CONSUMER DIRECTED SERVICES
Personal Care Attendant
Employment Application Instructions & Questionnaire

Your application will not be processed if information is missing or incomplete.

- Please use non-erasable blue or black ink only. Do not use white out on the application or other documents.
- Complete the employment application in its entirety. Incomplete applications will not be processed.
- Background screenings are required to be an eligible attendant for the Consumer Directed Services (CDS) program. You must be registered with the Family Care Safety Registry (FCSR) for the screenings. If you are not already registered, you can complete the registration by going to www.health.mo.gov/safety/fcsr/index.php. You will be charged a **nonrefundable one-time fee of $15.55** ($15.00 registration fee & an additional 55¢ processing fee). If you do not have a valid credit/debit card or access to the internet to complete the online registration, include the one-time fee of $15.55 in the form of cash or money order made payable to RAIL and we will complete the registration for you. Fee not required if already registered.
- Bring with you/provide 2 forms of proper and current identification listed on the I-9 List of Acceptable Forms page. **Please make sure that both forms of identification have the same name on them and are unexpired.**
- If a Consumer hires you to work for them as a Personal Care Attendant, you are considered an employee of that Consumer/Employer. You are not an employee of RAIL.
- After the initial application is processed and after a Consumer has hired you, you will have additional forms to complete before you may work. **You will be required to choose to have your earnings deposited into an existing personal account or enroll in the US Bank Focus Card program (please see attached flyer).**

I consent and acknowledge that Rural Advocates for Independent Living (RAIL) will perform a background screening via the Family Care Safety Registry and Office of Inspector General. If I have resided out the of the State of Missouri in the past 5 years, a nationwide screening will also be conducted. Any subsequent screening may result in termination, depending on the results.

If I am unable to complete the online registration with Family Care Safety Registration myself, I will include the above-mentioned fee of $15.55 and give my permission for Rural Advocates for Independent Living (RAIL) to complete it for me.

I verify that I have fully read and understand the conditions described in this letter. I also understand that I am required to complete all employment documentation before I am authorized to work.

Continued ⟶

CONSUMER DIRECTED SERVICES
Personal Care Attendant
Employment Application Instructions & Questionnaire

1.) Your Name (please print): _____

2.) Do you have a potential Employer/CDS Consumer planning to hire you?

☐ **Yes** ☐ **No - If yes,** please provide more information below:

a.) Potential Employer/Consumer Name: _____

b.) Are you related to this Consumer? ☐ **Yes** ☐ **No**

c.) How are you related? I am the Consumer's _____

3.) Please select each county you're currently seeking employment in:

☐ **Please DO NOT SEND my application to other potential Employers/CDS Consumers.**

☐ **Adair**	☐ **Chariton**
☐ **Knox**	☐ **Linn**
☐ **Macon**	☐ **Putnam**
☐ **Schuyler**	☐ **Scotland**
☐ **Shelby**	☐ **Sullivan**

4.) If you only wish to work in a specific town(s), please explain below:

_____

_____ _____

Applicant Signature **Date**

Consumer Directed Services
Employment Application for Personal Care Attendant

Please Print Clearly

Attendant/Employee Name:_____

Complete Address:_____
Street Address City State Zip

Email Address (Required):_____

Telephone Number: (___)_____ Cell ☐ Alternate Number: (___)_____ Cell ☐

Have you lived in any state(s) other than Missouri in the past 5 years? If so, please list them here _____

Are you 18 Years of Age or Older? _____Yes _____No **(State Requirement: Must be able to show proof you are at least 18 years of age and older)**

Do you meet the physical and mental demands required to perform specific tasks of the consumer; agree to maintain confidentiality of personal and medical information; are emotionally mature and dependable; are able to handle emergency situations? _____Yes _____No **(Requirement)**

Are you registered with Family Care Safety Registry? _____Yes _____No

If no, please register using the internet by going to http://health.mo.gov/safety/fcsr/index.php. You will be charged a **nonrefundable $15.55 fee** ($15.00 registration fee & an additional 55¢ processing fee). If you are unable to complete the registration yourself, you may submit the fee of $15.55 to RAIL via cash or money order and we will do so on your behalf. Submission of the fee is considered consent.

Do you have a **valid MO** Driver's License? _____Yes _____ No

Do you have regular access to reliable transportation? _____Yes _____No

Can you read, write and follow directions? _____Yes _____No

Do you prefer working with males, females, or either? _____

What experience do you have caring for children, individuals with chronic illness, or individuals with disabilities? _____

_____

Please list any certifications, professional designations and/or licenses you have: _____

_____

_____

PLEASE COMPLETE THE BACK OF THE FORM →

EMPLOYMENT HISTORY- List the last 5 years of employment with the most recent first. If you were previously an attendant employed by an individual receiving Consumer Directed Services, list them as the Company only if you have received their permission to disclose their name. Failure to complete this page in its entirety may result in your ineligibility to be a Personal Care Attendant.

1) Company Name: _____; Supervisor: _____

Mo/Yr Employed: From_____To_____ Position Held: _____

Complete Address: _____
Street Address City State Zip Code

Phone: _____ Duties: _____

Reason for leaving: _____ May we contact the employer? Yes_____ No _____

2) Company Name: _____; Supervisor: _____

Mo/Yr Employed: From_____To_____ Position Held: _____

Complete Address: _____
Street Address City State Zip Code

Phone: _____ Duties: _____

Reason for leaving: _____ May we contact the employer? Yes_____ No _____

3) Company Name: _____; Supervisor: _____

Mo/Yr Employed: From_____To_____ Position Held: _____

Complete Address: _____
Street Address City State Zip Code

Phone: _____ Duties: _____

Reason for leaving: _____ May we contact the employer? Yes_____ No _____

REFERENCES: List three credible references not related to you.

1) Name:_____Relationship_____Phone # _____

Complete Address: _____
Street Address City State Zip Code

2) Name:_____Relationship_____Phone # _____

Complete Address: _____
Street Address City State Zip Code

3) Name:_____Relationship_____Phone # _____

Complete Address: _____
Street Address City State Zip Code

Acknowledgment:

I certify the answers herein are true and accurate to the best of my knowledge and I hereby authorize performance of pre-employment criminal records checks for employment purposes only. I hereby give consent to performance of closed records checks pursuant to Section 610.120 RSMO. I understand any employment with Consumer(s) is conditioned on my consent to such checks as well as the findings/results of such checks. I hereby release any person or organization such background checks and/or furnishings such criminal record information and Consumer(s) from any and all liability arising out of the conducting of a check or the furnishing or receipt of criminal records information. Any such person or organization may rely on a copy of this release. In the event of employment with Consumer(s), I understand that false or misleading information given on this application or in interview(s) may result in refusal to hire or, if employed, may result in discharge after its discovery.

Signature of Applicant: _____ Date: _____

All qualified applicants will be considered without regard to race, color, gender (sex), religion, veteran status, disability, age, sexual orientation, national origin, ancestry, or any other classification protected by law.

Updated 06/07/2023

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
FAMILY CARE SAFETY REGISTRY

WORKER REGISTRATION

FCSR USE ONLY

Register online at www.health.mo.gov/safety/fcsr OR mail this form, copy of Social Security card, and payment to **Missouri Dept. of Health and Senior Services, Fee Receipts, PO Box 570, Jefferson City, MO 65102.** Register only once!

REGISTRATION TYPE (Check all that apply. Complete column on right only if Long Term Care/Personal Care selected from left.)

