TEXAS Department of Aging and Disability Services

* SAMPLE *

Form 1724
December 2014-E

Consumer Directed Services

New Employee Packet Cover Sheet

Name of Individual Receiving Services	Employer Name
Client/Consumer Name Here	Employer Name Here
Employee Name	Employee Name Here
Date of Hire	Hire Date
First Day of Work	1st 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			
☐	DADS	☐	**DADS Form 1725,** Criminal Conviction History and Registry Checks
☐	DADS	☐	**DADS Form 1729,** Applicant Verification for Employees; **DADS Form 1734,** Service Provider and Employer Certification of Relationship Status for CDS
☐	USCIS	☐	**USCIS Form I-9,** Employment Eligibility Verification
☐	DADS	☐	**DADS Form 1728,** Liability Acknowledgement
☐	DADS	☐	**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)
☐	DADS	☐	**DADS Form 1730,** Wage and Benefits Plan Employee Compensation, and any court-ordered garnishment(s); **DADS Form 1731,** Employee Work Schedule and Assigned Tasks; **DADS Form 1737,** Employer and Employee Service Agreement; **DADS Form 1739,** Service Provider Agreement
☐	DADS	☐	***CLASS, DBMD and MDCP only:*** **Cardiopulmonary resuscitation (CPR) certification** — Effective at time of service delivery initiation, and maintained. *Verify again before expiration date.*
☐	DADS	■	**Texas Department of Public Safety driver's license** (if transporting client) — *Verify again before expiration date.*
☐	DADS	■	**Proof of minimum auto insurance** (if transporting client)
☐	CDC OSHA	■	**DADS 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)
☐	DADS	☐	***If hiring a nurse:*** **DADS Form 1747,** Acknowledgment of Nursing Requirements
☐	CDS DADS	☐	***If applicable:*** **DADS Form 1733,** Employer and Employee Acknowledgement of Exemption from Nursing Licensure for Certain Services Delivered through Consumer Directed Services
☐	DADS	☐	**DADS 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			
☐	DADS	☐	**DADS 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.)
☐	DADS	☐	**DADS Form 1732-EMR,** Management and Training of Service Provider Addendum — Must be signed by the employee within five days of hire.
☐	DADS	☐	**Time sheets/service logs — DADS 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
DADS	Texas Department of Aging and Disability Services
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)

EMPLOYMENT APPLICATION

NAME: Employee/Applicant Name DATE: mm/DD/YY
STREET ADDRESS: employee address CITY: city
STATE: State ZIP: ZIP code SOCIAL SECURITY #employee social
HOME PHONE NUMBER: phone # OTHER: cell or other #

Date available for employment: mm/DD/YY

How many hours a week can you work? # of hours

Are you interested in a live-in position? (If Applicable) ✓ YES ✓ NO check yes or NO

Are you interested in serving as a back-up assistant? ✓ YES ✓ NO check yes or NO

ANSWER THE FOLLOWING QUESTIONS:

1) Why do you want to be a personal assistant?
your answer goes here

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.]
Answer yes or NO. If yes explain.

3) Do you have a valid Texas driver's license? ✓ YES ✓ NO check yes or NO

CPR Info

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: Most recent employer
DATES OF EMPLOYMENT: mm/DD/YY to mm/DD/YY
EMPLOYER'S ADDRESS Address of most recent job
PHONE NUMBER: phone # SUPERVISOR'S NAME: Name of supervisor
DESCRIPTION OF WORK DUTIES: List duties of most recent job
REASON FOR LEAVING reason for leaving most recent job

****

EMPLOYER'S NAME: Previous Employer
DATES OF EMPLOYMENT: mm/DD/YY to mm/DD/YY
EMPLOYER'S ADDRESS work address
PHONE NUMBER: phone # SUPERVISOR'S NAME: Name of supervisor
DESCRIPTION OF WORK DUTIES: list duties
REASON FOR LEAVING reason for leaving

****

Employment Application / Page 2 of 2 **Applicant Name:** Name Here

EMPLOYER'S NAME: Previous Employer
DATES OF EMPLOYMENT: mm/DD/yy to mm/DD/yy
EMPLOYER'S ADDRESS work address
PHONE NUMBER: phone # SUPERVISOR'S NAME: Name of supervisor
DESCRIPTION OF WORK DUTIES: list of duties
REASON FOR LEAVING reason for leaving

