MAKE COPIES FOR EACH NEW EMPLOYEE

MAKE EXTRA COPIES OF TIMESHEETS. YOU WILL NEED 24 TIMESHEETS FOR EACH EMPLOYEE DURING THE YEAR

IMPORTANT

**NO** EMPLOYEE CAN BE HIRED UNTIL CLEARED BY THE CDS OFFICE

**NO** EMPLOYEE CAN BE PAID FOR HOURS WORKED PRIOR TO CLEARANCE BY THE CDS OFFICE

TO CLEAR AN EMPLOYEE TO WORK WE NEED THE DOCUMENTS LISTED ON STEP ONE ON THE NEXT PAGE

PHONE: 866-675-7331 or 210-798-3779, ext. 1691

EMAIL: NewHires@cdsintexas.com

FAX: 877-726-4919 or 210-785-3479
Employee Hiring Checklist

Date: __________

General Information

Employer Name: __________________________
Client(s): __________________________
Applicant: __________________________
Misc: __________________________

All of the employee forms are available on our website at www.cdsintexas.com or call our office to have them mailed, faxed, or emailed to you. The main number is 866-675-7331 or 210-798-3779. The New Hire general mailbox is 1691.

Step One (**Review the list of forms that are required BEFORE your employee can start work)

<table>
<thead>
<tr>
<th>Form</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1725</td>
<td>Criminal History and Registry Check</td>
</tr>
<tr>
<td>1728</td>
<td>Liability Acknowledgement</td>
</tr>
<tr>
<td>1729</td>
<td>Applicant Verification - Includes CPR for CLASS, DBMD, and MDCP</td>
</tr>
<tr>
<td>1734</td>
<td>Certificate of Relationship</td>
</tr>
<tr>
<td>I-9</td>
<td>United States Employment Verification</td>
</tr>
<tr>
<td>W-4</td>
<td>Employee's Pay Check Tax Election Form</td>
</tr>
<tr>
<td>*1747</td>
<td>Any licensed professional: we will need to be able to verify a current license. Nursing, employees cannot begin working until the appropriate Form 1747 is on file. If hiring an LVN include the LVN Supervision form 1747-LVN</td>
</tr>
<tr>
<td>*CPR</td>
<td>This is required for CLASS, DBMD, and MDCP. Must include choking prevention. CLASS and DBMD must be hands on training. MDCP may be online but must include first aid</td>
</tr>
</tbody>
</table>

All Documents Listed Above Must Be Submitted and processed by our office before your employee can start working.

Step Two

<table>
<thead>
<tr>
<th>Form</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1735</td>
<td>CLASS, HCS, DBMD, MDCP, TxHmL, CFC: Make sure you review the section on Form 1735 which explains the requirement for a high school diploma or GED, or if one is lacking, what additional documentation you need to obtain from your employee. Note: you do not need to provide us with this documentation, but you must have it in your personnel files for review by DADS, your case manager, service coordinator or utilization review nurse.</td>
</tr>
</tbody>
</table>

Step Three

Send in the documents listed in Step One. Your HR Coordinator in New Hires will notify you when your employee is cleared to work. If you do not hear within 48 hours, please contact the office. Your paperwork may not have been received. Your employee cannot work until cleared.

***Important

You will first be notified that your employee has or has not passed the background checks. This does not mean they can start work. They must meet all other qualifications before working. If CPR, first aid and choking prevention is a requirement, your employee will not be paid for hours worked prior to receiving those certifications. If you are a new client, your employee cannot be paid for hours worked prior to the authorized start date for your employee.

***We will process the initial documents in Step One within 48 business hours. If you have not heard from us within that time frame please contact our office.

Fax to: 877-726-4919 or 210-785-3479 or Email: NewHires@cdsintexas.com
<table>
<thead>
<tr>
<th>Completed</th>
<th>Form</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1730</td>
<td>Wage and Benefit Plan</td>
</tr>
<tr>
<td></td>
<td>1731</td>
<td>Employee Work Schedule and Assigned Tasks</td>
</tr>
<tr>
<td></td>
<td>1732</td>
<td>Management and Training of Service Provider (Must provide training detail—see extra form)</td>
</tr>
<tr>
<td></td>
<td>1733</td>
<td>Exemption from Nursing License. Review form. Sign top section of page two. If your attendant will be providing any of the services listed under &quot;Examples,&quot; you will need to complete and sign the bottom section of this form.</td>
</tr>
<tr>
<td></td>
<td>1737</td>
<td>Employer and Employee Service Agreement</td>
</tr>
<tr>
<td></td>
<td>1739</td>
<td>Service Provider Agreement</td>
</tr>
<tr>
<td></td>
<td>SPI Form</td>
<td>Service Provider Information on Employment and CDS in Texas</td>
</tr>
<tr>
<td></td>
<td>NHR</td>
<td>Texas Employer New Hire Reporting Form</td>
</tr>
<tr>
<td></td>
<td>DD Form</td>
<td>Direct Deposit or Payday Card—Please choose one method of payment for your employee</td>
</tr>
<tr>
<td></td>
<td>2 Proofs of Residence</td>
<td>For HCS and TxHmL only (Utility bill, lease agreement, voter registration)</td>
</tr>
<tr>
<td></td>
<td>1727</td>
<td>Occupational Exposure to Blood borne Pathogens—(Remains in Employee’s Personnel File)</td>
</tr>
<tr>
<td></td>
<td>1732</td>
<td>EMR Notice to Employee (One copy goes to Employee and one copy for your file)</td>
</tr>
<tr>
<td></td>
<td>Employee Physical Profile (Optional)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skills Competency Checklist (Optional to use with Form 1732)</td>
<td>If used write &quot;See attached detail&quot; in Section II of the Form 1732.</td>
</tr>
</tbody>
</table>

**Step Five**

If this employee will be providing professional services, call your HR Coordinator to find out what additional information may be needed.

