TEXAS Health and Human Services

Form 1724
August 2015-E

Consumer Directed Services

New Employee Packet Cover Sheet

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

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

Code	Action
☑	Employer checks off each item for the **personnel file** and retains original or copy.
☑	Employer checks each required item when completed and sends original or copy to the FMSA as indicated. Employer retains original or copy.
■	Items the employer is **not** required to send to the FMSA, but which the employer **must** maintain on file in the employee's **personnel file**.

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

TEXAS Health and Human Services

Form 1730
October 2013-E

Consumer Directed Services

Wage and Benefits Plan Employee Compensation

Employee Name *(Last, First, Middle Initial)*		Social Security No.
Date of Hire	First Date of Work	☐ Initial Wage and Benefit Plan ☐ Plan Change – Effective Date:
Name of Program Service Being Provided		

Compensation

Regular Hourly Wage		Calculation of Overtime Hourly Wage				
☐ Employee =		Hourly	+	(50%) =		
☐ Respite =		Hourly	+	(50%) =	$ 0.00	

Benefits *(Optional)*

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

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

Withholdings

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

☐ **Required Garnishments**

Type	Amount
Frequency	Payment To

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

Type	Amount
Frequency	Payment To

☐ **Other** *(Specify)*:

Acknowledgment or Agreement

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

Accurate, signed time sheets are due:

Paychecks are distributed by *(method)*: at least twice a month on

or every other week starting

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

Signature — Employer or Designated Representative	Date	Signature — Employee	Date

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)

EMPLOYMENT APPLICATION

NAME: _____ DATE: _____

STREET ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ SOCIAL SECURITY# _____

HOME PHONE NUMBER: _____ OTHER: _____

Date available for employment: _____

How many hours a week can you work? _____

Are you interested in a live-in position? (If Applicable) ☐ YES ☐ NO

Are you interested in serving as a back-up assistant? ☐ YES ☐ NO

ANSWER THE FOLLOWING QUESTIONS:

1) Why do you want to be a personal assistant?

2) Have you ever been convicted of a crime, plead guilty or no contest to a crime, or received deferred adjudication for any offense? If so, please explain. [A criminal conviction record must be verified before an offer for employment may be made to an applicant.]

3) Do you have a valid Texas driver's license? ☐ YES ☐ NO

4) Are you certified in CPR? ☐ YES, Effective Date: _____ Expires on: _____

☐ NO

CPR Certification is a condition of employment. If you are not certified, are you willing to be certified? ☐ Yes ☐ No

LIST ALL JOBS YOU HAVE HAD BEGINNING WITH THE MOST RECENT;

EMPLOYER'S NAME: _____

DATES OF EMPLOYMENT: _____

EMPLOYER'S ADDRESS: _____

PHONE NUMBER: _____

SUPERVISOR'S NAME: _____

DESCRIPTION OF WORK DUTIES: _____

REASON FOR LEAVING: _____

****

EMPLOYER'S NAME: _____

DATES OF EMPLOYMENT: _____

EMPLOYER'S ADDRESS: _____

PHONE NUMBER: _____ SUPERVISOR'S NAME: _____

DESCRIPTION OF WORK DUTIES: _____

REASON FOR LEAVING: _____

****

EMPLOYER'S NAME: _____

DATES OF EMPLOYMENT: _____

EMPLOYER'S ADDRESS: _____

PHONE NUMBER: _____ SUPERVISOR'S NAME: _____

DESCRIPTION OF WORK DUTIES: _____

REASON FOR LEAVING. _____

****

EMPLOYER'S NAME: _____

DATES OF EMPLOYMENT: _____

EMPLOYER'S ADDRESS _____

PHONE NUMBER: _____ SUPERVISOR'S NAME: _____

DESCRIPTION OF WORK DUTIES: _____

REASON FOR LEAVING _____

****

LIST THREE PERSONAL REFERENCES:

1 _____

(Name) (Address) (Phone Number)

2. _____

(Name) (Address) (Phone Number)

3. _____

(Name) (Address) (Phone Number)

****

What skills or experiences do you have related to being a personal assistant?