****

EMPLOYER'S NAME: Previous Employer
DATES OF EMPLOYMENT: mm/DD/yy to mm/DD/yy
EMPLOYER'S ADDRESS Work address
PHONE NUMBER: phone # SUPERVISOR'S NAME: Name of Supervisor
DESCRIPTION OF WORK DUTIES: list of duties
REASON FOR LEAVING reason for leaving

****

LIST THREE PERSONAL REFERENCES:

1 Reference Name Reference Address Reference phone#
(Name) (Address) (Phone Number)

2. Reference Name Reference Address Reference phone#
(Name) (Address) (Phone Number)

3. Reference Name Reference Address Reference Phone #
(Name) (Address) (Phone Number)

****

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

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 your comments here
check yes or NO

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: Employee/Applicant Signs Date of Signature: mm/DD/yy

Received by: _____ Date: _____

Texas Department of Aging and Disability Services

Consumer Directed Services

Criminal Conviction History and Registry Checks

Form 1725
July 2013-E

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) Employee Name Here, 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.

Employee Signs here
Signature - Applicant

mm/DD/YY
Date

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

Individual's Name (Last, First, Middle) Employee Last Name, Employee First Name, Employee Middle Name	
Alias	Maiden Name Employee Maiden Name
Date of Birth (mm/dd/yyyy) Employee DOB mm/DD/YY	Social Security No. Employee SSN ###-##-####

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

Individual's Name Clients Name Here	Employer Name Employer's Name Here

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.

Employer Signs Here
Signature - Employer

mm/DD/YY
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.

Employer Signs Here
Signature - Employer

mm/DD/YY
Date

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

- ☐ Verbally
- ☐ Encrypted email
- ☐ Certified mail

mm/dd/yy
Date

Section III - Criminal Conviction History and Registry Check Results

DPS Criminal Conviction Criminal History Check

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 request report – sent Form 1725

Date FMSA staff notified employer: _____

FMSA staff:

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 (Call 1-800-452-3934)

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 Keeps the Original of this Form and Employer Must Keep a Copy of this Form.

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

Employee Print info (All CAPS)

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

TEXAS
Department of Aging and Disability Services

Form 1729
November 2014-E

Consumer Directed Services

Applicant Verification for Employees

Individual's Name	Employer Name
Client/Consumer Name Here	Employer Name Here
Applicant Name	**Applicant Social Security Number**
Employee Name Here	123-456-789

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

Employer Verifies

- ☐ 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) certification (applies to Community Living Assistance and Support Services [CLASS], Deaf Blind with Multiple Disabilities [DBMD], and Medically Dependent Children Program [MDCP] only).

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.

Employer Signs	mm/dd/yy		
Signature — Employer	Date	Signature — FMSA	Date

Form W-4 (2007)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Because your tax situation may change, you may want to refigure your withholding each year.

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 2007 expires February 16, 2008. See Pub. 505, Tax Withholding and Estimated Tax.

Note. You cannot claim exemption from withholding if (a) your income exceeds $850 and includes more than $300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on their tax return.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earner/multiple job situations. Complete all worksheets that apply. However, you may claim fewer (or zero) allowances.

Head of household. Generally, you may 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.

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. 919, How Do I Adjust My Tax Withholding, 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. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners/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.

Nonresident alien. If you are a nonresident alien, see the Instructions for Form 8233 before completing this Form W-4.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the dollar amount you are having withheld compares to your projected total tax for 2007. See Pub. 919, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Personal Allowances Worksheet (Keep for your records.)

Employee Fills Out

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A ____
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,000 or less.	B ____
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C ____
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	D ____
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	E ____
F	Enter "1" if you have at least $1,500 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.)	F ____
G	**Child Tax Credit** (including additional child tax credit). See Pub 972, Child Tax Credit, for more information. • If your total income will be less than $57,000 ($85,000 if married), enter "2" for each eligible child. • If your total income will be between $57,000 and $84,000 ($85,000 and $119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have 4 or more eligible children.	G ____
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.) ▶	H ____

For accuracy, complete all worksheets that apply.