- ☐ Adoptive Parent
  Agency Name: _____
- ☐ Child Care
- ☐ Missouri Foster Parent/Family Member of Foster Parent
  Children's Division County Office: _____
- ☐ Hospital
- ☐ Long Term Care/Personal Care (Please choose subcategory at right ▸.)
- ☐ Mental Health/Psychiatric Hospital
- ☐ Voluntary *(Select voluntary if no other registration type applies.)*

A one-time registration fee of **$15.00** applies to all categories except Missouri Foster Parents, who must list the Missouri Children's Division county office.

Have you or an immediate family member ever served in the U.S. Armed Forces? ☐ Yes ☐ No
If Yes, would you like information about military-related services in Missouri? ☐ Yes ☐ No

Long Term Care / Personal Care Subcategories
(Complete if LTC/PC selected at left.)

- ☐ Adult Day Care
- ☐ Assisted Living Facility
- ☐ Hospice
- ☐ Hospital LTAC/Swing Bed
- ☐ Mental Health – Residential Facility/ICF
- ☐ Nursing Facility/Skilled Nursing
- ☐ Personal Care – Home Health
- ☐ Personal Care – In-Home Services
- ☐ Personal Care – Consumer Directed Services/Center for Independent Living
- ☐ Personal Care – HCY/PDW/DDD/Other

SOCIAL SECURITY NUMBER (Mail copy of card with form.)

— —

PERSONAL INFORMATION (Provide all names you have used, starting with most recent. Include legal names and nicknames.)

LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX (JR., SR., II, III)

BIRTH NAME (LIST FULL NAME)	PRIOR NAMES USED (IF APPLICABLE, LIST FIRST AND LAST NAMES.)	DATE OF BIRTH (MM-DD-YYYY)	GENDER ☐ M ☐ F

CONTACT INFORMATION

MAILING ADDRESS (ENTER YOUR STREET ADDRESS OR POST OFFICE BOX. THIS ADDRESS MUST BE DIFFERENT FROM EMPLOYER ADDRESS.)

CITY	STATE	ZIP CODE	COUNTY

TELEPHONE	EMAIL ADDRESS (REQUIRED)	COUNTRY (COMPLETE ONLY IF OUTSIDE U.S.)

EMPLOYER ASSOCIATED WITH THIS REGISTRATION (Complete either left or right column, not both.)

☐ My current/potential child care, long term care or mental health care employer is:

EMPLOYER NAME

EMPLOYER ADDRESS

EMPLOYER CITY	STATE	ZIP

EMPLOYER TELEPHONE	EMPLOYER CONTACT NAME	EMPLOYER CONTACT TITLE

☐ No Employer, because I am a(n):

- ☐ Adoptive Parent
- ☐ Foster Parent/Family Member
- ☐ Home Child Care Provider
- ☐ Private Pay/Private Duty
- ☐ Student
- ☐ Volunteer
- ☐ Other (Explain:_____)

REGISTRATION AGREEMENT

The information provided is complete and accurate to the best of my knowledge. I understand it is unlawful to withhold or falsify information required on this form. I grant my permission for the Missouri Department of Health and Senior Services (DHSS) to obtain any and all background information authorized by law to process this request. Furthermore, I authorize the DHSS to release the fact that I am a registrant in the Family Care Safety Registry (FCSR) and any related background information to the requester of the FCSR for employment purposes only, as provided in §210.921, subsection 1, subdivisions (1) and (2), RSMo. For purposes of the FCSR, "employment purposes" includes direct employer/employee relationships, prospective employer/employee relationships, and screening and interviewing of persons or facilities by those persons contemplating the placement of an individual in a child care, elder care or personal care setting. I understand that if I dispute the information contained in the FCSR I have the right to appeal the accuracy of the transfer of information to the FCSR within thirty (30) days of receiving the results of the background screening.

NOTICE: The FCSR may choose to deposit the check enclosed electronically as an ACH debit entry to my designated bank account. I understand that my signature below authorizes my financial institution to deduct this payment from my account. In the event that DHSS or its subcontractor is unable to secure funds from my account or I provide insufficient or inaccurate information regarding my account, my obligation to the DHSS will remain unpaid and further collection action may be taken by the DHSS or its subcontractor, including, but not limited to, returned check fees.

SIGNATURE OF APPLICANT	DATE OF SIGNATURE (MUST BE WITHIN SIX MONTHS OF SUBMISSION.)

WHAT IS THE FAMILY CARE SAFETY REGISTRY?

The Family Care Safety Registry (FCSR), administered by the Missouri Department of Health and Senior Services (DHSS), provides families and employers with a method to obtain background screening information. The Registry, through various state agencies, offers several resources to screen child care, long term care and mental health workers:

- State criminal history and sex offender registry records maintained by the Missouri State Highway Patrol
- Child abuse/neglect records maintained by the Missouri Department of Social Services
- The Employee Disqualification List maintained by the Missouri Department of Health and Senior Services
- The Employee Disqualification Registry maintained by the Missouri Department of Mental Health
- Child care facility licensing records maintained by the Missouri Department of Elementary and Secondary Education
- Foster parent records maintained by the Missouri Department of Social Services

WHO HAS TO REGISTER?

Any person hired on or after January 1, 2001, as a child care worker or elder care worker, hired on or after January 1, 2002, as a personal care worker, or hired on or after January 1, 2009, as a mental health worker, as provided in §210.906, RSMo, is required to make application for registration in the Family Care Safety Registry within fifteen (15) days of the beginning of employment. **Such person who fails to submit a completed registration form to the DHSS without good cause, as determined by the department, is guilty of a class B misdemeanor.** Employees and volunteers from non-state and/or federally regulated entities are NOT REQUIRED to register with the FCSR.

HOW DO I COMPLETE THE REGISTRATION FORM?

Registration Type – Check at least one box from the left column for type of registration that best describes your worker category. If no other type applies, select "Voluntary." (A "voluntary registrant" is a person who is not mandated to register with the Family Care Safety Registry pursuant to §210.900 et seq., RSMo.) If you checked Long Term Care / Personal Care, please also make one or more selections from the column on the right for subcategory.

Social Security Number – You must provide your Social Security number pursuant to 19CSR 30-80.030(1). This identifying information, including Social Security number, will be used for internal identification purposes and to conduct background screenings for the resource information listed in paragraph one above.

Personal Information – List your current Last Name, First Name, Middle Name, and any suffix associated with your last name. List any other names by which you may have been known, including maiden names, past married names, and nicknames (attach additional sheets if needed). For identification purposes, list your gender and date of birth.

Contact Information – List your address, city, state, ZIP code, and county. Include your telephone number and email address. We will use this information to notify you of registration results and any background screenings conducted. Email notifications will be encrypted for improved security. To reduce postage costs, the Registry may contact you to request a personal email address if one is not provided.

Employer Associated with this Registration - If you are currently employed by or are seeking employment with a child care or long term care provider, please list the facility name, address, telephone number, and contact person. If registration is not for employment purposes, make a selection from column on right. The employer entered in this section will not receive a copy of the registration notification. Employers eligible to use the Registry for caregiver screenings must make a separate request for your background information.

Registration Agreement – Sign and date the registration form. Your signature will authorize the Family Care Safety Registry to conduct the background screening outlined in §210.903.2, RSMo and to provide the information to requesters for employment purposes, as provided in §210.921.1, RSMo.

WHERE DO I SEND MY REGISTRATION FORM?

Send your completed registration form and photocopy of Social Security card and required fee to the **Missouri Department of Health and Senior Services, ATTN: Fee Receipts, P.O. Box 570, Jefferson City, MO 65102.** If you have questions, please call the Registry using the toll-free telephone number, **866-422-6872**.