Applicant Acknowledgement:

If offered a position, will you be able to be at work on time and according to the schedule discussed? ☐ Yes ☐ No Comments _____

I, the applicant, verify that the *information provided* is *true and correct* to the best of my knowledge. I also acknowledge that a *Criminal Conviction Check is required* and that some convictions prevent employment. I also acknowledge that an employee *must have and maintain current certification in CPR.*

Signature: _____ Date of Signature: _____

Received by: Date:

TEXAS Health and Human Services

Form 1725
March 2023

Consumer Directed Services

Criminal Conviction History and Registry Checks

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

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

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

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

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

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

Individual's Name (Last, First, Middle)	Alias	Maiden Name

Date of Birth (mm/dd/yyyy)	Social Security No.

_____ _____

Signature - Applicant | Date

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

Individual's Name	Employer Name

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

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

_____ _____

Signature - Employer | Date

Registry Check

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

_____ _____

Signature - Employer | Date

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

- ☐ Verbally
- ☐ Encrypted email
- ☐ Certified mail

_____
Date of Employer Request

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

DPS Criminal Conviction Criminal History Check

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

Date of DPS Check	Time (specify a.m. or p.m.)
Obtained By	Convictions: ☐ **Yes** ☐ **No**

DPS approved dissemination method used to inform employer of results:

- ☐ Verbally
- ☐ Encrypted email
- ☐ Certified mail
- ☐ Did not specify method

Date FMSA staff notified employer: _____

FMSA staff:

If yes, does the conviction(s) prohibit service delivery in compliance with Health and Safety Code Chapter 250, Section 250.006(a), or Section 250.006(b)? ..... ☐ 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 **emr.dads.state.tx.us/DadsEMRWeb/**)

Date of Registry Checks	Time (specify a.m. or p.m.)	Obtained By	☐ Employer ☐ FMSA Representative

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

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

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

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

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

_____
Signature - FMSA Representative

_____
Date FMSA notified the employer or Designated Representative

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

DPS Computerized Criminal History (CCH) Verification

(AGENCY COPY)

I, _____ , acknowledge that a Computerized Criminal

APPLICANT or EMPLOYEE NAME (Please print)

History (CCH) check may be performed by accessing the Texas Department of Public Safety Secure Website and may be based on name and DOB identifiers. (This is not a consent form, but serves as information for the applicant.) Authority for this agency to access an individual's criminal history data may be found in Texas Government Code 411; Subchapter F.

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

In order to complete the fingerprint process I must make an appointment with the Fingerprint Applicant Services of Texas (FAST) as instructed online at www.txdps.state.tx.us */Crime Records/Review of Personal Criminal History* or by calling the DPS Program Vendor at 1-888-467-2080, submit a full and complete set of fingerprints, request a copy be sent to the agency listed below, and pay a fee of $25.00 to the fingerprinting services company.

Once this process is completed the information on my fingerprint criminal history record may be discussed with me.

(This copy must remain on file by this agency. Required for future DPS Audits)

_____
Signature of Applicant or Employee (optional)

_____
Date

_____
Agency Name (Please print)

_____
Agency Representative Name (Please print)

_____
Signature of Agency Representative

_____
Date

Please:
Check and Initial each Applicable Space

CCH Report Printed:

YES ☐ NO ☐ _____ initial

Purpose of CCH: _____

Empl ☐ Vol/Contractor ☐ _____ initial

Date Printed:_____ _____ initial

Destroyed Date:_____ _____ initial

Retain in your files

Rev. 09/2015

Figure:1 TAC §55.303(c)(1)(B)

Texas Employer New Hire Reporting Form

Submit within20 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: www.employer.texasattorneygeneral.gov**	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. Date of Hire (MM/DD/YYYY):
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

TEXAS Health and Human Services

Form 1729
March 2023

Consumer Directed Services

Applicant Verification for Employees

Individual's Name

Employer Name

Applicant Name

Applicant Social Security No.

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

Employment Qualifications

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

FMSA Certification

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

Only applicants who meet all qualifications may be employed.