<table>
<thead>
<tr>
<th>Completed</th>
<th>Form</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1747</td>
<td>If providing Nursing, an LVN will need to have an RN Supervisor. Form 1747 and/or Form 1747-LVN must be completed and turned in before the first payroll can be processed. The LVN is not eligible to work and cannot be paid for hours worked prior to the RN’s signature date on the Form 1747-LVN. Check with your HR Coordinator to see if you need to have additional nursing documents sent to you, or download them from our website: <a href="http://www.cdsintexas.com">www.cdsintexas.com</a>. <strong>With the exception of the MDCP program, all nursing or professional services (OT, PT, ST) provided must have a plan of care signed by a physician.</strong></td>
</tr>
</tbody>
</table>

**Services that can now be self-directed in many programs include nursing, PT, OT, SP, CRT (Cognitive Rehabilitation Therapy), Employment Assistance, and Supported Employment.** There are special qualifications that must be met for these employment categories. See the appropriate Form 1735 Addendum for a complete list of those services that can be self-directed in your program and for details on employee qualifications.

***Important***

You’ve done 1-5 above. Can your employee start work? If you are new to CDS, be sure to verify that your “start date” with CDS has been approved. You can check with our Intake Coordinator at ext. 1690 or your Service Advisor (general mailbox is ext. 1693). Being qualified to work does not mean that your new employee can start work if your CDS service plan date has not been approved or if the Start of Care date as not been reached.

Fax to: **877-726-4919** or **210-785-3479** or Email: NewHires@cdsintexas.com
Applicant is a person being considered as a service provider (employee or independent contractor [when required]).

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

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

I understand that I must not provide services for payment until the required criminal history and registry checks are conducted, the employer and Financial Management Services Agency (FMSA) review the results and determine that I can be paid for services, and this form is signed by the FMSA.

---

Signature - Applicant

Date

---

Applicant Information Required by the Texas Department of Public Safety (DPS) (Applicant must print.)

Is this a New Employee? ☐  Is this a Re-hire of an old employee? ☐

<table>
<thead>
<tr>
<th>Individual's Name (Last, First, Middle)</th>
<th>Alias</th>
<th>Maiden Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth (mm/dd/yyyy)</th>
<th>Social Security No.</th>
<th>Employee Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

X I request that my FMSA obtain a current Criminal Conviction History Check of the applicant from DPS. I authorize the FMSA to be reimbursed for the cost of obtaining the DPS Criminal Conviction History Check and if I request the report, the cost of sending the report from my budgeted funds.

X I understand that if I request the report, the FMSA must send it to me through a secure method, DPS approved encrypted software or certified mail.

X I understand that all criminal records and reports obtained by my FMSA, and the information they contain, are confidential information.

X I understand all DPS criminal history information reports must be destroyed five days after I make the hiring decision. Paper records need to be shredded, pulped or burned. For electronic records, destroying the media or using specialized software to copy over the data are acceptable methods.

X I understand that sharing of criminal history information with any person or agency may be prosecuted as a Class A Misdemeanor.

---

Signature - Employer

Date

---

Registry Check

X I request that my FMSA obtain the applicant's status with the Employee Misconduct Registry and the Nurse Aide Registry initially and annually.

X I understand that the FMSA will screen the applicant initially and monthly using both the state and federal lists of excluded individuals and entities (LEIE).

X I also understand that the applicant cannot provide services and cannot be paid with program funds until the criminal history and registry checks are completed and my FMSA has notified me that the applicant meets the qualifications.

---

Signature - Employer

Date
I request that the FMSA provide the criminal history to me:
- [ ] Verbally
- [ ] Encrypted email
- [ ] Certified mail (cost will be about $10.00 and will be billed to your budget)

Date

Section III - Criminal Conviction History and Registry Check Results

DPS Criminal Conviction Criminal History Check

<table>
<thead>
<tr>
<th>Date of DPS Check</th>
<th>Time (specify a.m. or p.m.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Obtained By

<table>
<thead>
<tr>
<th>Convictions:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DPS approved dissemination method used to inform employer of results:
- [ ] Verbally
- [ ] Encrypted email
- [ ] Certified mail
- [ ] Did not request report – sent Form 1725

Date disseminated by FMSA:

If yes, does the conviction(s) prohibit service delivery in compliance with Health and Safety Code Chapter 250, §250.006(a), or §250.006(b)?
- [ ] Yes
- [ ] No

Within five calendar days after the hiring decision, the FMSA must destroy the criminal history record information obtained from DPS whether or not hired or retained by the employer or designated representative.

- Date report was destroyed: ____________________________
- Date employer notified FMSA of hiring decision: __________

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

<table>
<thead>
<tr>
<th>Date of Registry Checks</th>
<th>Time (specify a.m. or p.m.)</th>
<th>Obtained By</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Employer</td>
</tr>
</tbody>
</table>

- Employee Misconduct Registry: [ ] No Record
- Nurse Aide Registry: [ ] No Record
- Medicaid Exclusion List: [ ] No Record

Certification - I acknowledge that the applicant's DPS criminal conviction history and registry record were checked. The applicant [ ] is  [ ] is not eligible for hire, to be retained for service delivery based on the checks above.

Signature - FMSA Representative  __________________________

Date FMSA notified the employer or Designated Representative __________

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

INDIVIDUAL’S NAME: ____________________________________________
(Person receiving services)

EMPLOYEE NAME: _____________________________________________
Liability Acknowledgement Between the Employer and the Applicant for Employment

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

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

Employees or service providers are not employed or retained by the Texas Department of Aging and Disability Services (DADS); any other state or federal governmental agency; or by the Financial Management Services Agency (FMSA).

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

---

Signature – Employer
(Must be signed by the employer) Date
Signature – Applicant for Employment Date

Liability Notice to Applicants for Employment

Section I:

The employer:

☐ is a subscriber of Texas Workers' Compensation through the Texas Department of Insurance, Division of Workers' Compensation.