WHEN WILL I KNOW THE RESULTS OF MY BACKGROUND SCREENING?

After the background screening has been completed, you will be notified in writing of the results that will be recorded in the Family Care Safety Registry. You will also be notified in writing each time background screening information is provided. The notification will contain the name and address of the person who made the request and the background information disclosed. The person making the request will be informed that information will be released for employment purposes only, pursuant to §210.921.1, RSMo. Any person using Registry information for any other purpose is guilty of a class B misdemeanor. In addition, state agencies can request information for licensure or regulatory purposes. Prior to disclosing information, the Registry obtains the name and address of the requester, and determines that the request is for employment or regulatory purposes. To ensure you receive these notifications, it will be important for you to notify the Family Care Safety Registry when you have a change in your contact information. Notify the Family Care Safety Registry of changes in personal or contact information using the toll-free telephone number, 866-422-6872, by email to fcsr@health.mo.gov, or by mail to FCSR, PO Box 570, Jefferson City, MO 65102.

WHAT IF I DON'T AGREE WITH THE RESULTS OF MY BACKGROUND SCREENING?

As provided in §210.912, RSMo, you have the right to appeal the information transferred to the Family Care Safety Registry. Your right to appeal is limited to the accuracy of the transfer of information from the state agency that maintains the background information and does not include a right to appeal the accuracy of the substance of the information transferred. An appeal must be filed in writing to the Office of the Director, Missouri Department of Health and Senior Services, P.O. Box 570, Jefferson City, MO, 65102, within 30 days of receiving the results of the background screening determination. An administrative appeal shall be set within 30 days of the filing of the appeal and a decision shall be made within 60 days. This right to appeal is in addition to any other appeal rights granted by state law.

WHAT INFORMATION WILL BE DISCLOSED BY THE FAMILY CARE SAFETY REGISTRY?

Disclosure of background information on a person registered in the Family Care Safety Registry will be limited. If the person is registered, the Registry worker will disclose whether the person's name is listed in any of the background checks pursuant to §210.903, subsection 2, RSMo, and if so, which one(s). Specific information will be disclosed by the Registry pursuant to §210.921, subsection 1, subdivision (2).

Datasource

Investigative Consumer Report Authorization Document
(Nationwide Background Screening)

By signing below, I authorize Rural Advocates for Independent Living, Inc (RAIL) / CDS Payroll (the "Company") to order consumer reports and investigative consumer reports from Datasource, Inc. ("Datasource"), 1200 NW South Outer Road, Suite 319, Blue Springs, MO 64015, (877) 577-3832, to the extent allowed by law. I understand that, to the extent allowed by law, the Company may rely on this authorization to order additional consumer reports and investigative consumer reports from Datasource without asking me for my authorization again during any period of employment.

For the specific purpose of preparing consumer reports and investigative consumer reports for the Company, and *subject to all laws protecting my privacy*, I authorize the following to disclose to Datasource the information needed to compile the reports: law enforcement and all other federal, state, and local agencies; and all courts.

The below-requested information will be used for background screening purposes only.		
Last Name	First Name	Middle Name
Other Name(s) (Alias) Used		
☐ Check this box if you have **no** middle name **or** initial		
Social Security Number:		
Date of Birth:		
Driver's License Number:		
Current Street Address		Apt.
City	State	Zip
Applicant Signature of Acknowledgement and Authorization:		
Signature:		
Date:		

RAIL
Rural Advocates for Independent Living INC.

CONFIDENTIALITY AGREEMENT

The nature of services provided by RAIL (Rural Advocates for Independent Living) in reference to the Consumer Directed Service (CDS) program and HIPAA requires information to be handled in a private, confidential manner.

Any and all information pertaining to RAIL's CDS consumer(s) that the attendant is working for will **only** be released to people and/or agencies outside of RAIL with written or verbal consent from the consumer(s). Following legal or regulatory guidelines provide the only exceptions to this policy. All reports, memoranda, notes, or other documents pertaining to the consumer(s) are part of the consumer(s) confidential records and as such will not be disclosed to any other agencies or individuals other than those the consumer(s) has provided their consent.

The name, addresses, phone numbers, and any other pertinent information concerning the consumer(s) will only be released to the people authorized by the nature of their duties to receive such information and only with the consent of the consumer(s) (as applicable).

In signing the agreement you are agreeing to this policy and are aware of the fact that any violation of this agreement can lead to fine of up to $250,000 according to HIPAA, or Section 210.150 RSMO.

_____
Attendant Name (Printed)

_____ _____
Attendant Signature Date

Medicaid	Attendant Care Contract
Non-Public Entity OHCDS	Services to be Subcontracted by
Organized Health Care Delivery System	Rural Advocates for Independent Living
Home and Community Based Services	
Request for Proposal	

A. Consumer/Employer's Name: _____

B. Attendant/Employee's Name: _____

ATTENDANT CARE CONTRACT

Read each section thoroughly before signing.

This Attendant Care Contract ("**Contract**") is made by Rural Advocates for Independent Living and the Attendant/Employee identified in line B. above who will be employed by the Consumer/Employer identified in line A. above.

1. Definitions. In order to make this Contract more easily understood, certain terms are defined and various responsibilities are described as follows:
a.) The term **"Consumer/Employer"** means the individual identified in line A. above, who, requires Attendant care services in his/her home. Hereafter, the Consumer/Employer will be referred to as "**Consumer.**" Consumer is the employer of Attendant/Employee and as such is responsible for directing, managing, scheduling (within the parameters of authorized service hours), and supervising Attendant/Employee. Consumer is responsible for maintaining and reviewing all timekeeping records connected with Attendant/Employee's hours of service for accuracy, and Consumer is responsible for promptly forwarding the same to Rural Advocates for Independent Living. Consumer is responsible for keeping the timekeeping records in their home for monitoring purposes until they are mailed or delivered to a Rural Advocates for Independent Living office. Consumer, through the fiscal intermediary, will pay the Attendant/Employee at a rate chosen by Consumer for services authorized in Consumer's Plan of Care and by this Contract.

b.) The term "**Attendant/Employee**" means the individual identified in line B. above, who, as a party to this contract, agrees to provide Attendant care services to Consumer. Hereafter, the Attendant/Employee will be referred to as "**Attendant.**"

c.) The term "**consumer-directed services**" (CDS) means those services that Consumer needs to have provided to him/her within his/her home in order to achieve independent living within the community. Consumer-directed services may include but are not limited to helping Consumer with eating, dressing, meal preparation, toileting, bathing, grooming, transferring, and specific health maintenance tasks, as well as some incidental housekeeping tasks that insure Consumer's health and safety, like grocery shopping and laundry. The consumer-directed services that Attendant will perform pursuant to the CDS program will be described and authorized in the Consumer's Plan of Care.

d.) The term "**Rural Advocates for Independent Living**" means the agency signing this Contract. Hereafter, Rural Advocates for Independent Living will be referred to as "**RAIL.**" It is recognized as a vendor of Consumer Directed Services and enrolled as an Organized Health Care Delivery System with the Department of Health and Senior Services, Division of Senior and Disability Services. RAIL is authorized to provide administrative support to Consumer and is authorized to enter into payroll service contracts with payroll service companies to provide fiscal intermediary services as set forth below.

e.) The term "**fiscal intermediary**" means a payroll service company, under contract with RAIL, retained to perform "**fiscal intermediary services**". These include calculating the amount that an attendant is to be paid by Consumer, writing payroll checks (or making direct deposits), withholding and paying state and federal income taxes to the appropriate authorities, withholding and paying Social Security (FICA) and Medicare payments and/or Consumer's portions as is required by law or regulations and paying them to the appropriate authorities, and making unemployment/workers compensation insurance payments, as well as withholding/paying those amounts as may be required by law or regulations from time-to-time. The fiscal intermediary will provide Attendant with a written summary of all deductions and payments made. The fiscal intermediary will prepare and provide Consumer and Attendant with end-of-year tax information and forms within the time prescribed by law, such as W-2's, so that Consumer and Attendant may comply with all tax filing requirements. The fiscal intermediary will maintain copies of all records required by law or regulations for tax and other purposes, and these shall be the official records documenting the employer/employee (Consumer/Attendant) relationship.