- If you plan to **itemize or claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $40,000 ($25,000 if married) see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

Cut here and give Form W-4 to your employer. Keep the top part for your records.

Form **W-4** — Department of the Treasury, Internal Revenue Service

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

2007

1 Type or print your first name and middle initial: First Name Middle Initial — Last name: Employee last Name

2 Your social security number: ### ## ####

Home address (number and street or rural route): Employee Address

City or town, state, and ZIP code: Employee Address

3 ☑ Single ☑ Married ☑ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box. ← check one

4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ▶ ☐

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	5
6	Additional amount, if any, you want withheld from each paycheck	6 $
7	I claim exemption from withholding for 2007, 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 ▶	7

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 (Form is not valid unless you sign it.) ▶ employee signs here — **Date** ▶ MM/DD/YY

8	Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

▶START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire 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 Names Used *(if any)*
Employee Last Name	First Name	Middle ini	

Address *(Street Number and Name)*	Apt. Number	City or Town	State	Zip Code
Employee Address	Apt #	City	TX	#####

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

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):

select one

- ☑ A citizen of the United States
- ☑ A noncitizen national of the United States *(See instructions)*
- ☑ A lawful permanent resident (Alien Registration Number/USCIS Number): 1234567890
- ☐ 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: 1234567 8

OR

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*)

3-D Barcode
Do Not Write in This Space

Signature of Employee: Employee signature	Date *(mm/dd/yyyy)*: mm/dd/yy

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.

Signature of Preparer or Translator:			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 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.)

Employee Last Name, First Name and Middle Initial from Section 1:

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title:		Document Title: TX Drivers License/ID		Document Title: Social Security card
Issuing Authority:		Issuing Authority: TXDPS		Issuing Authority: SS Administration
Document Number:		Document Number: 123456789		Document Number: 123-45-6789
Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*: 01/01/2017		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)*:				

3-D Barcode
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	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
Employer Sign	mm/DD/YY	Employer Name HERE

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

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:	Date *(mm/dd/yyyy)*:	Print Name of Employer or Authorized Representative:

* Please include a copy of drivers license/ID, social security card, & CPR card w/ packet

LISTS OF ACCEPTABLE DOCUMENTS

LIST A

Documents that Establish Both Identity and Employment Eligibility

1. U.S. Passport (unexpired or expired)
2. Certificate of U.S. Citizenship *(INS Form N-560 or N-561)*
3. Certificate of Naturalization *(INS Form N-550 or N-570)*
4. Unexpired foreign passport, with *I-551 stamp or* attached *INS Form I-94* indicating unexpired employment authorization
5. Permanent Resident Card or Alien Registration Receipt Card with photograph *(INS Form I-151 or I-551)*
6. Unexpired Temporary Resident Card *(INS Form I-688)*
7. Unexpired Employment Authorization Card *(INS Form I-688A)*
8. Unexpired Reentry Permit *(INS Form I-327)*
9. Unexpired Refugee Travel Document *(INS Form I-571)*
10. Unexpired Employment Authorization Document issued by the INS which contains a photograph *(INS Form I-688B)*

OR

LIST B

Documents that Establish Identity

1. Driver's license or ID card issued by a state or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color and address
2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color and address
3. School ID card with a photograph
4. Voter's registration card
5. U.S. Military card or draft record
6. Military dependent's ID card
7. U.S. Coast Guard Merchant Mariner Card
8. Native American tribal document
9. Driver's license issued by a Canadian government authority

For persons under age 18 who are unable to present a document listed above:

10. School record or report card
11. Clinic, doctor or hospital record
12. Day-care or nursery school record

AND

LIST C

Documents that Establish Employment Eligibility

1. U.S. social security card issued by the Social Security Administration *(other than a card stating it is not valid for employment)*
2. Certification of Birth Abroad issued by the Department of State *(Form FS-545 or Form DS-1350)*
3. Original or certified copy of a birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official seal
4. Native American tribal document
5. U.S. Citizen ID Card *(INS Form I-197)*
6. ID Card for use of Resident Citizen in the United States *(INS Form I-179)*
7. Unexpired employment authorization document issued by the INS *(other than those listed under List A)*

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

Texas Department of Aging and Disability Services

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

Form 1733
August 2006

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.

