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This packet is designed for single sided paper printing.

CONSUMER DIRECT CARE NETWORK

ATTENDANT DATA FORM

Reset/clear all fields > Clear Form

Attendant Contact Information

Name: _____
First Middle Last

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

Mailing Address: _____
(If different from above) Street/P.O. Box Apt/Unit # City State Zip Code

Email Address: _____

Phone: Home _____ Cell _____

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

Emergency Contact – Name & Phone #: _____

Attendant Fingerprint Background Check Information

Aliases 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 ☐ Unknown

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

Hair 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 DIRECT CARE NETWORK

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.

CONSUMER DIRECT CARE NETWORK

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 any 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.

Exempt from FUTA[1] and SUTA[2]. Subject to FICA[3] if all three boxes checked above; else FICA exempt.

☐ **I am the child of the Employer.**

If child checked, check one option below:

- ☐ I am 21 years of age or older. *Subject to FICA, FUTA, and SUTA.*
- ☐ I am less than 21 years old. *Subject to SUTA. Exempt from FICA and FUTA.*

☐ **I am not related to the Employer or my relationship is not described above.**

Subject to FICA, FUTA, and SUTA.

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*

[1]FUTA – Federal Unemployment Tax Act
[2]SUTA – State Unemployment
[3]FICA – 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)	First Name (Given Name)	Middle Initial (if any)	Other Last Names Used (if any)
① Doe	Jane	Q	N/A

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code
② 123 Main St.	N/A	Anytown	NM	87101

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number
③ 03/13/1964	④ 1 2 3 4 5 6 7 8 9	⑤ employee@email.com	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.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

⑦
- [X] 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)

Example

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)
⑧ Jane Doe	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 <u>one document from List A</u> **OR** <u>one from List B and one from List C.</u>

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	*Driver's License*		*Social Security Card*
Issuing Authority			*State of Residence*		*SSA*
Document Number (if any)			*0123456789abcde*		*123-45-6789*
Expiration Date (if any)			*08/17/2027*		*N/A*
Document Title 2 (if any)			**Additional Information**		
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Example

Do not check. You must physically examine documents.

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.

First Day of Employment (mm/dd/yyyy): ② *09/15/2023*

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)
③ *Smith, Ronald Employer*	④ *Ronald Smith*	⑤ *09/15/2023*

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
⑥ *Ronald Smith*	⑦ *500 Fictional Street, Anytown NM 87018*

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 05/31/2027

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

Section 1. Employee Information and Attestation: Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.

Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	Other Last Names Used (if any)

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number
/ /			

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. 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)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)
Employer		

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

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

LISTS OF ACCEPTABLE DOCUMENTS

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

LIST A **Documents that Establish Both Identity and Employment Authorization**	OR	LIST B **Documents that Establish Identity**	AND	LIST C **Documents that Establish Employment Authorization**
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, 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.
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		**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		

Acceptable Receipts

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2025

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.)

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 (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)

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 2025 if you meet both of the following conditions: you had no federal income tax liability in 2024 **and** you expect to have no federal income tax liability in 2025. You had no federal income tax liability in 2024 if (1) your total tax on line 24 on your 2024 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 2025 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 17, 2026.

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

CAUTION

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

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You 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 2025 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 2025 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:
- $30,000 if you're married filing jointly or a qualifying surviving spouse
- $22,500 if you're head of household
- $15,000 if you're single or married filing separately

. . . . . **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	$700	$850	$910	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020
$10,000 - 19,999	0	700	1,700	1,910	2,110	2,220	2,220	2,220	2,220	2,220	2,220	3,220
$20,000 - 29,999	700	1,700	2,760	3,110	3,310	3,420	3,420	3,420	3,420	3,420	4,420	5,420
$30,000 - 39,999	850	1,910	3,110	3,460	3,660	3,770	3,770	3,770	3,770	4,770	5,770	6,770
$40,000 - 49,999	910	2,110	3,310	3,660	3,860	3,970	3,970	3,970	4,970	5,970	6,970	7,970
$50,000 - 59,999	1,020	2,220	3,420	3,770	3,970	4,080	4,080	5,080	6,080	7,080	8,080	9,080
$60,000 - 69,999	1,020	2,220	3,420	3,770	3,970	4,080	5,080	6,080	7,080	8,080	9,080	10,080
$70,000 - 79,999	1,020	2,220	3,420	3,770	3,970	5,080	6,080	7,080	8,080	9,080	10,080	11,080
$80,000 - 99,999	1,020	2,220	3,420	4,620	5,820	6,930	7,930	8,930	9,930	10,930	11,930	12,930
$100,000 - 149,999	1,870	4,070	6,270	7,620	8,820	9,930	10,930	11,930	12,930	14,010	15,210	16,410
$150,000 - 239,999	1,870	4,240	6,640	8,190	9,590	10,890	12,090	13,290	14,490	15,690	16,890	18,090
$240,000 - 259,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$260,000 - 279,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$280,000 - 299,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$300,000 - 319,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,170	19,170
$320,000 - 364,999	2,040	4,440	6,840	8,390	9,790	11,100	12,470	14,470	16,470	18,470	20,470	22,470
$365,000 - 524,999	2,790	6,290	9,790	12,440	14,940	17,350	19,650	21,950	24,250	26,550	28,850	31,150
$525,000 and over	3,140	6,840	10,540	13,390	16,090	18,700	21,200	23,700	26,200	28,700	31,200	33,700

