriate state agencies to assess the Member's ability to direct his or her own care, if necessary.
- Ensure the Member has an approved IPoC.
- Comply with federal, state, and local laws and Medicaid regulations.
- Submit written Incident Reports to the state for abuse, neglect, exploitation, environmental hazard, law enforcement intervention, emergency services or death.
- Provide the state with PCSP reports.
- Perform FEA/fiscal intermediary functions:
 - Pay the Attendant on behalf of the Member/LR.
 - Comply with wage and hour laws.
 - Process federal and state income tax withholdings, workers' compensation and unemployment insurance.
 - Maintain service records and personal files for the Member and Attendant.
 - Perform Attendant background checks.
 - Verify Attendants meet and maintain program eligibility requirements
 - Obtain a signed sobriety agreement from the Attendant

9. Non-Emergent Care

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

10. Inactive Status

I understand if I do not work for a CDCN Member for six (6) months, I will become inactive. If this happens, I must re-apply for my job through the Member and receive a new *Okay to Work* Form.

11. Sobriety Agreement

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

12. Member Relationship

I am not the spouse, Member's legal guardian or attorney. If I am, I have received prior approval from the Managed Care Organization (MCO) to be the Member's Attendant.

My relationship to the Member is: _____ initial ().

Attendant Signature

Date

Member/LR Signature

Date



Print Employee (Attendant) Name

Instructions:

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

_____ **Receipt of AuthentiCare training materials:** I received the IVR instruction sheet or AuthentiCare App information and I have received training on how to use the EVV system.

_____ **Acknowledgement of the required use of the EVV system AuthentiCare:** I understand that the use of the EVV system AuthentiCare is required by the New Mexico Human Services Department and the Managed Care Organizations. I understand that I am responsible for clocking in and clocking out for each scheduled shift using the AuthentiCare IVR phone system or the AuthentiCare App.

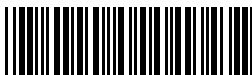
_____ **Acknowledgement of the EVV system AuthentiCare time reporting methods:** I understand that all personal care workers must check in and check out using the member's registered phone. I understand that if my member does not have a phone, phone service or a phone is not available, or if I experience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

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

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

Attendant Signature

Date



Score _____

TEST YOURSELF

True or False

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

Attendant's Name: **Please Print**

Attendant Signature

Date

Member's Name: **Please Print**

Member/Representative Signature

Date

Employee Name: _____
(please print)

Background: You have been conditionally hired to provide services for the service recipient in accordance with their authorized plan of care. You may be required to perform physical tasks. The purpose of this Health Questionnaire is to assess your ability to safely perform the authorized tasks. The information provided on this Questionnaire will be used to help manage your employment in a safe manner. Your responses are considered *Confidential*.

Instructions: Respond to each item as to whether you have a medical or physical activity restriction or limitation. **Please explain each "Yes" answer on the backside of this form and attach additional information as necessary.**

Return this completed form and other employment forms to the Consumer Direct Care Network (CDCN) office.

	Do you currently have a Physical Activity Restriction for:	NO	YES
1	Sitting		
2	Stationary Standing		
3	Walking		
4	Ability to be Mobile		
5	Crouching (bending at knee)		
6	Kneeling/Crawling		
7	Stooping (bending at waist)		
8	Twisting (knees/waist/neck)		
9	Turning/Pivoting		
10	Climbing		
11	Balancing		
12	Reaching overhead		
13	Reaching extension		
14	Grasping		
15	Pushing/Pulling		
16	Lifting/Carrying		
17	Whole/Partial Loss of Hearing		
18	Blindness (partial or complete) or Eye Problems		
19	Have you ever been advised by a health care professional to restrict your physical activities in any way?		
	Personal Medical History – In the past 5 years, have you had or been treated for:	NO	YES
20	Epilepsy		
21	Fainting/Dizzy Spells		
22	Hernia		
23	Muscular Strain		
24	Neck or Back Injury		
25	Ruptured Intervertebral Disc		
26	Joint Injury or Pain		
27	Fractures		
28	Tuberculosis or Non-Negative TB Test		
29	Lung Problems/Disease		
30	Head Injury		
31	Other Current Problems, Diseases, Conditions		
32	Have you been hospitalized or undergone surgery, other than for childbirth?		
33	Have you refused a recommended surgical procedure?		
34	Are you currently taking any medication or drugs, whether by prescription or not, that could impair your judgment?		



Print Attendant's Name

Print Member's Name

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

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

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

Driving is only authorized for Support Services that are on the member's plan of care. The attendant will not be paid for driving services when going to doctor's appointments, driving out of state, or driving while on vacation. Additionally, this program does not pay for driving-related expenses such as mileage or gas.

Attachments Required

Please attach a photocopy of the following documents:

Attendant's Driver's License

State: _____ Number: _____ Expiration Date: _____

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

Expiration Date: _____ Vehicle owner: _____

Acknowledgement

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

Attendant Signature

Date

Member/LR Signature

Date



No DRIVING CONFIRMATION

Print Attendant's Name

Print Member's Name

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

State regulations require a copy of the attendant's driver's license or state identification card be on file even if the attendant will not be providing the member with driving-related services.

New Mexico Administrative Code 8.315.4.11 B.1. (a) verifying that the attendant possesses a current and valid state driver's license if there are any driving-related activities listed on the IPoC; a copy of the current driver's license must be maintained in the attendant's personnel file at all times; if no driving-related activities are listed on the IPoC, a copy of a valid state ID is kept in the attendant's personnel file at all times.

Attachment Required

Please attach a photocopy of one of the following documents:

☐ **Attendant's Driver's License**

State: _____ Number: _____ Expiration Date: _____

☐ **Attendant's State ID Card**

State: _____ Number: _____ Expiration Date: _____

Acknowledgement

The member and attendant hereby agree that the attendant will not provide driving services at any time while providing program services.

Attendant Signature

Date

Member/LR Signature

Date



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

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

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



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

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



Medicaid fraud is a crime against all taxpayers and is a State and Federal crime.

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

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

Attendant Name

Attendant Signature

Date





Work Opportunity Tax Credits - Consumer Direct Care Network

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

Applicant Instructions

- Open <https://tcs.adp.com/consumerdirectcare> or scan the QR code below.
***Note: If using a shared screening device, ensure the device does not have an autofill/auto complete function enabled*
- Please answer each question to complete the voluntary screening.
- Eligible applicants will be asked to **Electronically Sign and click Submit** to complete the screening.
- Ineligible applicants will be asked to click **Submit** to finish the screening. You will not be asked to electronically sign.

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

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

IVR CODE: 410849



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