The following text is from the Government Code, Title 4, Subtitle I, Chapter 531, Subchapter B, §531.051, Voucher program for payment of certain services for persons with disabilities, states the types of services

that may be delivered are:

(1) bathing, including feminine hygiene;
(2) grooming, including nail care, except for clients 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;
(7) the administering of a bowel and bladder program, including suppositories, catheterization, enemas, manual evacuation, and digital stimulation; and
(8) administering oral medications that are normally self-administered, including administration through a gastrostomy tube.

Acknowledgement – I acknowledge that I, the employee, have read and understand the above information. I understand that the employer may train and supervise me in the delivery of the services listed above without the involvement of a licensed nurse.

Employee:

Employee Name Here
Printed Name

employee signs Here
Signature

mm/DD/YY
Date

Employer:

Employer Name Here
Printed Name

employer signs Here
Signature

mm/DD/YY
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 other nursing service must not be provided by the employee. Checked tasks indicate the employee may perform those tasks when the LAR is not present to supervise.

example

☑ administer Medication	☑ exercising	☐
☑ bathing	☑ bowel/bladder program	☐
☑ grooming	☐	☐
☑ feeding / tube feeding	☐	☐
☑ transferring	☐	☐

Employee:

employee signs here
Signature

mm/DD/YY
Date

Employer:

employer signs here
Signature

mm/DD/YY
Date

TEXAS
Department of Aging
and Disability Services

Form 1734
November 2014-E

Consumer Directed Services (CDS)

Service Provider and Employer Certification of Relationship Status for CDS

Service Provider Name: Employee Name Here	Maiden Name — if applicable: Employee Maiden Name
Individual Receiving Services: Client/Consumer Name Here	Employer Name: Employer Name Here
Service Provider's Relationship to Individual: Employee's relationship to client	Designated Representative (DR) — if applicable: Designated Representative
Service Provider's Relationship to Employer: Employee's relationship to Employer	Service Provider's Relationship to DR: Employee's relationship to DR

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

Section 1: All Programs

All service providers must answer the following questions.

*please ✓ one

	Service Provider Status and Relationship	Yes	No	N/A
1.	Are you under age 18?	☐	☐	
2.	Are you the individual's legally authorized representative (LAR)? (That is, the individual's natural parent, legal/adopted parent, stepparent or managing conservator if the individual is under age 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/adopted parent, stepparent or managing conservator if the individual is under age 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? (CMPAS providers should mark this item N/A.)**	☐	☐	☐
5.	Are you the spouse* of the employer? (CMPAS providers should mark this item N/A.)**	☐	☐	☐
6.	If the individual is a Texas Department of Family and Protective Services (DFPS) foster child or adult, are you the individual's foster parent? (If the individual is not with DFPS, mark this item N/A.)	☐	☐	☐
7.	If the individual is a DFPS foster child or adult, are you the spouse* of the individual's foster parent? (If the individual is not with DFPS, mark this item N/A.)	☐	☐	☐
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 for the individual or the employer for CDS?	☐	☐	
10.	Are you the spouse* of the employer's DR?	☐	☐	

Must be No or N/A

* **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 Consumer Managed Personal Attendant Services (CMPAS). (The spouse may be employed.)

Section 2: Medically Dependent Children Program (MDCP) – only MDCP Providers

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.)

No or N/A

	Service Provider Status and Relationship	Yes	No	N/A
1.	Are you the parent or primary caregiver of the individual under age 18?	☐	☐	☐
2.	Are you the spouse* of the parent or primary caregiver?	☐	☐	☐

Section 3: Home and Community-based Services (HCS) and Texas Home Living (TxHmL)

If providing supported home living, community support, 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.)

	Service Provider Status and Relationship	Yes	No	N/A
1.	Are you a person living in the same household as the individual? (Applies to supported home living, community support and respite services.)	☐	☐	☐
2.	Are you the spouse* of a person living in the same household as the individual? (Applies to supported home living, community support and respite services.)	☐	☐	☐
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.)	☐	☐	☐

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 habilitation 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 habilitation service provider.)