2. Purpose and background information. The purpose of this Contract is to allow the Consumer to interview, hire, direct, manage, schedule (within the parameters of authorized service hours for purposes of the CDS program), supervise, and discharge his/her Attendant. RAIL is a vendor of consumer- directed services and as such it is authorized by the Missouri Department of Health and Senior Services to provide administrative support and case management for consumer-directed services. RAIL may contract with payroll service companies to act as a fiscal intermediary. The fiscal intermediary will act as an agent for and provide payroll services for Consumer, as explained herein.

Consumer will employ Attendant to work in Consumer's home, at the direction and under the supervision of Consumer, to provide the attendant care services described and authorized in Consumer's Plan of Care. Because of the work arrangement contemplated in this contract, Attendant is an employee of Consumer, and not an independent contractor. It is, therefore, necessary that Consumer, through the fiscal intermediary, withhold and pay all income taxes required by law, as well as all other withholdings or payments that employers generally make in connection with employees in order to comply with applicable laws and regulations.

The fiscal intermediary will perform intermediary services as described above and prepare payment for hours worked to Attendant on behalf of Consumer.

3. Basis for payment. Attendant agrees to perform the consumer-directed services described and authorized in Consumer's Plan of Care at an hourly rage chosen by Consumer. Attendant will be paid through a fiscal intermediary only for those consumer-directed services described and authorized in Consumer's Plan of Care for the particular month at issue. Medicaid will provide funds to the fiscal intermediary to pay Attendant on behalf of Consumer for authorized attendant care services actually performed for Consumer.

4. Method of payment. RAIL will provide Consumer with documents authorizing payment on behalf of the Consumer for the consumer-directed services described and authorized in Consumer's Plan of Care. The documents will set forth the maximum number of hours to be worked for purposes of the CDS program during a specific time period; and the applicable time period for performance of the consumer-directed services. RAIL will also provide Consumer with timekeeping forms to record Consumer's name, Attendant's name, dates and times of services delivered, types of activities performed at each visit, Attendant's signature for each visit and Consumer's signature verifying service delivery for each visit.

Payroll will be processed bi-weekly. At the end of each payroll period, Consumer will review and approve the completed and legible timekeeping records (if any) and forward the same to RAIL. Timekeeping records must be received by RAIL the following Monday after the end of a payroll period to be included in the applicable payroll. If RAIL does not receive the timekeeping records within the prescribed time, then payment may not be processed until the next payroll, and Attendant's payment may be delayed.

It is imperative that Consumer and Attendant accurately record and report services and hours. Falsification or misrepresentation on any timekeeping record/document constitutes fraud. Payments made on behalf of Consumer as a result of inaccurate/false documentation will be recouped from Attendant and/or Consumer to the extent permitted under applicable law. Any incidents of apparent fraud will be reported to Medicaid and/or other appropriate authorities.

5. Conditions and understandings of Contract. Attendant understands an investigation to determine if fraud has occurred with respect to timekeeping records related to the CDS program may be performed and agrees to provide any requested assistance with respect to any such investigation. Additionally, as Medicaid funds are used, in whole or in part, to pay Attendant, the Missouri Department of Social Services and the U.S. Department of Health and Human Services, and/or its/their designee(s), have the right to evaluate, through inspection or other means, the consumer-directed services rendered and reimbursed hereunder.

Attendant understands and agrees that he/she is not an employee of RAIL. Attendant will not represent that he/she is an employee of RAIL. Attendant understands and agrees that pursuant to this Contract, he/she is employed solely by Consumer. Attendant understands that, depending on the results of a background check or information revealed on an application, Attendant may not be eligible to provide services and receive payment under the CDS program unless and until Attendant obtains a Good Cause Waiver. Attendant shall not receive any wages through RAIL or a fiscal intermediary on behalf of Consumer for services rendered unless and until they are eligible for employment for purposes of the CDS program. The Attendant shall not hold RAIL or a fiscal intermediary responsible for failing to process or pay any wages on behalf of Consumer for services provided to Consumer prior to fulfilling CDS program pre-employment responsibilities.

6. Liability for work related injury/illness. Attendant understands and agrees that Attendant and/or Consumer is/are solely responsible for any injuries or illness Attendant sustains while providing consumer-directed services and/or acting within the scope of his/her employment, and that neither RAIL nor the State of Missouri has any liability for such injuries or illness.

7. Mandated Reporter. Attendant agrees and understands that he/she is required by law to report suspected abuse, neglect, and/or exploitation as determined under Sections *660.00, 565.188, 208.912, 208.915* and *198.070* RSMo to **MISSOURI RESPONSE SYSTEM, 1-800-392-0210.**

8. Direction and supervision of Consumer. Attendant understands and agrees that he/she will perform the consumer-directed services specified in Consumer's Plan of Care under the direction and supervision of Consumer on such dates and at such times as agreed upon by Attendant and Consumer; however, for purposes of reimbursement through the CDS program, the service time shall not exceed the number of hours authorized for service.

9. Termination. Attendant understands and agrees that he/she is an at-will employee of Consumer and that he/she can resign at any time and Consumer can discharge him/her at any time for no reason or any lawful reason unless Consumer and Attendant separately agree to more limited circumstances and notice requirements under which the employment relationship and this Contract can be terminated. This Contract shall terminate upon the ending of the employment relationship between Consumer and Attendant. Consumer or Attendant shall inform RAIL when Consumer's employment relationship with Attendant has ended.

10. Confidentiality. Attendant understands that Consumer is entitled to have his/her personal and health care information treated with confidentiality. Attendant agrees to protect and maintain Consumer's confidentiality in accordance with HIPAA any other applicable laws. Under no circumstances will Attendant discuss or disclose any Consumer's personal or health care information without legal authorization. Consumer's right to confidential treatment of personal and health care information survives the termination of this Contract.

11. Hospital stays. Should services be provided by Attendant to Consumer during Consumer's hospital stay, Consumer is solely responsible for paying the Attendant and those services shall not be reimbursable on behalf of Consumer through RAIL or a fiscal intermediary. Should an Attendant receive wages during the Consumer's hospital stay through RAIL or a fiscal intermediary on behalf of Consumer, RAIL ***shall exercise*** the legal right to recoup the entire amount to the extent allowed by law as identified by the Department of Health and Senior Services and/or Missouri HealthNet. Additionally, Attendant and Consumer will be referred to the Central Registry Unit and/or Office of Attorney General for an investigation of record falsification.

12. Miscellaneous provisions. This Contract shall be interpreted in accordance with and governed by the laws of the State of Missouri. The place of contract is the county where RAIL has its principle office.

13. Subsequent background screenings. State law mandates an initial background screening for every potential attendant. Additionally, a subsequent background screening is performed upon the attendant's request to work for additional consumers. Depending on the results of a background check or information revealed, Attendant may be ineligible to provide services and receive payment under the CDS program unless and until Attendant obtains a Good Cause Waiver.