☐ is not a subscriber of Texas Workers' Compensation through the Texas Department of Insurance, Division of Workers' Compensation.

(Employer completes Section II below if this option applies.)

Section II:

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

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

☐ self-insurance;

☐ homeowner's personal liability insurance;

☐ renter's personal liability insurance;

☐ medical coverage insurance;

☐ risk pool insurance;

☐ other: _____________________________

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

Acknowledgement by Employer and Applicant for Employment

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

---

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

**Employment Qualifications**

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

**FMSA Certification**

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

Only applicants who meet all qualifications may be employed.

**Acknowledgement**

The applicant and employer acknowledge that the applicant meets the qualifications for employment and that a copy of this form must be submitted to the FMSA. The FMSA must verify the applicant's qualifications before the employer offers employment to the applicant.
## Service Provider and Employer Certification of Relationship Status for CDS

**Service Provider Name**

**Maiden Name- if applicable**

**Individual Receiving Services**

**Employer Name**

**Service Provider's Relationship to Individual**

**Designated Representative (DR)-if applicable**

**Service Provider's Relationship to Employer**

**Service Provider's Relationship to DR**

### Section 1: All Programs

All service providers must answer the following questions.

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

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

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

### Section 2: Medically Dependent Children Program (MDCP)

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

<table>
<thead>
<tr>
<th>Service Provider Status and Relationship</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are you the parent or primary caregiver of the individual?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Are you the spouse* of the parent or primary caregiver?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Section 3: Home and Community-based Services (HCS) and Texas Home Living (TxHmL)**

If providing CFC PAS/HAB, respite, adaptive aids or behavioral support services in the HCS or TxHmL program, please answer the following additional questions, as applicable. (Mark these items N/A if the individual is not receiving an applicable HCS or TxHmL service.)

<table>
<thead>
<tr>
<th>Service Provider Status and Relationship</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are you a person living in the same household as the individual? (Applies to CFC and respite services.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. Are you the spouse* of a person living in the same household as the individual? (Applies to CFC and respite services.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3. Are you a person related to the individual within the fourth degree of consanguinity or within the second degree of affinity? (Applies to adaptive aids and behavioral support services.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

**Section 4: Community Living Assistance and Support Services (CLASS)-Respite Service Providers Only**

If providing respite services in the CLASS program and the primary caregiver is the Community First Choice (CFC) Personal Assistance Services/Habilitation (PAS/HAB) service provider, please answer the following additional question. (Mark this item N/A if the individual is not receiving CLASS respite services. Also mark this item N/A if the individual is receiving CLASS respite services, but the primary caregiver is not the CFC PAS/HAB service provider.)

<table>
<thead>
<tr>
<th>Service Provider Status and Relationship</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you live in the same household as the individual?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

**Section 5: Primary Home Care (PHC), Community Attendant Services (CAS) and Family Care (FC)**

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

<table>
<thead>
<tr>
<th>Service Provider Status and Relationship</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are you the primary caregiver for the individual?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. Are you the spouse* of the primary caregiver for the individual?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

**Employer and Service Provider Certification**

Employer: Place a check mark to determine eligibility for employment in CDS.

If any item above is marked Yes, the service provider is not eligible to be a paid service provider (employee, contractor or vendor) in the CDS option for this individual. If every item above is marked No or N/A, the service provider meets relationship eligibility for employment in CDS for this individual unless contraindicated by requirements of the individual’s program. (N/A only applies where indicated.) The employer and the service provider certify that the responses are accurate.

Employer check one: The service provider ☐ is or ☐ is not eligible for employment in CDS for this individual.

Printed Employer Name ___________________________ Signature - Employer ___________________________ Date __________

Printed Service Provider Name ___________________________ Signature - Service Provider ___________________________ Date __________

If Application is filled out with assistance of CDS Field Representative, please write in name: ___________________________
**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.)

<table>
<thead>
<tr>
<th>Last Name (Family Name)</th>
<th>First Name (Given Name)</th>
<th>Middle Initial</th>
<th>Other Names Used (if any)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address (Street Number and Name)</td>
<td>Apt. Number</td>
<td>City or Town</td>
<td>State</td>
</tr>
<tr>
<td>Date of Birth (mm/dd/yyyy)</td>
<td>U.S. Social Security Number</td>
<td>E-mail Address</td>
<td>Telephone Number</td>
</tr>
</tbody>
</table>

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):

- [ ] A citizen of the United States
- [ ] A noncitizen national of the United States (See instructions)
- [ ] A lawful permanent resident (Alien Registration Number/USCIS Number): ____________________________
- [ ] An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) ____________________. Some aliens may write "N/A" in this field. (See instructions)

For aliens authorized to work, provide your Alien Registration Number/USCIS Number OR Form I-94 Admission Number:

1. Alien Registration Number/USCIS Number: ____________________________

2. Form I-94 Admission Number: ____________________________

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

- Foreign Passport Number: ____________________________
- Country of Issuance: ____________________________

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (See instructions)

**Preparer and/or Translator Certification** (To be completed and signed if Section 1 is prepared by a person other than the employee.)