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	$200	$850	$1,020	$1,020	$1,020	$1,370	$1,870	$1,870	$1,870	$1,870	$1,870	$2,040
$10,000 - 19,999	850	1,700	1,870	1,870	2,220	3,220	3,720	3,720	3,720	3,720	3,890	4,090
$20,000 - 29,999	1,020	1,870	2,040	2,390	3,390	4,390	4,890	4,890	4,890	5,060	5,260	5,460
$30,000 - 39,999	1,020	1,870	2,390	3,390	4,390	5,390	5,890	5,890	6,060	6,260	6,460	6,660
$40,000 - 59,999	1,220	3,070	4,240	5,240	6,240	7,240	7,880	8,080	8,280	8,480	8,680	8,880
$60,000 - 79,999	1,870	3,720	4,890	5,890	7,030	8,230	8,930	9,130	9,330	9,530	9,730	9,930
$80,000 - 99,999	1,870	3,720	5,030	6,230	7,430	8,630	9,330	9,530	9,730	9,930	10,130	10,580
$100,000 - 124,999	2,040	4,090	5,460	6,660	7,860	9,060	9,760	9,960	10,160	10,950	11,950	12,950
$125,000 - 149,999	2,040	4,090	5,460	6,660	7,860	9,060	9,950	10,950	11,950	12,950	13,950	14,950
$150,000 - 174,999	2,040	4,090	5,460	6,660	8,450	10,450	11,950	12,950	13,950	15,080	16,380	17,680
$175,000 - 199,999	2,040	4,290	6,450	8,450	10,450	12,450	13,950	15,230	16,530	17,830	19,130	20,430
$200,000 - 249,999	2,720	5,570	7,900	10,200	12,500	14,800	16,600	17,900	19,200	20,500	21,800	23,100
$250,000 - 399,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$400,000 - 449,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$450,000 and over	3,140	6,490	9,160	11,660	14,160	16,660	18,660	20,160	21,660	23,160	24,660	26,160

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	$450	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,870	$1,870	$1,870	$1,890
$10,000 - 19,999	450	1,450	2,000	2,200	2,220	2,220	2,220	3,180	4,070	4,070	4,090	4,290
$20,000 - 29,999	850	2,000	2,600	2,800	2,820	2,820	3,780	4,780	5,670	5,690	5,890	6,090
$30,000 - 39,999	1,000	2,200	2,800	3,000	3,020	3,980	4,980	5,980	6,890	7,090	7,290	7,490
$40,000 - 59,999	1,020	2,220	2,820	3,830	4,850	5,850	6,850	8,050	9,130	9,330	9,530	9,730
$60,000 - 79,999	1,020	3,030	4,630	5,830	6,850	8,050	9,250	10,450	11,530	11,730	11,930	12,130
$80,000 - 99,999	1,870	4,070	5,670	7,060	8,280	9,480	10,680	11,880	12,970	13,170	13,370	13,570
$100,000 - 124,999	1,950	4,350	6,150	7,550	8,770	9,970	11,170	12,370	13,450	13,650	14,650	15,650
$125,000 - 149,999	2,040	4,440	6,240	7,640	8,860	10,060	11,260	12,860	14,740	15,740	16,740	17,740
$150,000 - 174,999	2,040	4,440	6,240	7,640	8,860	10,860	12,860	14,860	16,740	17,740	18,940	20,240
$175,000 - 199,999	2,040	4,440	6,640	8,840	10,860	12,860	14,860	16,910	19,090	20,390	21,690	22,990
$200,000 - 249,999	2,720	5,920	8,520	10,960	13,280	15,580	17,880	20,180	22,360	23,660	24,960	26,260
$250,000 - 449,999	2,970	6,470	9,370	11,870	14,190	16,490	18,790	21,090	23,280	24,580	25,880	27,180
$450,000 and over	3,140	6,840	9,940	12,640	15,160	17,660	20,160	22,660	25,050	26,550	28,050	29,550

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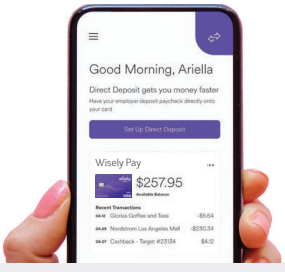

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CONSUMER DIRECT CARE NETWORK

PAY SELECTION FORM

Employee Name: _____ Date of Birth: ___/___/_____

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

Please check one pay option below.