The invalidity or unenforceability of any portion or provision of this Contract shall not effect, impair, or render unenforceable any other portion or provision. It is intended that each provision herein that is invalid or unenforceable as written be valid and enforceable to the fullest extent possible.

The captions in this Contract are for convenience only and are not to be construed as substantive parts of this contract.

This contract shall not be modified except in writing signed and dated by all parties.

At the time of termination of this contract, Attendant agrees to promptly provide Consumer with all final timekeeping information so that the last payroll for Attendant may be completed.

14. Signatures. BY SIGNING BELOW YOU ACKNOWLEDGE YOU HAVE READ THIS CONTRACT, YOU ACCEPT IT, UNDERSTAND IT, AND AGREE TO ITS TERMS.

_____ _____

Signature: Employee/Personal Care Attendant **Date**

_____ _____

Witness **Date**

(Attendant/Employee)

Rural Advocates for Independent Living (RAIL)
Consumer Directed Services
Initial/Annual Electronic Visit Verification (EVV) Training

Electronic Visit Verification (EVV) is a system that uses a landline, app or validator to capture clock-ins, clock-outs and task documentation for each consumer/attendant visit. The 21st Century Cures Act requires EVV be used for all Medicaid-funded personal care services. As an attendant/employee of individuals on the Consumer Directed Services program through RAIL, I understand my responsibilities are as follows **(Please initial on the line of each section of this training form):**

1. _____ I have been assigned an Access Code used to identify me in the EVV system. I have also been provided instructions on how to access the EVV system.

2. _____ I will not share my Access Code and/or log in information (used in the app) with anyone. I am the only person allowed to clock myself in and out. Misuse of my Access Code may be reported to Missouri Medicaid Audit and Compliance and other applicable agencies for Medicaid Fraud investigation.

3. _____ I understand the time of day the services are provided to my employer will be recorded by using the EVV system and should accurately document my times worked.

4. _____ I will clock in to begin work using my Access Code and will clock out using my Access Code to document my end time and tasks completed. I am allowed to clock in and out as many times a day as it takes to complete the tasks authorized for that day.

5. _____ I have been given the phone number to dial into the EVV system on my employer's **landline**. That number is **1-833-434-1092 and Agency ID# 21026**. I have also been given information to access the EVV system via an app which uses GPS on my phone.

6. _____ I understand it is mandatory for my employer to notify RAIL within 24 hours of a missed clock in/out. They will need to provide my start time, end time, completed tasks and the reason EVV was not used. Failure to do so may result in me not being paid.

7. _____ I understand that if needed, modifications to my start or end time can be made through the app but require my employer's signature as well as the reason for the modification.

8. _____ I understand the use of the EVV system is Mandatory and frequent missed clock in and/or outs or modifications may require additional training. Additionally, my employer and I may be required to come into the RAIL office and speak with a Supervisor or the Executive Director.

9. _____ I understand if I am having problems using the EVV system, I need to contact RAIL and can leave a voice message after hours.

10. _____ I understand if my employer's landline phone number changes, they will need to notify RAIL or I may not be able to access the EVV system.

11. _____ I understand I need to have completed my work and be clocked out by 11:59 pm each day as a new day starts at midnight.

12. _____ I will only use the hours and tasks authorized on my employer's care plan. I will not make up time without permission of my employer and RAIL.

13. _____ I understand that I cannot be clocked in or paid for doing my own personal tasks, errands or eating. If I need to take a break to smoke, make a phone call, etc., I must first clock out. I can clock back in when I am ready to start working again.

14. _____ I understand that providing transportation for things such as shopping and errands must be listed on my employer's care plan. Additionally, I understand if I provide unapproved transportation services (doctor appointments, social events, Christmas shopping) I will not be paid.

15. _____ I understand RAIL conducts monthly visits with my employer which may be during my work shift. They will document whether or not I was present and verify this in the EVV system.

16. _____ I understand that my employer's Plan of Care can change at any time. It is their responsibility to inform me of any changes.

17. _____ It is not required, but recommended I keep a log of the days and times worked for each RAIL employer as well as a list of tasks completed. This log should be kept in each employer's home.

18. _____ Misuse of my Access Code or log in information, signing my employer's name or any falsification through EVV is considered Medicaid Fraud and will be reported to the Division of Senior and Disability Services, Missouri Medicaid Audit and Compliance, and any other legal entity deemed necessary. Committing fraud may result in me being unable to be an attendant for anyone on the CDS program.

I agree that each section of this training form has been explained and I have received all information listed. By signing this document, I am affirming I have reviewed and understand each section.

_____ _____

Attendant Signature Date

_____ _____

Witness Date

This Organization Participates in E-Verify

Esta Organización Participa en E-Verify

This employer participates in E-Verify and will provide the federal government with your Form I-9 information to confirm that you are authorized to work in the U.S.

If E-Verify cannot confirm that you are authorized to work, this employer is required to give you written instructions and an opportunity to contact Department of Homeland Security (DHS) or Social Security Administration (SSA) so you can begin to resolve the issue before the employer can take any action against you, including terminating your employment.

Employers can only use E-Verify once you have accepted a job offer and completed the Form I-9.

E-Verify Works for Everyone

For more information on E-Verify, or if you believe that your employer has violated its E-Verify responsibilities, please contact DHS.

Este empleador participa en E-Verify y proporcionará al gobierno federal la información de su Formulario I-9 para confirmar que usted está autorizado para trabajar en los EE.UU..

Si E-Verify no puede confirmar que usted está autorizado para trabajar, este empleador está requerido a darle instrucciones por escrito y una oportunidad de contactar al Departamento de Seguridad Nacional (DHS) o a la Administración del Seguro Social (SSA) para que pueda empezar a resolver el problema antes de que el empleador pueda tomar cualquier acción en su contra, incluyendo la terminación de su empleo.

Los empleadores sólo pueden utilizar E-Verify una vez que usted haya aceptado una oferta de trabajo y completado el Formulario I-9.

E-Verify Funciona Para Todos

Para más información sobre E-Verify, o si usted cree que su empleador ha violado sus responsabilidades de E-Verify, por favor contacte a DHS.

888-897-7781

dhs.gov/e-verify

E-VERIFY IS A SERVICE OF DHS AND SSA

English / Spanish Poster

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

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 a nonimmigrant alien authorized to work for a specific employer because of his or her status: **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 alien's nonimmigrant status 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
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

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

Refer to the instructions for more information about acceptable receipts.

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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	Other Last Names Used *(if any)*

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

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear 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.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			**B.** Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

Form **MO W-4**

MISSOURI DEPARTMENT OF REVENUE

Employee's Withholding Certificate

This certificate is for income tax withholding and child support enforcement purposes only. Type or print.

Employee

Full Name		Social Security Number
Home Address (Number and Street or Rural Route)	**City or Town**	**State** / **ZIP Code**

1. Filing Status: Check the appropriate filling status below.
   - ☐ Single or Married Spouse Works or Married Filing Separate
   - ☐ Married (Spouse does not work)
   - ☐ Head of Household

2. Additional withholding: If you expect to have a balance due (as a result of interest income, dividends, income from a part-time job, etc.) on your tax return, you may request your employer to withhold an additional amount of tax from each pay period. To calculate the amount needed, divide the amount of the expected tax by the number of pay periods in a year. Enter the additional amount to be withheld each pay period on line 2. 2

3. Reduced withholding: If you expect to receive a refund (as a result of itemized deductions, modifications or tax credits) on your tax return, you may direct your employer to only withhold the amount indicated on line 3. Your employer will not use the standard calculations for withholding. If you designate an amount that is too low, it could result in you being under withheld. To calculate the amount needed, divide the amount of your expected tax by the number of pay periods in a year. Enter the amount to be withheld instead of the standard calculation. If no amount is indicated on line 3, the standard calculations will be used. 3

4. Exempt Status: Select the appropriate reason you are claiming an exemption from withholding below and indicate EXEMPT on line 4. 4

   - ☐ I am exempt because I had a right to a refund of all Missouri income tax withheld last year and expect to have no tax liability this year. A new MO W-4 must be completed annually if you wish to continue the exemption.
   - ☐ I am exempt because I meet the conditions set forth under the Servicemember Civil Relief Act, as amended by the Military Spouses Residency Relief Act and have no Missouri tax liability.
   - ☐ I am exempt because my income is earned as a member of any active duty component of the Armed Forces of the United States and I am eligible for the military income deduction.