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

<table>
<thead>
<tr>
<th>Signature of Preparer or Translator:</th>
<th>Date (mm/dd/yyyy):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name (Family Name)</td>
<td>First Name (Given Name)</td>
</tr>
<tr>
<td>Address (Street Number and Name)</td>
<td>City or Town</td>
</tr>
</tbody>
</table>

**Employer Completes Next Page**
**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 examine a combination of one document from List B and one document from List C as listed on the “Lists of Acceptable Documents” on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

<table>
<thead>
<tr>
<th>List A</th>
<th>OR</th>
<th>List B</th>
<th>AND</th>
<th>List C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identity and Employment Authorization</td>
<td>Document Title:</td>
<td>Document Title:</td>
<td>Document Title:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Issuing Authority:</td>
<td>Issuing Authority:</td>
<td>Issuing Authority:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Document Number:</td>
<td>Document Number:</td>
<td>Document Number:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Expiration Date (if any)(mm/dd/yyyy):</td>
<td>Expiration Date (if any)(mm/dd/yyyy):</td>
<td>Expiration Date (if any)(mm/dd/yyyy):</td>
<td></td>
</tr>
</tbody>
</table>

**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.)

<table>
<thead>
<tr>
<th>Signature of Employer or Authorized Representative</th>
<th>Date (mm/dd/yyyy)</th>
<th>Title of Employer or Authorized Representative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name (Family Name)</td>
<td>First Name (Given Name)</td>
<td>Employer's Business or Organization Name</td>
</tr>
<tr>
<td>Employer's Business or Organization Address</td>
<td>City or Town</td>
<td>State Zip Code</td>
</tr>
</tbody>
</table>

**Section 3. Reverification and Rehires**

(To be completed and signed by employer or authorized representative.)

A. New Name (if applicable) Last Name (Family Name) First Name (Given Name) Middle Initial

B. Date of Rehire (if applicable) (mm/dd/yyyy):

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

<table>
<thead>
<tr>
<th>Document Title:</th>
<th>Document Number:</th>
<th>Expiration Date (if any)(mm/dd/yyyy):</th>
</tr>
</thead>
</table>

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.

<table>
<thead>
<tr>
<th>Signature of Employer or Authorized Representative:</th>
<th>Date (mm/dd/yyyy):</th>
<th>Print Name of Employer or Authorized Representative:</th>
</tr>
</thead>
</table>
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.

<table>
<thead>
<tr>
<th>LIST A</th>
<th>Documents that Establish Both Identity and Employment Authorization</th>
<th>LIST B</th>
<th>Documents that Establish Identity</th>
<th>LIST C</th>
<th>Documents that Establish Employment Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. U.S. Passport or U.S. Passport Card</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1. A Social Security Account Number card, unless the card includes one of the following restrictions:</td>
</tr>
<tr>
<td>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(1) NOT VALID FOR EMPLOYMENT</td>
</tr>
<tr>
<td>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</td>
</tr>
<tr>
<td>4. Employment Authorization Document that contains a photograph (Form I-766)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</td>
</tr>
<tr>
<td>5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. Certification of Birth Abroad issued by the Department of State (Form FS-545)</td>
</tr>
<tr>
<td>a. Foreign passport and</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3. Certification of Report of Birth issued by the Department of State (Form DS-1350)</td>
</tr>
<tr>
<td>b. Form I-94 or Form I-94A that has the following:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal</td>
</tr>
<tr>
<td>(1) The same name as the passport and</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5. Native American tribal document</td>
</tr>
<tr>
<td>(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.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6. U.S. Citizen ID Card (Form I-197)</td>
</tr>
<tr>
<td>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</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7. Identification Card for Use of Resident Citizen in the United States (Form I-179)</td>
</tr>
</tbody>
</table>

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.
Form W-4 (2016)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2016 expires February 15, 2017. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:
• is age 65 or older,
• is blind, or
• Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

Basic instructions. If you are not exempt, complete the Personal Allowances Worksheet below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if:
• you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Income tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the Personal Allowances Worksheet below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2016. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at www.irs.gov/w4.

Personal Allowances Worksheet (Keep for your records.)

A Enter “1” for yourself if no one else can claim you as a dependent.
B Enter “1” if:
C Enter “1” for your spouse. But, you may choose to enter “0-0” if you are married and have either a working spouse or more than one job. (Entering “0-0” may help you avoid having too little tax withheld).
D Enter number of dependents (other than your spouse or yourself) you will claim on your tax return.
E Enter “1” if you will file as head of household on your tax return (see conditions under Head of household above).
F Enter “1” if you have at least $2,000 of child or dependent care expenses for which you plan to claim a credit. (Note: Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)
G Child Tax Credit. (Including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.
H Add lines A through G and enter total here. (Note: This may be different from the number of exemptions you claim on your tax return.)

For accuracy, complete all worksheets that apply.

W-4

Employee's Withholding Allowance Certificate

Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.

OMB No. 1545-0074

2016

Your first name and middle initial

Last name

Your social security number

Home address (number and street or rural route)

City or town, state, and ZIP code

Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)

Additional amount, if any, you want withheld from each paycheck

I claim exemption from withholding for 2016, and I certify that I meet both of the following conditions for exemption.

• Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and

• This year I expect a refund of all federal income tax withheld because I expect to have no tax liability.

If you meet both conditions, write “Exempt” here.

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

Employee’s signature

Date

For Privacy Act and Paperwork Reduction Act Notice, see page 26.
Consumer Directed Services (CDS)

Wage and Benefits Plan - Employee Compensation

<table>
<thead>
<tr>
<th>Service Provider Name</th>
<th>Social Security No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Individual Receiving Services</th>
<th>Employer Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Hire</th>
<th>Initial Wage and Benefit Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plan Change: Effective Date:</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>First Date of Work</th>
<th>Program: Circle one: CLASS, DBMD, HCS, MDCP, PCS, PHC, STAR Kids (PAS or Respite), STAR+PLUS, TxHmL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**COMPENSATION**

Choose from Service categories below at arrow (►)

<table>
<thead>
<tr>
<th>First Service Type</th>
<th>Hourly Wage</th>
<th>Second Service Type</th>
<th>Hourly Wage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NOTICE:** Any employee who works more than 40 hours a week will be paid overtime, following TWC guidelines.


**Benefits:** (Benefits are optional)

Hepatitis B Vaccination (attach completed Form 1727 if vaccination is requested by employee.)