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

☐ **Direct Deposit to a Wisely Pay Card Account.** I authorize CDCN to issue me a Wisely Pay card. The card will be tied to my identification on file. CDCN will make payroll deposits to my card account. I will receive the card in 7 to 10 business days after initial processing.

☐ **Direct Deposit to an Existing Checking, Savings or Pay Card Account.** I authorize CDCN to initiate payroll deposits to my bank or financial institution.

The Name of my bank is: _____

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

AN ATTACHMENT IS REQUIRED.

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

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

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

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

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

_____ _____

Employee Signature *Date*

CONSUMER DIRECT CARE NETWORK

WAGE MEMORANDUM

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 ($12.65 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 ☐ $12.65/hour ☐ $13.10/hour

Other: ☐ $_____/hour (minimum $12.00/hr, or $12.65 in Las Cruces, maximum $13.10/hour)*

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

_____ _____ _____ _____

Attendant Signature *Date* *Member/LR Signature* *Date*

Office Use Only- Completed by Consumer Direct
Effective Date:_____

01077

CONSUMER DIRECT CARE NETWORK

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*

CONSUMER DIRECT CARE NETWORK

ATTENDANT EVV ACKNOWLEDGEMENT

_____

Print Employee (Attendant) Name

Instructions:

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

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

_____ **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*

09676

CONSUMER DIRECT CARE NETWORK

ELECTRONIC VISIT VERIFICATION QUIZ

Score _____

TEST YOURSELF

True or False

1.	You must notify Consumer Direct Care Network within 24 hours of a missing or pending claim.	**T F**
2.	I can contact Consumer Direct Care Network to request a correction form without a valid reason.	**T F**
3.	Any missed visits not reported immediately cannot be processed.	**T F**
4.	The use of the EVV system is required by the New Mexico 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*

CONSUMER DIRECT CARE NETWORK

EMPLOYEE HEALTH QUESTIONNAIRE

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?		

CONSUMER DIRECT CARE NETWORK

EMPLOYEE HEALTH QUESTIONNAIRE

Do you currently have, or have you ever been told by a health care professional that you have any physical limitations related to the list below?							
		NO	**YES**			**NO**	**YES**
A	Back			H	Arm		
B	Shoulder			I	Hip		
C	Neck			J	Knee		
D	Elbow			K	Ankle		
E	Wrist			L	Foot		
F	Hand			M	Leg		
G	Finger			N	Other		

CDCN does not discriminate in hiring, promotion, or other terms and conditions of employment. In addition, CDCN does not discriminate against persons who have, in good faith, filed a claim for or received benefits according to State Workers' Compensation Laws. Requests for Accommodations which allow employees to perform the essential functions need to be requested in writing and will be provided if they do not cause an undue hardship.

Please explain any "Yes" answers from page 1 and 2 in detail below and note the associated number or letter. Also, include the dates of injuries & surgeries. Use additional pages, if necessary:

I affirm that I have answered the above questions to the best of my knowledge. My answers are true and complete. I understand that knowingly providing false information is cause for dismissal and may result in denial of workers' compensation benefits.

Employee Signature: _____ Date: _____/_____/_____

Office Use Only

Reviewed by: [_____] Date _____/_____/_____ Date sent to Risk Mgr: _____/_____/_____

State Office/Location: _____ Risk Mgr Review: [_____] Date _____/_____/_____

05095

CONSUMER DIRECT CARE NETWORK

DRIVING CONFIRMATION

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* _____

CONSUMER DIRECT CARE NETWORK

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 <u>one of the following</u> documents:

☐ **Attendant's Driver's License**

State: _____ Number: _____ Expiration Date: _____

☐ **Attendant's State ID Card**

State: _____ Number: _____ Expiration Date: _____

Acknowledgement

The 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*

CONSUMER DIRECT CARE NETWORK

ATTENDANT MEDICAID FRAUD STATEMENT

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

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

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

All cases of possible Medicaid fraud and program abuse should be reported immediately to New Mexico's 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

2025 Payroll Calendar

Symbol Key: ◯ Pay Day △ Postal and Bank Holiday

CONSUMER DIRECT CARE NETWORK

JANUARY						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
			△1	2	3	4
5	6	7	8	9	◯10	11
12	13	14	15	16	17	18
19	△20	21	22	23	◯24	25
26	27	28	29	30	31	

FEBRUARY						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
						1
2	3	4	5	6	◯7	8
9	10	11	12	13	14	15
16	△17	18	19	20	◯21	22
23	24	25	26	27	28	

MARCH						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
						1
2	3	4	5	6	◯7	8
9	10	11	12	13	14	15
16	17	18	19	20	◯21	22
23	24	25	26	27	28	29
30	31					