Signature

Under penalties of perjury, I certify that the information provided on this form is true and accurate.

Employee's Signature (Form is not valid unless you sign it)	Date (MM/DD/YYYY)
	__ __ / __ __ / __ __ __ __

Employer

Employer's Name	Employer's Address	
City	**State**	**ZIP Code**
Date Services for Pay First Performed by Employee (MM/DD/YYYY)	**Federal Employer I.D. Number**	**Missouri Tax Identification Number**
__ __ / __ __ / __ __ __ __		

Notice to Employer:
Within 20 days of hiring a new employee, a copy of the Employee's Withholding Certificate (Form MO W-4) must be submitted by one of the following methods:

- **Email:** withholding@dor.mo.gov
- **Fax:** 877-573-6172
- **Mail to:** Missouri Department of Revenue
  P.O. BOX 3340
  Jefferson City, MO 65105-3340

Please visit dss.mo.gov/child-support/employers/new-hire-reporting.htm for additional information regarding new hire reporting.

Notice to Employee:
Return completed form to your Employer. Consider completing a new Form MO W-4 each year and when your personal or financial situation changes. Visit our online withholding calculator mytax.mo.gov/rptp/portal/home/withholding-calculator.

Items to Remember:

- Employees must complete a new form if their filing status changes or to adjust the amount of withholding.
- If you are claiming an "Exempt" status due to the Military Spouses Residency Relief Act you must provide one of the following to your employer: Leave and Earnings Statement of the non-resident military servicemember, Form W-2 issued to the nonresident military servicemember, a military identification card, or specific military orders received by the servicemember. You must also provide verification of residency such as a copy of your state income tax return filed in your state of residence, a property tax receipt from the state of residence, a current drivers license, vehicle registration or voter ID card. For additional assistance in regard to Military, visit the department's website dor.mo.gov/military/.
- Additional information can be found at mo.gov/business/withhold/.

Mail to: Taxation Division
P.O. Box 3340
Jefferson City, MO 65105-3340
Phone: (573) 522-0967
Fax: 877-573-6172

Ever served on active duty in the United States Armed Forces?
If yes, visit dor.mo.gov/military/ to see the services and benefits we offer to all eligible military individuals. A list of all state agency resources and benefits can be found at veteranbenefits.mo.gov/state-benefits/.

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

2023

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, other details, and privacy.

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) Reserved for future use.

(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 . . . . . ☐

TIP: If you have self-employment income, see page 2.

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.

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 2023 if you meet both of the following conditions: you had no federal income tax liability in 2022 **and** you expect to have no federal income tax liability in 2023. You had no federal income tax liability in 2022 if (1) your total tax on line 24 on your 2022 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 2023 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, 2024.

Your privacy. If you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c).

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 income and self-employment taxes through withholding from your wages, you should enter the self-employment income on Step 4(a). Then compute your self-employment tax, divide that tax by the number of pay periods remaining in the year, and include that resulting amount per pay period on Step 4(c). You can also add half of the annual amount of self-employment tax to Step 4(b) as a deduction. To calculate self-employment tax, you generally multiply the self-employment income by 14.13% (this rate is a quick way to figure your self-employment tax and equals the sum of the 12.4% social security tax and the 2.9% Medicare tax multiplied by 0.9235). See Pub. 505 for more information, especially if the sum of self-employment income multiplied by 0.9235 and wages exceeds $160,200 for a given individual.

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.

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 roughly 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 2023 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.

RAIL
Rural Advocates for Independent Living INC.

Consumer Directed Services: Authorization to Release Information

To assist Rural Advocates for Independent Living with reducing fraud, waste and abuse, I hereby give permission to them to access specific employment records from my current employer(s). Records to be disclosed by my employer shall only include those containing my name, hours worked, and time in/time out. All other records are not to be released unless I provide additional written consent prior to the release of requested records. I have listed my current employer(s) below; I assure Rural Advocates for Independent Living that I will update my employment record upon changing employers.

Company Name: _____

Address: _____

Phone: _____

Supervisor: _____

Company Name: _____

Address: _____

Phone: _____

Supervisor: _____

Company Name: _____

Address: _____

Phone: _____

Supervisor: _____

The above Release of Information shall remain in effect for a period of one year beginning _____. All records obtained shall be open to inspection by the State of Missouri and/or its agents or designees.

_____ _____

Employee/Attendant Signature Date

_____

Print Name

Updated 01/13/2021

Payment Authorization Form

Fill out this form and return to your Manager or the Payroll Department. Your U.S. Bank Focus Card will be mailed to the address provided in 7-10 business days or provided to you by your Manager or Payroll Department.

Employee Information

First Name: Last Name:

Address: City:

State: Zip Code: Phone Number[1]:

Email Address[2]: SSN (if required):

Date of Birth: Employee ID (if required):

Two Convenient Options

To receive your pay via direct deposit or to enroll in the Focus Card, please include your bank account information in the section provided below. (You may choose either direct deposit or the Focus Card.) **If choosing direct deposit, please attach a voided check or copy of check here. Do not attach a deposit slip, the routing number is not always correct.**

By selecting the payment method indicated below and signing this document, I authorize my employer to initiate credit entries (deposits or loads) and debit entries and adjustments for any credit entries made in error to the bank account or Focus Card indicated below. This authorization will remain in effect until cancelled by me with written notification to my employer.

Option 1 ☐ Direct Deposit — By choosing traditional direct deposit, your pay will be deposited directly into your checking or savings account each payday. Fill out your account information below:

Bank Name: Account Number:

ABA Routing/Transit #: Type of Account: ☐ Checking ☐ Savings

Option 2 ☐ Focus Card — With the Focus Card, your pay will be deposited onto a prepaid Visa® or Mastercard® card. Your card can be used anywhere Visa or Mastercard debit cards are accepted worldwide. It's not a credit card and there is no cost to enroll. Fees and transaction limits apply. See Cardholder Agreement and Fee Schedule for details.

I acknowledge receipt of the Pre-Acquisition Disclosure, the Fee Schedule, and the Pre-Enrollment Disclosures, as evidenced by my signature below.

Signature: Date:

Important information about procedures for opening a new account

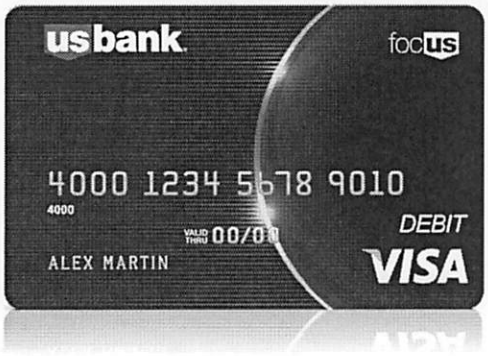
To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. What this means for you: when you open an account, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

[1] By providing us with a telephone number for a cellular phone or other wireless device, including a number that you later convert to a cellular number, you are expressly consenting to receiving communications— including but not limited to prerecorded or artificial voice message calls, text messages, and calls made by an automatic telephone dialing system—from us and our affiliates and agents at that number. This express consent applies to each such telephone number that you provide to us now or in the future and permits such calls for non-marketing purposes. Calls and messages may incur access fees from your cellular provider. [2] By providing your email address on this form, you are not consenting to receive any notifications via email from U.S. Bank. Upon card activation, you may opt in to receive email and text alerts.

usbank

THE U.S. BANK FOCUS CARD™

Product Overview



Easy Sign Up!