List any other optional benefits here (attach additional sheet if necessary)

**Withholdings:**

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

**Required Garnishments**

<table>
<thead>
<tr>
<th>Type</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Payment to: Frequency:

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

<table>
<thead>
<tr>
<th>Type</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Payment to: Frequency:

**Other:**

Acknowledgement/Agreement:

Time Sheets/Service Delivery Logs must be completed accurately each work shift/day. Payment for services delivered is made from state and/or federal funds. Falsification of a time sheet is considered fraud and is punishable under the law. Accurate, signed timesheets are due the 1st & 16th of the month before 5:00 p.m. Paychecks are distributed by Check for the first pay period and subsequently by direct deposit or paycard at least twice a month according to the posted payday schedule. I agree to receive paychecks by regular 1st class U.S. Mail.

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

Printed Employer Name ___________________________ Signature - Employer ___________________________ Date _____________

Printed Service Provider Name ____________________ Signature - Service Provider _______________________ Date ___________
## Employee Work Schedule and Assigned Tasks

### Purpose of Form:
- Initial
- Change

### Activity Involved:
- Tasks
- Schedule

### Effective Date: ____________________

---

### Schedule I

**LIST WORK SCHEDULE: IT MAY CHANGE WITHOUT NOTICE TO CDS**

<table>
<thead>
<tr>
<th>Day</th>
<th>Time In</th>
<th>Time Out</th>
<th>Time In</th>
<th>Time Out</th>
<th>Total Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sunday</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monday</td>
<td></td>
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<td>Tuesday</td>
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<td>Wednesday</td>
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<td>Friday</td>
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</tr>
<tr>
<td>Saturday</td>
<td></td>
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</tr>
</tbody>
</table>

**Weekly Total Hours**

---

### Schedule I – Tasks

- Check those that apply - refer to your care plan or your Habilitation plan

- Assist with medications
- Bathing
- Grooming
- Toiling
- Personal Hygiene
- Dressing
- Cleaning
- Meal Preparation
- Feeding, Eating
- Laundry
- Assistance with Shopping
- Escort
- Transfer and Ambulation
  (includes positioning, standby assistance, assistance with wheelchair and/or prostheses or braces.)
- Locomotion/Mobility
  (inside or outside)
- Habilitation Training
  (refer to person centered planning or habilitation plan)
- Approved Health Related Tasks
- Other: _________________________
- Other: _________________________

---

### Schedule II

**OPTIONAL**

<table>
<thead>
<tr>
<th>Day</th>
<th>Time In</th>
<th>Time Out</th>
<th>Time In</th>
<th>Time Out</th>
<th>Total Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sunday</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monday</td>
<td></td>
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<td>Tuesday</td>
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<td>Friday</td>
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</tr>
<tr>
<td>Saturday</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

**Weekly Total Hours**

---

### Acknowledgment of Work Schedule and Assigned Tasks – Sign and Date:

Signature – Employer: _________________________  Date: _________________________
Signature – Employee: _________________________  Date: _________________________
**Consumer Directed Services**

**Management and Training of Service Provider**

<table>
<thead>
<tr>
<th>Service Provider Name (Employee)</th>
<th>First Day of Work</th>
<th>Annual Evaluation Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Individual Receiving Services</th>
<th>Program</th>
<th>Services Delivered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Name of Consumer Directed Services Employer | |
|---------------------------------------------| |

I. **Purpose** (Choose one)

- [ ] Initial Orientation  
- [ ] Ongoing Training

- [ ] Evaluation
  - [ ] 30-Day
  - [ ] 3-Month
  - [ ] 6-Month
  - [ ] Annual
  - [ ] Other

- [ ] Supervision
  - [ ] Verbal Warning:  
    - [ ] First
    - [ ] Second
    - [ ] Third
    - [ ] Other
  - [ ] Written Warning:  
    - [ ] First
    - [ ] Second
    - [ ] Third
    - [ ] Other

- [ ] Conflict Resolution  
- [ ] Other

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

   - [ ] Employee oriented to individual’s condition and trained to perform approved tasks.
   - [ ] Employee demonstrated knowledge of individual’s condition, any special needs, and showed competence to perform the approved Tasks.

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

   - [ ] Employee was trained on acts which constitute abuse, neglect, and/or exploitation and understands the responsibility to report instances of ANE and understands actions that will be taken if they are reported to have committed ANE.

IV. **Evaluation/Performance Review:**

V. **Corrective Action Plan (if applicable):**

   - Date for follow-up on corrective action plan: _______________

VI. **Service Provider Comments:** (if any)

   - [ ]

   ________________________________  ________________________________
   Signature of Service Provider  Date

   ________________________________
   Signature of Employer  Date

   ________________________________  ________________________________
   Signature of Witness  Date

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

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

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

Government Code, Title 4, Subtitle I, Chapter 531, Subchapter B, §531.051, Consumer Direction for certain services for persons with disabilities, states the employee must not perform those service that are expressly prohibited from delegation by the Texas Board of Nursing (Texas Administrative Code, §225.12, Tasks Prohibited From Delegation), including:

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

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

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

(9) non-invasive and non-sterile treatments with low risk of infection.

(Signing this section indicates you understand what tasks are exempt from the requirement to have a nursing license.)

Employee:

Employer:

Signed Name

Signed Name

Date

Date

Certification  We, the employee and the employer, certify that the employer has trained and supervised the employee in the delivery of the services listed below. We understand that those services that cannot be provided by anybody except a licensed nurse, according to Texas Administrative Code, §225.12, Tasks Prohibited From Delegation, must not be provided by the employee. Checked tasks indicate the employee may perform those tasks when the LAR is not present to supervise.

If the employee will be doing any of the tasks listed in 1 – 9, fill in those tasks here; otherwise, leave blank.

☐ ☐ ☐

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Employee:

Employer:

Signed Name

Signed Name

Date

Date

NOTE: ONLY FILL IN THE SECOND SECTION ABOVE IF THE EMPLOYEE WILL BE PROVIDING ANY OF THE 9 TYPES OF SERVICE LISTED ON THIS FORM.
Consumer Directed Services

Employer and Employee Service Agreement

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

The Individual's program, after referred to as the "program," is funded and administered by the Texas Department of Aging and Disability Services (DADS). The name of the employer, hereafter referred to as "Employer" is . The Employer is the Individual, parent of a minor or court-appointed guardian of the Individual.