Acknowledgement

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

Signature — Employer | Date | Signature — FMSA | Date

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

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

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:		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**10.** School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

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

Refer to the instructions for more information about acceptable receipts.

TEXAS
Health and Human Services

Form 1733
January 2018-E

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

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

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

Government Code, Title 4, Subtitle I, Chapter 531, Subchapter B, Section 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, Section 225.13,Tasks Prohibited From Delegation),*** including***:***

1. physical, psychological, and social assessment, which requires professional nursing judgment, intervention, referral, or follow-up;
2. formulation of the nursing care plan and evaluation of the client's response to the care rendered;
3. specific tasks involved in the implementation of the care plan that require professional nursing judgment or intervention;
4. he 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 Section 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 Section 225.10(10) of this title (relating to Task That May Be Delegated);
    D. responsibility for receiving or requesting verbal or telephone orders from a physician, dentist, or podiatrist; and
    E. administration of the initial dose of a medication that has not been previously administered to the client.

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

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

Employee:	**Employer:**
Printed Name	**Printed Name**
Date	**Date**
Signature	**Signature**

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, Section 225.13, **Tasks Prohibited From Delegation**, must not be provided by the employee. Checked tasks indicate the employee may perform those tasks when the LAR is not present to supervise.

- ☐ AMINISTER MEDICATION
- ☐ G-TUBE FEEDING
- ☐ THERAPY ROM
- ☐ TRANSFERRING
- ☐ AMBULATION/POSITIONING
- ☐ BOWEL PROGRAM
- ☐ CATHETERIZATION
- ☐ ADMINISTER ENEMAS, SUPPOSITORS
- ☐ MANUAL & DIGITAL STIMULATIONS
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐

TEXAS Health and Human Services

Form 1734
March 2023

Consumer Directed Services (CDS)

Service Provider and Employer Certification of Relationship Status for CDS

Section 1: Basic Information

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

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

Section 2: All Programs

The applicant must answer the following questions.

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

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

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

Section 3: Medically Dependent Children Program (MDCP)

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

	Service Provider Status and Relationship	Yes	No	NA
1.	Are you the parent or primary caregiver of the individual?	☐	☐	☐
2.	Are you the spouse* of the parent or primary caregiver?	☐	☐	☐

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

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

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

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

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

	Applicant Status and Relationship	Yes	No	NA
1.	Do you live in the same household as the individual?	☐	☐	☐

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

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

	Applicant Status and Relationship	Yes	No	NA
1.	Are you the primary caregiver for the individual?	☐	☐	☐
2.	Are you the spouse* of the primary caregiver for the individual?	☐	☐	☐

Employer and Service Provider Applicant Verification

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

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

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

Printed Employer Name	Signature — Employer	Date

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

Printed Service Provider Applicant Name	Signature — Service Provider Applicant	Date

TEXAS Health and Human Services

Form 1739
October 2013-E

Consumer Directed Services

Service Provider Agreement

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

The **service provider,** _____ ☐ an individual or

☐ an entity, located at (Address) _____ ,

_____; Telephone _____ Fax _____

The service provider agrees to:

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

The FMSA and HHSC agree:

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

The service provider, FMSA and HHSC mutually agree that:

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

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

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

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

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

TEXAS Health and Human Services

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

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

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

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

The Employer Agrees:

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

The Employee Agrees:

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

Both the Employer and the Employee Agree:

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

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

Duration and Modification of Service Agreement

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

The following required documents are incorporated by reference:

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

Acknowledgement of service agreement, including documents incorporated by reference:

Employer:

Printed Name

Signature

Date

Employee:

Printed Name

Signature

Date

Consumer Directed Services

Occupational Exposure to Bloodborne Pathogens

Universal Precautions

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

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

Employee Initials: _____ Date: _____

Hepatitis B

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

Employee Initials: _____ Date: _____

Hepatitis B Vaccination

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

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

Dose 2 is administered 30 days after Dose 1.

Dose 3 is administered five months following Dose 2.

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

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

Employee Initials: _____ Date: _____

Informed Choice Related to Hepatitis B Vaccination

Employee Statement – Check one statement below.

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

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

☐ I **decline** the Hepatitis B vaccination at this time because I have previously received the Hepatitis B vaccination.