$0.00 No cost to sign up.

$0.00 No monthly account maintenance.

No credit check or bank account required.[3]

Card Can Be Used Free And Clear

Purchases:	Free
In-Network ATMs:	Free
Customer Service:	Free

What is the Focus Card?

- A Visa® prepaid card issued by U.S. Bank.
- Payroll is automatically loaded to the card just like direct deposit to a bank account.
- Works like other Visa debit cards to make purchases, pay bills or get cash.
- Can be reloaded with other direct deposits, cash or checks.[1]

Why a Prepaid Card?

Employer Perspective

Issuing paper checks is expensive. Postage, paper, administrative costs, replacement expenses, etc. The Focus Card is a form of direct deposit that allows for greater electronic payments while providing a benefit to employees.

Employee Benefits

Convenient – Allows employees to receive payroll electronically without needing a bank account.

Fast – Funds available the morning of payroll. No waiting for a check.

Safe – Safer than carrying cash. Visa protection if lost or stolen.[2]

Ideal for employees who:

- Don't have or want a bank account
  – or –
- Want a separate account to help with budgeting
- Want access to their money without the hassle of paper checks

For more information regarding the Focus Card Program you can visit www.usbankfocus,com or call Cardholder Services 877-474-0010.

[1] Businesses performing your reload may charge a fee. Cash reload services are provided by unaffiliated third parties. U.S. Bank is not responsible for the product service or performance of the third party including the privacy policy, level of security and terms of use, which are different from ours.

[2] The Visa Zero Liability Policy protects you against unauthorized purchases. U.S.-issued cards only. This does not apply to ATM transactions or to PIN transactions not processed by Visa. You must immediately report any unauthorized use.

[3] Successful identity verification required. To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. If necessary, we may also ask to see your driver's license or other identifying documents.

RAIL Rural Advocates for Independent Living INC.

focus

Features

Add More Money[1]
Cardholders can add other direct deposits, cash or funds from checks to the card.

Account Alerts
Optional alerts by text or email when funds have been deposited to cardholders' accounts or when their balance gets low.

Cash Back Rewards
For purchases at certain restaurants and retail locations.

Savings Account
Cardholders can create an interest-bearing savings account without ever going to a bank.

How Does It Work?

Purchases
The Focus Card can be used anywhere that accepts Visa debit cards. There is no cost to make purchases in stores, over the phone or online.

Getting Cash[4]
ATM – Cardholders can withdraw cash at any Visa/Plus ATM. *(Fees may apply)*

Teller Withdrawal – Cardholders can withdraw up to the penny of their paycheck by asking for a teller cash withdrawal. There is no cost to get a cash withdrawal at the teller of any bank or credit union that accepts Visa.

Cash Back – Cardholders can ask for 'cash back' when they make purchases at places like the grocery store or convenience store. They should select "**DEBIT**" on the authorization machine and select "**YES**" for cash back.

Card Balance
Cardholders can easily check their available balance:

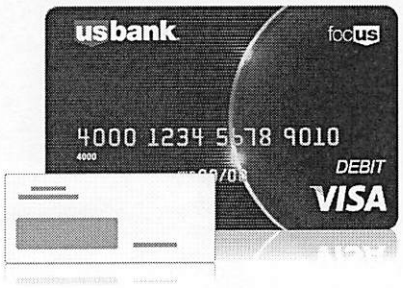
Online – View account online at **www.usbankfocus.com**

Phone – Call Cardholder Services at **877-474-0010**

Mobile App[5] – Search "**U.S. Bank Focus**" for Apple or Android smartphones.

Email/Text[5] – Receive email or text alerts when funds have been deposited to the account or when the balance gets low.

Customer Service
Cardholders must direct all of their Focus Card questions to the Cardholder Services line. They may also utilize the website:
Phone: 877-474-0010 | Online: www.usbankfocus.com



Card Packet

Envelope — For security purposes the card comes in a plain white envelope.

Card Carrier — Provides activation instructions, customer service contact and direct deposit account numbers. The card plastic is attached to the card carrier.

Usage Guide — Instructions on how to use the card.

Cardholder Agreement — Terms and conditions of the card along with the fee schedule.

For more details, cardholders should visit **www.usbankfocus.com**.

[4] Fees may apply to ATM transactions.
[5] U.S. Bank does not charge a fee for mobile banking. Standard messaging and data rates may apply.

RAIL
Rural Advocates for Independent Living INC.

U.S. Bank Focus Card Pre-Acquisition Disclosure
Program Number: 87265212

You have options as to how you receive your payments, including direct deposit to your bank account or this prepaid card. Ask your employer for available options and select your option.

Monthly fee	Per purchase	ATM withdrawal	Cash reload
$0	**$0**	**$0** in-network **$1.75** out-of-network	**$5.95***

ATM Balance Inquiry (in-network or out-of-network)	$0 or $1.00
Customer Service (automated or live agent)	$0 per call
Inactivity (after 90 days with no transactions)	$2.00* per month

We charge 4 other types of fees.

*This fee can be lower or charged differently depending on how and where this card is used and your state of employment or residence.

See the accompanying Fee Schedule for free ways to access your funds and balance information.

No overdraft/credit feature.
Your funds are eligible for FDIC insurance.

For general information about prepaid accounts, visit *cfpb.gov/prepaid.*
Find details and conditions for all fees and services inside the card package or call **1-877-474-0010** or visit **usbankfocus.com**.

CR-21603758

U.S. Bank Focus Card Fee Schedule
Program Number: 87265212

All fees	Amount	Details
Add money		
Check Reload	5% or $5.00 min.	This is not our fee and is subject to change. Fee of up to 5% of check value may apply when cashing a check to load your card at Ingo Money. Money in Minutes - 2% (pre-printed payroll or gov't checks) or 5% (all other checks), minimum $5.00. Money in 10 Days - no fee. Fee is deducted from check value. Go to *ingomoney.com* for more information.
Cash Reload – Visa Readylink	Varies by retailer	Third party fee may apply when reloading your card at a Visa Readylink network. Fee is paid to third party at the time of reload. Go to *usa.visa.com/pay-with-visa/cards/services-locator.html* for locations.
Cash Reload - GreenDot®	$5.95	This is not our fee and is subject to change. Fee of up to $5.95 may apply when reloading your card at GreenDot. Fee is paid to third party at the time of reload. Go to *greendot.com* for more information.
Get cash		
ATM Withdrawal (in-network)	$0	This is our fee per withdrawal. "In-network" refers to the U.S. Bank or MoneyPass® ATM networks. Locations can be found at *usbank.com/locations* or *moneypass.com/atm-locator.html*
ATM Withdrawal (out-of-network)	$1.75	This is our fee per withdrawal. "Out-of-network" refers to all the ATMs outside of the U.S. Bank or MoneyPass ATM networks. You may also be charged a fee by the ATM operator even if you do not complete a transaction.
Teller Cash Withdrawal	$0	This is our fee for when you withdraw cash from your card from a teller at a bank or credit union that accepts Visa®.
Information		
ATM Balance Inquiry (in-network)	$0	This is our fee per inquiry. "In-network" refers to the U.S. Bank or MoneyPass ATM networks. Locations can be found at *usbank.com/locations* or *moneypass.com/atm-locator.html*
ATM Balance Inquiry (out-of-network)	$1.00	This is our fee per inquiry. "Out-of-network" refers to all the ATMs outside of the U.S. Bank or MoneyPass ATM networks. You may also be charged a fee by the ATM operator.
Using your card outside the U.S.		
International Transaction	3%	This is our fee which applies when you use your card for purchases at foreign merchants and for cash withdrawals from foreign ATMs and is a percentage of the transaction dollar amount, after any currency conversion. Some transactions, even if you and/or the merchant or ATM are located in the United States, are considered foreign transactions under the applicable network rules, and we do not control how these merchants, ATMs and transactions are classified for this purpose. For Connecticut, Illinois, New York, and Pennsylvania workers, all international purchase fees are waived.
International ATM Withdrawal	$3.00	This is our fee per withdrawal. You may also be charged a fee by the ATM operator even if you do not complete a transaction.
International ATM Balance Inquiry	$1.00	This is our fee per inquiry. You may also be charged a fee by the ATM operator.
Other		