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

The Employer Agrees:

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

The Employee Agrees:

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

Both the Employer and the Employee Agree:

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

7. To bill only for actual time worked, allowable benefits and CDS-related expenses (billing for services and items not allowed or budgeted results in non-payment by the FMSA).

8. The Employer must not charge any fee to the Employee. The Employee must not make any payment to the Employer related to the Employee's employment. Any corrections to payroll are made by the FMSA.

9. That neither the FMSA or DADS is responsible or liable for any negligent acts, work-related injuries or omissions by the Employer, Individual, Employee, other Employees and service providers and/or the Designated Representative, if applicable.

10. That personal medical and personal information and data about the Individual and the Employee is confidential. This information is not to be discussed, directly or indirectly, with others outside of the work environment at any time, currently or in the future.

Duration and Modification of Service Agreement

1. This service agreement will be in effect as of the date this agreement is signed by the Employer and Employee. This service agreement must not precede the date the Individual is eligible to participate in the program or in CDS.

2. This service agreement can be modified by agreement of both parties, unless prohibited by DADS rules or policy, or by applicable state, federal and/or local regulations.

3. This service agreement will terminate when:
   a. the Individual's participation in CDS ends voluntarily or involuntarily;
   b. the individual is no longer eligible for the DADS program or for CDS participation;
   c. the Employee is convicted of a crime or listed on a registry that forbids employment by law;
   d. a relationship change occurs and continued employment is prohibited; or
   e. the Employee fails to maintain and provide documentation of eligibility or qualifications for continued employment.

4. This service agreement may be terminated, without cause, by either party with 14-calendar days written notice. A different time frame may be used if both parties agree in writing.

The following required documents are incorporated by reference:

<table>
<thead>
<tr>
<th>Document</th>
<th>Date of Signature</th>
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</thead>
<tbody>
<tr>
<td>DADS Form 1725, Criminal Conviction History and Registry Checks</td>
<td></td>
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<tr>
<td>DADS Form 1729, Applicant Verification for Employees</td>
<td></td>
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<tr>
<td>DADS Form 1733, Employer and Employee Acknowledgement of Exemption from Nursing Licensure for Certain Services Delivered through Consumer Directed Services, if applicable</td>
<td></td>
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<tr>
<td>DADS Form 1734, Applicant and Employer Certification of Relationship for Employment</td>
<td></td>
</tr>
</tbody>
</table>

Acknowledgement of service agreement, including documents incorporated by reference:

**Employer:**

- Printed Name
- Signature
- Date

**Employee:**

- Printed Name
- Signature
- Date
This agreement is between the Texas Health and Human Services Commission (HHSC), the state Medicaid agency; the Texas Department of Aging and Disability Services (DADS), the state operating agency; a Financial Management Services Agency (FMSA); and a service provider providing services to one or more individuals through the Consumer Directed Services (CDS) Option.

The service provider,  

☐ an individual or

☐ an entity, located at (Address) ,

; Telephone Fax Email:

The service provider agrees to:

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

The FMSA, HHSC and DADS agree:

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

The service provider, FMSA, HHSC and DADS mutually agree that:

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

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

Service Provider or Representative* (Print) Service Provider or Representative* (Signature) Date

FMSA Representative* (Print) FMSA Representative* (Signature) Date

* If the service provider is an entity, a representative from the entity with authorization to negotiate this agreement on behalf of the entity must sign.
Service Provider Information on Employment and CDS in Texas

<table>
<thead>
<tr>
<th>Consumer’s Name - Client</th>
<th>Employer or DR Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDS in Texas. 6243 IH 10 West, Suite 430, San Antonio, Texas 78201</td>
<td>Phone: 877 675 7331</td>
</tr>
</tbody>
</table>

CDS in Texas serves as the vendor fiscal/employer agent for individuals (consumers) who hire their own employees for their Medicaid services. We provide payroll services and deposit and report taxes on behalf of these individuals.

What does a FMSA do that involves a Service Provider?

- FMSAs have the following roles and responsibilities that apply to Service Providers:
  - verify qualifications of applicants before services are delivered;
  - monitor continued eligibility of service providers;
  - ensure all forms are complete for each employer’s service provider before issuing the initial payment for services;
  - manage payroll, including calculations of employee withholdings and employer contributions and depositing these funds with appropriate agencies;
  - comply with applicable government regulations concerning employee withholdings, garnishments, mandated withholdings, and benefits.

What do we want the Employer and Service Provider to know about CDS services?

- We (the FMSA) are NOT your employer. You work for the individual or that person’s legally authorized representative. Questions regarding hours, pay, timesheets, duties, etc. should be directed to your employer.
- We do need your current address, telephone number, and/or email. Notify us in writing of changes by fax to 877 726 4919 or email: New Hires@cdsintexas.com.
- You cannot work until our office has cleared you for employment and the service start date has occurred. If you work prior to either of these days, you will not be paid by our office.
- If the consumer is in the hospital or loses Medicaid, your employer must notify us. We cannot pay for services provided while the consumer is hospitalized or has no Medicaid. If you turn in a timesheet for payment during hospitalization or loss of Medicaid eligibility, that may be considered Medicaid fraud.
- You are not expected to perform tasks that are not directly related to support for the consumer. If you are concerned about the tasks you are asked to perform, please contact us. Examples would be: preparing food for the whole family or cleaning the garage.
- Payroll is issued twice a month. By signing this document, you are agreeing to receive your payroll by direct deposit or pay card and you understand and agree that the initial payrolls may be issued in the form of a check and sent to you by 1st class mail through the U.S. Post Office.
- If you work unauthorized hours, we will not pay for those hours. Your employer will be liable.
- Any over or under payment of payroll will be corrected as soon as possible but no later than the next payroll. You are agreeing to recoupment of overpayments when you sign this document.
- If you are working in a household where there is more than one consumer, you cannot charge twice for hours worked simultaneously.
- You certify your timesheets as true and correct. Record your hours each day and do not sign timesheets until your last shift for that payroll period has been worked. Never sign blank timesheets. Incorrect timesheets may be viewed as Medicaid fraud.
- Information on rules referenced in the Form 1729 can be found at www.dads.state.tx.us.
- Everyone has a responsibility to report abuse, neglect or exploitation (1-800-252-5400).
- Work with your employer until you fully understand what is expected of you and you understand how your employer wants all tasks completed.
- Make sure you understand how your employer wants to be notified if you cannot work a scheduled shift. This is an individual, not an agency, so you should give them time to arrange for back up.