☐ I **decline** the Hepatitis B vaccination.

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

Federal Register: 61 FR 5507, February 13, 1996
*****OSHA 1910.1030 App A - *Mandatory Declination Statement*

Certification by Employee

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

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

Employee:	**Employer:**
_____ Printed Name	_____ Printed Name
_____ Signature	_____ Signature
_____ Date	_____ Date

TEXAS
Health and Human Services

Form 1728
October 2013-E

Consumer Directed Services

Liability Acknowledgement

Liability Acknowledgement Between the Employer and the Applicant for Employment

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

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

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

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

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

Liability Notice to Applicants for Employment

Section I:

The employer:

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

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

Section II:

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

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

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

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

Acknowledgement by Employer and Applicant for Employment

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

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

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: [Name of employer] _____ does not have workers' compensation insurance coverage. As an employee of a non-covered employer, you are not eligible to receive workers' compensation benefits under the Texas Workers' Compensation Act However, a non-covered (non-subscribing) employer can and may provide other benefits to injured employees. You should contact your employer regarding the availability of other benefits for a work-related injury or occupational disease. In addition, you may have rights under the common law of Texas should you have an on the job injury or occupational disease. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

SAFETY VIOLATIONS HOTLINE: The Division has a 24 hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employers are prohibited by law from suspending, terminating, or discriminating against any employee because he or she in good faith reports an alleged occupational health or safety violation. Contact the Division at 1-800-452-9595.

Job Description

Habilitation Attendant

I. Summary of Position

Working with Participants to help them become as independent as possible.

II. Qualifications

A Is at least 18 years of age
B. Have 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 experience and competence to perform the job tasks that includes: a written competency-based assessment
C. At least three written personal references from persons not related by blood that indicate the ability to provide a safe, healthy environment for the individuals being served
D. Is not the parent of an individual who is under 18 years of age or the spouse of an individual
E. Current CPR certified through American Red Cross or American Heart Association

III. Description of Duties and Responsibilities

A. Working with Participant's schedule
B. Documentation of habilitation work done

The following are based on the Participant's IPP goals:

A Knowledge of the CLASS program
B. Perform personal care tasks as necessary
C. Health related tasks as necessary
D. Food and nutritional assistance as necessary
E. Money management as necessary
F. Household tasks as necessary
G. Community integration assistance as necessary
H. Assistance with personal decision making
I. Assistance with facilitation of self advocacy
J. Assistance with leisure time and recreational activities
K. Follow-up with any therapy goals as directed
L. Any other tasks as dictated by the IPP goals

IV. Performance Requirements

A. Compliance with guidelines of CLASS
B. Current CPR certification

I **have read, understand, and will comply** by **this job description.** I **acknowledge receipt of a copy.**

Employee Signature	Date
Supervisor Signature	Date

Revised 7/2015

TEXAS
Health and Human Services

Form 1731
January 2007-E

Consumer Directed Services

Employee Work Schedule and Assigned Tasks

Employee Name: _____

Purpose of Form:
- ☐ Initial
- ☐ Change

Activity Involved:
- ☐ Tasks
- ☐ Schedule

Effective Date: _____

Schedule I

Day	Time In	Time Out	Time In	Time Out	Time In	Time Out	Total Hours
Sunday							
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							
						Weekly Total Hours	0.00

Schedule I - Tasks

Schedule II

Day	Time In	Time Out	Time In	Time Out	Time In	Time Out	Total Hours
Sunday							
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							
						Weekly Total Hours	0.00

Schedule II - Tasks

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

_____ _____
Signature — Employer Date

_____ _____
Signature — Employee Date

TEXAS Health and Human Services

Form 1732
October 2015-E

Consumer Directed Services

Management and Training of Service Provider

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

I. Purpose

☐ Initial Orientation ☐ Ongoing Training

☐ Evaluation

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

☐ Supervision

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

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

☐ Conflict Resolution ☐ Other _____

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

☐ Hygiene (laying out supplies, Shaving, oral hygiene, washing hair)
☐ Dressing/undressing activities (buttons, socks, shoes, lay out clothes)
☐ Cleaning (general areas, after meal prep, durable equip, Do laundry)
☐ Community outings (accompany on appt, therapeutic activities etc)
☐ Toileting (standby assistance, assist w/urinals, change diapers, etc)
☐ Meal Preparation. Feeding (spoon feed, bottle feed, G-Tube)
☐ Exercise (ROM, going on walks, Therapy follow up, play catch etc)
☐ Transfer & Ambulations. Administer medications.