Card Replacement	$5.00	This is our fee per replacement of your card, whether mailed to you with standard delivery (up to 10 business days) or provided to you by your employer/sponsor. This fee is waived for your first card replacement in a 12-month period. This fee will be charged for each additional replacement during the same 12 months. For Connecticut, Hawaii and Pennsylvania workers, this fee is waived.
Card Replacement Expedited Delivery	$10.00	This is our fee for expedited delivery (up to 3 business days) charged in addition to any Card Replacement fee.
Card Replacement Overnight Delivery	$20.00	This is our fee for overnight delivery charged in addition to any Card Replacement fee.
Inactivity	$2.00	This is our fee charged each month after you have not completed a transaction using your card for 90 consecutive days. For Connecticut, Illinois, and Pennsylvania workers, this fee will be waived for the first 12 months of inactivity (based on cardholder-initiated balance changing transactions). For Texas residents, this fee will not be charged after one year of inactivity. For Minnesota, New York and Montana workers this fee is waived. For Hawaii workers, accounts with a balance of $0.00 and no activity for more than 6 months may be closed.
Other Third-Party Fees	Varies by provider	Some third-party service providers like person-to-person payment services or mobile wallet providers may charge you a fee for using your card to make payments.

Your funds are eligible for FDIC insurance up to $250,000. FDIC insurance protects deposits from loss due to bank insolvency. See *fdic.gov/deposit/deposits/prepaid.html* for details.

No overdraft/credit feature.
Contact Cardholder Services by calling 1-877-474-0010, by mail at P.O. Box 551617, Jacksonville, FL 32255 or visit *usbankfocus.com*.

For general information about prepaid accounts, visit *cfpb.gov/prepaid*. If you have a complaint about a prepaid account, call the Consumer Financial Protection Bureau at 1-855-411-2372 or visit *cfpb.gov/complaint*.

Important information: Fee waivers for workers of a particular state are applied based on information from the sponsoring employer regarding your state of employment.

CR-21603758

State-Specific Pre-Enrollment Disclosure

The following is important information about the U.S. Bank Focus Card program offered by your employer to you. If you are employed in **Connecticut, Hawaii, Illinois, Minnesota, New Hampshire, New York, Pennsylvania, or Vermont**, the following disclosures are applicable. Additionally, please review the U.S. Bank Focus Cardholder Agreement and Fee Schedule provided with this document for a complete list of terms and fees associated with the card.

Payroll Options. You have several options for receiving your pay, including the Focus Card direct deposit to another account, or a check. Use of the Focus Card is voluntary. You are not required to accept your wages on the Focus Card. You may change the method by which you receive your pay at any time. Please see your employer for details.

Access to Your Wages at No Charge. You own wages and other funds loaded to your payroll card. There are several ways to access your pay loaded to the Focus Card without incurring fees. Domestic withdrawals at any in-network ATM, as indicated on your Fee Schedule, are always at no cost. In addition, there is no cost for domestic teller assisted cash withdrawals of up to your full net wages at any bank that is a member of the network indicated on the front of your card (either Visa® or Mastercard®). You also may use your card to make purchases and pay bills wherever Visa or Mastercard cards are accepted, and many merchants provide cash back with purchases without fees. Foreign transactions may carry fees. Please note, there are transaction limits (including limits on withdrawals) on the Focus Card which protect you from potential fraud. In the event your balance exceeds the daily withdrawal limits and you would like to withdraw all your funds, please contact Cardholder Services at 877-474-0010.

Fees. The Focus Card offers many transactions and services at no cost. There are no fees for enrolling and participating in the program, receiving and activating your first payroll card or accessing your wages as specified above. *Some transactions, services and methods of cash access may have fees.* The Fee Schedule provided to you together with this disclosure contains a list of all fees that may be incurred when using your card. Please retain the Fee Schedule so you can refer to it. You may not be charged any fees by the card issuer other than those listed on the Fee Schedule. Your employer may not charge you fees for the payroll card. *Third-parties, like ATM operators and mobile carriers, may charge you additional fees when you use their services.*

How to Access Your Account Balance. You can access your account balance online at www.usbankfocus.com or by calling Cardholder Services at 877-474-0010. You can use these services 24 hours a day, 7 days a week without cost. You also can sign up to receive email or text alerts with information about your account balance. Log into www.usbankfocus.com and select the "ALERTS" option to sign up for these services.

How to Access Transaction Histories. You may view a 12-month history of your payroll card transactions electronically at www.usbankfocus.com. You also may request a 24-month written history, or elect to receive monthly written transaction histories, at no cost, by calling 877-474-0010 or writing us at Focus Card Services, P.O. Box 9127, Minneapolis, MN 55480.

Closing Your Payroll Card Account. You may close your payroll card account by calling Cardholder Services at 877-474-0010. When you close your account, you may request the remaining balance in the Focus Card account be paid to you by check. You will not be charged a fee for closing the account or receiving your balance by check. However, you will be responsible for applicable fees associated with transactions you authorized prior to closing the account.

Link to Credit. There are no overdraft fees associated with the Focus Card, and the card cannot be linked to any type of credit.

Replacement Card Prior to Expiration Date. U.S. Bank will send you a replacement card at no cost before the expiration date listed on your card. Funds loaded to your card do not expire.

Important Information: Fee waivers for workers of a particular state are applied based on information regarding your state of employment received during the registration process. Changes may only be made by your sponsoring employer.

Additional Disclosures Required for Minnesota Employees

Consent. You should receive a copy of the signed written consent from your employer, and the consent must include the terms and conditions of the payroll card account option.

Language Requirements. If your employer offers a payroll card to you using materials in a language other than English, all disclosures, written consent, and payroll card account agreements must be in that other language.

Change in Payment Option. You may request to be paid using another method allowed by law, using a form your employer must provide you. Your employer must begin payment using the new method within 14 days of receiving your request.

Personal Information. Unless you consent in writing, information generated by your possession or use of the Focus Card or card account may only be used to process transactions and administer the card and card account.

Additional Disclosures Required for New Hampshire Employees

Consent. The written consent must include the terms and conditions of the payroll card account option.

Change in Terms. Your employer must provide written notice of any changes to the terms and conditions of the payroll card, including the itemized list of fees, and obtain written assent from you to continue paying your wages to the payroll card after the change. Your employer is responsible for any increase in fees charged to you before written notice of the change is provided to you.