Acknowledged:

____________________________________   ______________________________
Signature of Employer                         Date    Signature of Employee                   Date
## Texas Employer New Hire Reporting Form

Submit within 20 calendar days of new employee’s first day of work to:

ENHR Operations Center, P.O. Box 149224
Austin, TX 78714-9224
Phone: 1-800-850-6442  FAX: 1-800-732-5015
Online: http://employer.oag.state.tx.us

To ensure the highest level of accuracy, please print neatly in capital letters and avoid contact with the edges of the boxes. The following will serve as an example:

A B C 1 2 3

### Employer Information

1. **Federal Employer ID Number (FEIN):**
   - Please use the same FEIN that appears on quarterly wage reports.

2. **State Employer ID Number (Optional):**

3. **Employer Name:**

4. **Employer Address** (Please indicate the address where the Income Withholding Orders should be sent):

5. **Employer City** (if US):

6. **State** (if US):

7. **ZIP Code** (if US):

8. **Province/Region** (if foreign):

9. **Country** (if foreign):

10. **Postal Code** (if foreign):

11. **Employer Telephone** (Optional):

12. **Employer FAX** (Optional):

13. **New Hire Contact Person** (Optional):

### Employee Information

14. **Social Security Number (SSN):**

15. **First Day of Work** (MM/DD/YYYY) (Optional):

16. **Employee First Name:**

17. **Employee Middle Name:**

18. **Employee Last Name:**

19. **Employee Home Address:**

20. **Employee City** (if US):

21. **State** (if US):

22. **ZIP Code** (if US):

23. **Province/Region** (if foreign):

24. **Country** (if foreign):

25. **Postal Code** (if foreign):

26. **State Where Employee Was Hired** (Optional):

27. **Employee DOB** (MM/DD/YYYY) (Optional):

28. **Employee’s Salary** (Dollars and Cents) (Optional):

29. **Salary Frequency** (Check One ONLY) (Optional):
   - Hourly
   - Weekly
   - Biweekly
   - Semi-Monthly
   - Monthly
   - Annually

REV 8/07  ENHR RPT FORM
Direct Deposit Authorization for the CDS Program

INSTRUCTIONS: Please fill in the information requested below

☐ Send a copy of a voided check with this form. If you do not use paper checks, have your financial institution provide you with a form that indicates your bank account and routing numbers. This applies to savings accounts as well. Your direct deposit will not be set up without a copy of a voided check or a form from your financial institution. (THIS INCLUDES RE-LOADABLE CREDIT/DEBIT CARDS)

☐ Fax or mail completed form to FMSA along with the copy of the voided check.

☐ Employees must keep the FMSA informed of any changes to the banking information in order to receive their direct deposit without interruption.

☐ Please allow 2 to 3 payrolls for the direct deposit to take effect.

Employer’s Name________________________________________       Date: _________________________

☐ Initial Setup       ☐ Change       ☐ Cancel

Name of Employee: __________________________________________ Social Security Number: __________________________

Address (Street, Route, P.O. Box): __________________________ Email address: __________________________

City, State, Zip Code ______________________________________ Telephone Number: __________________________

☐ Checking       ☐ Savings       ☐ Re-loadable card

Type of Account: __________________________________________ Employee Account Number: __________________________

Name and Address of Financial Institution/Bank: __________________________ Routing Number: __________________________

FMSA Use: __________________________

I hereby authorize my FMSA to directly deposit my pay in the account listed above. This authorization is to remain in force until the company has received written authorization from me of its termination or change. Also, I grant my FMSA the right to correct my Electronic Funds Transfer resulting from an erroneous overpayment by debiting my account to the extent of such overpayment.

Employee Signature: __________________________ Date: __________________________

PLACE CHECK COPY HERE: ( or attach letter from financial institution)

TEMPORARY CHECKS WITHOUT THE ACCOUNT HOLDERS NAME ARE NOT ACCEPTABLE

DEPOSIT SLIPS ARE NOT ACCEPTABLE

ACCOUNTS IN THE NAME OF THE CLIENT OR EMPLOYER (OR JOINTLY HELD) ARE NOT ACCEPTABLE.

THIS FORM MAY ALSO BE USED FOR YOUR RE-LOADABLE CREDIT OR DEBIT CARD
** SEND COMPLETED FORMS TO YOUR PAYROLL CENTER **

Card Number _____--_____--_____--_____

<table>
<thead>
<tr>
<th>Global Cash Card – Account Owner Information (Please Print Legibly)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First Name:</strong></td>
</tr>
<tr>
<td>Street Address:</td>
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<tr>
<td>City:</td>
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<tr>
<td>Home Telephone: ( )</td>
</tr>
<tr>
<td>Social Security Number: -- --</td>
</tr>
</tbody>
</table>

| **Employee Signature** | **Employee email:** | **Date** |

LOCATION INFORMATION (All fields must be completed by a company representative)

<table>
<thead>
<tr>
<th><strong>Location Name:</strong></th>
<th><strong>Location Number:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Form Completed By:</strong></td>
<td><strong>Telephone Number:</strong></td>
</tr>
</tbody>
</table>

ATTACH COPY OF CARD
Universal Precautions

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

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

Employee Initials:  Date:

Hepatitis B

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

Employee Initials:  Date:

Hepatitis B Vaccination

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

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

Dose 2 is administered 30 days after Dose 1.