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

Employee has been instructed to observe and report any abuse, neglect and exploitation of the client.
Employee understands that if they commit any acts of the above offenses, they will be reported and will be placed on the Employee Misconduct Registry and will not be eligible to work in Home Health in any capacity.

IV. Evaluation/Performance Review:

V. Corrective Action Plan (if applicable):

Date for follow-up on corrective action plan: _____

VI. Service Provider Comments:

_____ Signature of Service Provider

_____ Date

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

_____ Signature of Employer

_____ Date

_____ Signature of Witness

_____ Date

Date sent to FMSA: _____

Date received by FMSA: _____

TEXAS Health and Human Services

Form 1732-EMR
October 2014-E

Consumer Directed Services (CDS)

Management and Training of Service Provider Addendum

Employee Misconduct Registry Notification

Employee Name: _____ Date of Hire: _____

Position: _____ Employer Name: _____

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

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

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

Rules regarding the EMR can be found on the Secretary of State's website at:
http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=40&pt=19&ch=711&sch=O&rl=Y.

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

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

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

_____ _____
Signature Date

DIRECT DEPOSIT AUTHORIZATION

I, _____, hereby authorize Touch of Class to
Print Name
begin Direct Deposit of my payroll check to my bank account number

_____at _____ Bank, ABA # _____ .

A voided check is attached for reference.

This authorization remains in effect **until** written notice is given to Touch of Class by me. If my bank account information changes, I will promptly notify Touch of Class so that my payroll check will be deposited into the correct account.

_____ _____

Signature Date

ATTACH VOIDED CHECK HERE:

Please note a deposit ticket will not suffice. Some banks use a different Routing number on deposit tickets than on checks

Touch of Class payroll is paperless. If you request direct deposit, you will not be receiving your stub by mail.

TOUCH OF CLASS NOTICE TO EMPLOYERS SERVICE AGREEMENT

Touch of Class is proud to be a part of the CLASS program through the State of Texas Medicaid Program. We are the Financial Management Agency, (FMSA) that our valued clients have chosen to manage their service funds in the CDS option.

The employer is responsible for reviewing and completing the employee application packet and ensuring that is completed in accordance with the Consumer Directed Service (CDS) rules and regulations. The employer *is* responsible for the employee training, managing the schedules, assigns appropriate tasks and can terminate employees. The employer is to turn in all required paperwork to the FMSA for processing prior to the employee start date to avoid any payroll delays. All employee related issues or concerns should be brought to the employer's attention for resolution.

As the employer, no employee will begin work until Touch of class has given you the approval of the applicant's eligibility for employment. A mandatory criminal background check must be comp!et d prior to the offer of employment.

Touch of Class must have current information on clients and employees always.

Name, Address, and Phone Number

Changes must be made in writing by email or fax

- No employee can begin work without Touch of Class approval.
- " Hours worked prior to approval will not be paid by FMSA. Employer will be responsible.
- Unauthorized hours will be not be paid by FMSA. If worked, Employer will be responsible.
- o No payments will be issued until all required paperwork has been received by Touch of Class.
- o Timesheets are expected on time. Dates are printed on the Touch of Class payroll calendar. Late timesheets will be processed the following payroll.
- q Hours cannot be called in without valid reason and approval.
- Timesheets should be legible with all dates filled in with appropriate payroll dates, hours totaled, and hours indicated as PAS or Respite and both employee and employer must sign.
- e Employees cannot work for the client while they are in the hospital.
- If you are working in a household with more than one client, you cannot charge for the time worked simultaneously.
- CPR must be presented and kept current, copy sent to FMSA. The Employer is responsible to ensure that the CPR is current.