	Service Provider Status and Relationship	Yes	No	N/A
1.	Do you live in the same household as the individual?	☐	☐	☐

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.)

	Service Provider Status and Relationship	Yes	No	N/A
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 Certification

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.

The service provider ☐ ***is*** **or** ☐ ***is not*** **eligible for employment in CDS for this individual.** *

(Employer: Please check one.)

Employer Name Here	Employer Signs Here	mm/dd/yy
Printed Employer Name	Signature — Employer	Date
Employee Name Here	Employee Signs Here	mm/dd/yy
Printed Service Provider Name	Signature — Service Provider	Date

Employee must Complete 1.

Texas Department of Aging and Disability Services

Consumer Directed Services
Service Provider Agreement

Form 1739
October 2013-E

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,** Employee Name Here ☑ an individual or

☒ an entity, located at (Address) Employee Address Here,

; Telephone 123-456-789 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, 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 Touch of Class, doing business in 7171 Highway 6 North, Suite 130, Houston, TX 77095, 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 mm/dd/yy, and terminates when the service provider is no longer providing services to individuals through the FMSA.

Employee Name Here	Employee Signs Here	mm/dd/yy
Service Provider or Representative* (Print)	Service Provider or Representative* (Signature)	Date
Amorette Casimir		
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.*

Consumer Directed Services

Employer and Employee Service Agreement

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

The Individual's program, CLASS OR MDCP OR PHC -(Pick ONE), hereafter 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: Employer Name Here.

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

This agreement is between the Employer and Employee Name Here 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, Employee Name Here 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 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:

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

Acknowledgement of service agreement, including documents incorporated by reference:

Employer:

Employer Name Here
Printed Name

Employer Signs Here
Signature

mm/DD/YY
Date

Employee:

Employee Name Here
Printed Name

Employee Signs Here
Signature

mm/DD/YY
Date

Texas Department of Aging
and Disability Services

Form 1727
August 2005

Consumer Directed Services

Occupational Exposure to Bloodborne Pathogens

* employee read & initial

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: Employee Date: mm/DD/YY

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: Employee Date: mm/DD/YY

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: Employee Date: mm/DD/YY

Informed Choice Related to Hepatitis B Vaccination

Employee Statement — Check one statement below.

employee check one

☑ 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:

write arrangements here

☑ 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, Employee Name Here, 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:

Employee Name Here
Printed Name

employee signs Here
Signature

mm/DD/YY
Date

Employer:

Employer Name Here
Printed Name

employer signs Here
Signature

mm/DD/YY
Date

Texas Department of Aging
and Disability Services

Form 1728
January 2007

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 Department of Aging and Disability Services (DADS); any other state or federal governmental agency; or by the Consumer-Directed Services Agency (CDSA).

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.

Employer Signs Here — Signature – Employer (Must be signed by the employer)
mm/dd/yy — Date
Employee Signs Here — Signature – Applicant for Employment
mm/dd/yy — 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 Worker's Compensation.

Employer choose

- ☑ 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: Write in other

OR

- ☑ 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.

Employer sign Here — Signature – Employer (Must be signed by the employer)
mm/dd/yy — Date
Employee sign Here — Signature – Applicant for Employment
mm/dd/yy — Date

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: (Employer Name Here) has elected not to
Name of Employer

obtain 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 employer can and may provide other benefits to injured employees. You should contact your employer regarding the availability of other benefits or compensation for a work-related injury or illness. In addition, you may have rights under the common law of Texas should you suffer an on the job injury or illness. 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 HOTLINE: The Commission has established 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 of Workers' Health & Safety at 1-800-452-9595.

employee Initials

Job Description

Habilitation Attendant

I. Summary of Position

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

II. Qualifications

A. Be at least 18 years of age
B. Be neither legal nor foster parents of the minor child receiving the service
C. Not be spouse of the Participant receiving the service

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 Manual
B. Current CPR certification

employee Signs Here _____ mm/dd/yy _____

Employee Signature Date

Texas Department of Aging and Disability Services

Consumer Directed Services

Employee Work Schedule and Assigned Tasks

Form 1731
September 2005

Employee Name: Employee Name Here

choose ☑ Initial ☑ Tasks
☑ Change ☑ Schedule

Effective Date: mm/DD/YY

Schedule I In school schedule

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

Schedule I – Tasks

Write tasks to be performed

example:

- transferring
- cooking
- cleaning
- therapy follow up
- exercising
- feeding
- bathing

* Must complete section

Schedule II Out of school schedule

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

Schedule II – Tasks

Write tasks to be performed

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

employer signs here (Signature – Employer) mm/DD/YY (Date)

Employee signs here (Signature – Employee) mm/DD/YY (Date)

Texas Department of Aging
and Disability Services

Form 1730
February 2008

Consumer-Directed Services
Wage and Benefits Plan
EMPLOYEE COMPENSATION

Employee Name (Last, First, Middle Initial)	Social Security No.
Employee Last, Employee First, MI	###-##-####
Date of Hire mm/dd/yy: Hire Date	First Date of Work mm/dd/yy: Date 1st Day
☑ Initial Wage and Benefit Plan ☑ Plan Change – Effective Date:	1 choose one

Name of Program Service Being Provided: CLASS

Compensation:

Regular Hourly Wage

- ☑ Employee = $ rate of pay
- ☑ Respite = $ rate of pay

Calculation of Overtime Hourly Wage

Hourly $ _____ + $ _____ (50%) = $ _____

Hourly $ _____ + $ _____ (50%) = $ _____

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.)

Employer writes in optional benefits Here
example: bonuses
vacation/sick pay
Holiday pay

Withholdings:

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

☐ **Required Garnishments** Employee Fills in

Type:	Amount:
Frequency:	Payment To: (Attach detail.)

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

Type:	Amount:
Frequency:	Payment To: (Attach detail.)

☐ **Other** (specify): _____ (Attach detail.)

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 time sheets are due: Tuesdays by 12pm - See Calendar

Paychecks are distributed by (method): mail or direct Deposit at least twice a month on Friday

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 Consumer-Directed Services Agency.

Employer signs Here	mm/dd/yy	Employee signs Here	mm/dd/yy
Signature – Employer or Designated Representative	Date	Signature – Employee	Date

Texas Department of Aging
and Disability Services

Form 1732
March 2014-E

Consumer Directed Services

Management and Training of Service Provider

Service Provider Name (Employee)	First Day of Work	Annual Evaluation Due Date
Employee Name Here	mm/dd/yy	mm/dd/yy
Name of Individual Receiving Services	**Program**	**Services Delivered**
Client Name Here	CLASS/or MDCP	
Name of Consumer Directed Services Employer		
Employer Name Here		

I. Purpose choose one

1st, ☒ Initial Orientation ☐ Ongoing Training - Yearly

☐ 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 complete as directed for initial orientation

- Put tasks to be completed Here!

III. Evaluation/Performance Review:

IV. Corrective Action Plan (if applicable):

Date for follow-up on corrective action plan: _____

V. Service Provider Comments:

Employee Signs Here — Signature of Service Provider

mm/dd/yy — Date

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

Employer Signs Here — Signature of Employer

mm/dd/yy — Date

_____ — Signature of Witness

_____ — Date

Date sent to FMSA: _____ **Date received by FMSA:** _____

TEXAS
Department of Aging
and Disability Services

Form 1732-EMR
October 2014-E

Consumer Directed Services (CDS)

Management and Training of Service Provider Addendum

Employee Misconduct Registry Notification

Employee Name: Employee Name Here Date of Hire: Hire date

Position: Personal Attendant Employer Name: Employer Name Here

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, Chaper 711, Subchapter O.

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&rl=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, Employee, have read and understand the above notification.

Employee Sign Here
Signature

mm/dd/yy
Date

DIRECT DEPOSIT AUTHORIZATION

I, Employee Name Here, hereby authorize Touch of Class to
Print Name
begin Direct Deposit of my payroll check to my bank account number
Account # Here at Name of Bank Here Bank, ABA # Routing # Here.
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.

employee signs here — Signature

mm/DD/YY — 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

voided check goes here

* If employee does not have a checking account & wants direct deposit into a savings account they need to get a form from their bank.

(*) Must include the above with this form!