Dose 3 is administered five months following Dose 2.

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

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

Employee Initials:  Date:
Informed Choice Related to Hepatitis B Vaccination

**Employee Statement** — Check one statement below.

- [ ] I agree to receive the Hepatitis B vaccination and will be reimbursed by my employer within 30 days of presenting a paid receipt for each dose. I understand that I will only be reimbursed for doses received while employed by the employer.

- [ ] I agree to receive the Hepatitis B vaccination and the employer and I have agreed to the following arrangement(s) related to covering the cost of the vaccination:

- [ ] I decline the Hepatitis B vaccination at this time because I have previously received the Hepatitis B vaccination.

- [ ] I decline the Hepatitis B vaccination.
  
  * I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine at this time. However, I decline the Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Federal Register: 61 FR 5507, February 13, 1996

*OSHA 1910.1030 App A – Mandatory Declination Statement*

**Certification by Employee:**

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

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

**Employee:**

- Printed Name: __________________________
- Signature: __________________________
- Date: __________________________

**Employer:**

- Printed Name: __________________________
- Signature: __________________________
- Date: __________________________
Employee Misconduct Registry Notification

Employee Name:  Date of Hire:  
Position:  Employer Name:  

Consumer Name:  

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

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

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

Rules regarding the EMR can be found on the Secretary of State's website at: http://info.sos.state.tx.us/pls/pub/readtac$ext.ViewTAC?tac_view=4&ti=40&pt=1&ch=93&ri=Y.

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

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

I, have read and understand the above notification.

Signature of Employee  Date
I ___________________________certify that I am able to meet the following physical profile requirements for my position.

(please print name)

Measurement Criteria:

1. Lifting:
   _____ Light (must be able to lift 5-20 pounds).
   _____ Moderate (must be able to lift 20-50 pounds).
   _____ Heavy (must be able to lift weights in excess of 50 pounds).

2. Pushing:
   _____ Light (must be able to push light objects such as an empty wheelchair).
   _____ Moderate (must be able to push objects such as an occupied wheelchair).
   _____ Heavy (must be able to push an occupied motorized wheelchair).

3. Pulling:
   _____ Light (must be able to pull light objects such as an empty wheelchair).
   _____ Moderate (must be able to pull objects such as an occupied wheelchair).
   _____ Heavy (must be able to pull an occupied motorized wheelchair).

4. Mobility:
   _____ No mobility required for this position.
   _____ Moderate mobility.
   _____ Continual mobility.

5. Stair Climbing:
   _____ No climbing.
   _____ Must be able to climb stairs.
   _____ Must be able to climb ladders.
   _____ Must be able to climb ramps.

6. Standing:
   _____ No standing required.
   _____ Short duration (less than 10 minutes without a break).
   _____ Moderate duration (10-30 minutes without a break).
   _____ Continual (more than 30 minutes without a break).

7. Sitting:
   _____ Intermittent sitting.
   _____ Prolonged sitting.

8. Squatting:
   _____ It is not necessary to be able to bend at the knees in order to perform this job.
   _____ It is necessary to be able to bend at the knees in order to perform this job.

9. Stooping:
   _____ Ability to bend at the waist is not necessary in order to perform this job.
   _____ Ability to bend at the waist is necessary in order to perform this job.

10. Reaching:
    _____ No reaching required.
    _____ Must be able to reach above shoulder level.

11. Fine motor skills:
    _____ It is not necessary to have use of fine motor skills in order to perform the job duties.
    _____ It is necessary to have use of fine motor skills in order to perform the job duties.

12. Sight:
    _____ It is not necessary to have vision in order to perform this job.
    _____ It is necessary to have vision in order to perform this job.

13. Communication:
    _____ Not required to communicate with all staff or the general public.
    _____ Must be able to communicate effectively with staff and the public.

15 Other:
    _____ Must be able to provide maximum assistance when transferring patients.
    _____ Other physical specifications required to do this job.

By my signature I certify that I am able to perform the above physical requirements in order to perform my job duties.

Employee Signature: __________________________________________ Date: __________________

Witness Signature: __________________________________________ Date: __________________
<table>
<thead>
<tr>
<th>Date Trained</th>
<th>Date Competency Observed</th>
<th>Skill / Instructions</th>
<th>Initials Trainer</th>
<th>Initials Trainee</th>
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<tr>
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<td>Work Schedule</td>
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<td>Reviewed care plan &amp; person centered planning and/or goals</td>
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<td>Meal Preparation and/or feeding</td>
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<td>Household tasks (laundry, cleaning, etc.)</td>
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<td>Grocery Shopping</td>
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<td>Bathing</td>
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<td>Transfers and Ambulation</td>
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<td>Bed mobility / positioning</td>
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Payroll is on the 11th and 25th of the month unless that date falls on a holiday or weekend in which case it will be the first business day prior to payday.

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Signed timesheets can be scanned and emailed to: cds@cdsintexas.com

All timesheets are due by 5 PM following last day of the pay period. In other words if the last day of payroll is the 15th, timesheets are due by 5 PM on the 16th.

>>> TIMESHEETS ARE DUE ON THE 1ST AND 16th EVEN IF IT IS A WEEKEND OR HOLIDAY - THANKS <<<

PLEASE DO NOT TRY TO CASH YOUR CHECKS EARLY

Our bank receives a list of approved checks on payday. Any checks cashed prior to the actual payroll date will be returned. Your employee will incur expensive bank charges.

PLEASE USE THE FAX NUMBER THAT CORRESPONDS TO CONSUMER’S LAST NAME

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<th>B 877-726-0183</th>
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Alternate numbers: If above numbers are not working: 866 301 1182 or 866 462 6671 or 877 812 3789

New Hire Paperwork & Requests for reimbursement 877 - 726 - 4919 or 210 - 785 - 3479