I have read, understand and agree.

Printed Name Employer/DR	Date
Signature Employer/DR	Date

TOUCH OF CLASS APPLICATION PROCESS

Welcome to Touch of Class. We are happy you chose us as your FMSA.

Correct completion of the Application Packet is very important for you and your prospective employee.

Applications will be processed within 48 hours of receipt on regular business days, M-F, 9 am - 4 pm.

1. **AN APPLICANT WILL NOT BE HIRED WITHOUT THE FOLLOWING INTIAL ELIGIBILITY CRITERIA:**
   a. Form 1725, Criminal Conviction History and Registry, FORM DATED SEPTEMBER 2015
   b. Form 1729, Applicant Verification for Employees, providing proof of CPR
   c. Form 1734, Service Provider and Employer Certification of Relationship Status for CDS
   d. Form 1-9, Employment Eligibility Verification. WRITTEN VERIFICATION OF IDENTIFICATION MUST BE FILLED OUT BY THE EMPLOYER AND SIGNED ON PAGE 2. **NO EXCEPTIONS.**
   e. Form 1728, Liability Acknowledgement
   f. (OPTIONAL) Professional license verification (nursing, professional therapies)

2. PLEASE SEND THESE FORMS TO TOUCH OF CLASS WITH A CURRENT WORKING PHONE NUMBER OR E-MAIL AND WE WILL CONTACT YOU ON THE STATUS OF YOUR APPLICATION. ALL FORMS MUST BE COMPLETED AND SIGNED BY BOTH PARTIES.

   AN APPLICANT CANNOT BEGIN WORK UNTIL TOUCH OF CLASS HAS AUTHORIZED THE ELIBIUTY OF THE APPLICANT. THE DATE Of HIRE CAN ONLY OCCUR AFTER THE CRIMINAL BACKGROUND HAS BEEN COMPLETED AND YOU'VE BEEN NOTIFIED.

   No applicant will be paid for hours worked prior to date of hire and notification.

3. ONCE THE APPLICANT JS EMPLOYABLE, THE REMAINDER OF THE MANDATORY COMPLETED PAPERWORK AS LISTED BELOW SHOULD BE SENT TO TOC WITHIN 48 HOURS. PAYROLL WILL NOT BE PROCESSED UNTIL THE REMAINDER OF THE PACKET HAS BEEN RECEIVED.

- Form 1724 which list all paperwork and forms needed
- RS Form **W-4,** Employee's Withholding Allowance Certificate Due on date of hire
- Texas Employer New Hiring Reporting Form (www.employer.texasattorneygeneral.gov)
- Form 1730, Wage and Benefits Plan Employee Compensation
- Form 1731, Employee Work Schedule and Assigned Task5 (Tasks must be filled in)
- form 1737, Employer and Employee Service Agreement
- Form 1727, Occupational Exposure to Bloodborne Pathogens (Acknowledgement; Hepatitis B Vaccination and Universal Precautions)
- Form 1739, Service Provider Agreement
- Form 1732, Management and Training of Service Provider - Initial training must be conducted within 30 days of hire.
- form 1732, Ongoing: - Evaluation, employment status changes; documentation of training, documentation of conflict and Job performance Issues. (The employer must send the original *or* a copy to the FMSA within 30 calendar days of an initial orientation *or* annual evaluation and when an action affects the service provider's continued status with the employer, e.g., termination, change in payment.)
- Form 1732•EMR, Management and Training of Service Provider Addendum - Must be signed by the employee within five days of hire.
- Form 1733, Employer and Employee Acknowledgement of Exemption from Nursing Licensure for Certain Services Delivered through Consumer Directed Services
- TWCC Notice to Employees Concerning Workers' Compensation In Texas (TWC Notice SJ
- Cardiopulmonary resuscitation **(CPR)** certification - Effective at time of service delivery initiation, and maintained. Send copy of card.
- If transporting client: Verification of current Texas Dept. of Public Safety Driver's License and Proof of minimum insurance

I HAVE READ AND UNDERSTAND THIS POLICY

EMPLOYER	DATE	EMPLOYEE	DATE