APRIL						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
		1	2	3	◯4	5
6	7	8	9	10	11	12
13	14	15	16	17	◯18	19
20	21	22	23	24	25	26
27	28	29	30			

MAY						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
				1	◯2	3
4	5	6	7	8	9	10
11	12	13	14	15	◯16	17
18	19	20	21	22	23	24
25	△26	27	28	29	◯30	31

JUNE						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	2	3	4	5	6	7
8	9	10	11	12	◯13	14
15	16	17	18	△19	20	21
22	23	24	25	26	◯27	28
29	30					

JULY						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
		1	2	3	△4	5
6	7	8	9	10	◯11	12
13	14	15	16	17	18	19
20	21	22	23	24	◯25	26
27	28	29	30	31		

AUGUST						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
					1	2
3	4	5	6	7	◯8	9
10	11	12	13	14	15	16
17	18	19	20	21	◯22	23
24	25	26	27	28	29	30
31						

SEPTEMBER						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
	△1	2	3	4	◯5	6
7	8	9	10	11	12	13
14	15	16	17	18	◯19	20
21	22	23	24	25	26	27
28	29	30				

OCTOBER						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
			1	2	◯3	4
5	6	7	8	9	10	11
12	△13	14	15	16	◯17	18
19	20	21	22	23	24	25
26	27	28	29	30	◯31	

NOVEMBER						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
						1
2	3	4	5	6	7	8
9	10	△11	12	13	◯14	15
16	17	18	19	20	21	22
23	24	25	◯26	△27	28	29
30						

DECEMBER						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
	1	2	3	4	5	6
7	8	9	10	11	◯12	13
14	15	16	17	18	19	20
21	22	23	◯24	△25	26	27
28	29	30	31			

2025 Bank & Post Office Holidays

*Consumer Direct Care Network office closures

*__New Year's Day__ - Wednesday, January 1

*__Martin Luther King, Jr. Day__ - Monday, January 20

__Presidents Day__ - Monday, February 17

*__Memorial Day__ - Monday, May 26

*__Juneteenth__ - Thursday, June 19

*__Independence Day__ - Friday, July 4

*__Labor Day__ - Monday, September 1

__Columbus Day__ - Monday, October 13

*__Veterans Day__ - Tuesday, November 11

*__Thanksgiving Day__ - Thursday, November 27

*__Christmas Day__ - Thursday, December 25

CONSUMER DIRECT CARE NETWORK

Work weeks are Sunday through Saturday. You must submit time daily using Electronic Visit Verification (EVV). Corrections are due by the correction deadline. Late time or time with mistakes may result in late pay. Thank you!

Two Week Pay Period		EVV Time Correction	
Start Date	End Date	Deadline	Pay Date
Sunday	Saturday	Monday	Friday
12/15/2024	12/28/2024	12/30/2024	1/10/2025
12/29/2024	1/11/2025	1/13/2025	1/24/2025
1/12/2025	1/25/2025	1/27/2025	2/7/2025
1/26/2025	2/8/2025	2/10/2025	2/21/2025
2/9/2025	2/22/2025	2/24/2025	3/7/2025
2/23/2025	3/8/2025	3/10/2025	3/21/2025
3/9/2025	3/22/2025	3/24/2025	4/4/2025
3/23/2025	4/5/2025	4/7/2025	4/18/2025
4/6/2025	4/19/2025	4/21/2025	5/2/2025
4/20/2025	5/3/2025	5/5/2025	5/16/2025
5/4/2025	5/17/2025	5/19/2025	5/30/2025
5/18/2025	5/31/2025	6/2/2025	6/13/2025
6/1/2025	6/14/2025	6/16/2025	6/27/2025
6/15/2025	6/28/2025	6/30/2025	7/11/2025
6/29/2025	7/12/2025	7/14/2025	7/25/2025
7/13/2025	7/26/2025	7/28/2025	8/8/2025
7/27/2025	8/9/2025	8/11/2025	8/22/2025
8/10/2025	8/23/2025	8/25/2025	9/5/2025
8/24/2025	9/6/2025	9/8/2025	9/19/2025
9/7/2025	9/20/2025	9/22/2025	10/3/2025
9/21/2025	10/4/2025	10/6/2025	10/17/2025
10/5/2025	10/18/2025	10/20/2025	10/31/2025
10/19/2025	11/1/2025	11/3/2025	11/14/2025
11/2/2025	11/15/2025	11/17/2025	11/26/2025*
11/16/2025	11/29/2025	12/1/2025	12/12/2025
11/30/2025	12/13/2025	12/15/2025	12/24/2025*
12/14/2025	12/27/2025	12/29/2025	1/9/2026
12/28/2025	1/10/2026	1/12/2026	1/23/2026

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