INSTRUCTIONS FOR COMPLETING NEW EMPLOYEE PAPERWORK

This packet of should be completed and returned to begin your employment. Once you have completed and returned the packet you will be notified when you are cleared to begin working. Do not begin working before you receive clearance from your Mains'l contact. At that time, you will also receive additional instructions for using our online timesheet system.

Please follow the instructions below: Note that some forms have a front and back page. ***The Responsible Party is referred to multiple times in this paperwork. The Responsible Party is the person who manages the services for the person you are working with.***

O New Employee Information — Return this form

- Check with your Responsible party to confirm your pay rate and scheduled hours
- Complete top portion of the form

O Employment Relationship Disclosure (indicating your relationship to the employer) Return

- Answer the questions on both sides of the form. Sign and Date the form.

O Form W-4 Employee's Withholding Allowance Certification — Return this form

- Complete at least Steps 1 & 5.
  - Follow the instructions to determine if you should complete Steps 2, 3 & 4
- Sign and date at the bottom of the form

O W-4MN MN Employee Withholding Allowance/Exemption Certificate — Return this form

- Complete either Section 1 **or** Section 2.
- Sign and date

O Payroll Direct Deposit Authorization Form — Return this form

- Complete form- attach voided check (if you have) for your account. Sign and Date the form

O Paid Time Off (PTO) Status Form — Return this form

- Read this form and choose one box. Sign and Date

O Important Information for Employment Eligibility Verification Completion — Keep

- Read Important Information and Instructions
- Review Sample
- Look at the List of Acceptable Documents
- Find the forms of documentation you want to provide for the form to be completed.

O Employment Eligibility Verification (USCIS Form I-9) — Return this form

We recommend following the sample I-9 that is included in your packet EXACTLY when completing this form. This form needs to be completed EXACTLY like the sample.

- Meet with your responsible party or employer to complete this form. You will complete section 1 of this form. The responsible party needs to complete section 2 of the form.

You complete Section 1 - Employee Information and Attestation

- Complete each box. If you don't have something to write in a box, put "n/a" in that box.
- Sign and Date at the bottom of section 1.

Section 2: The Employer (not Mains'l) or the Responsible Party of the services for the person you are working with completes this section- Employer Review and Clarification.

- Reviews the documentation you provide them. The list of acceptable documents is included. Responsible Party or Employer needs to complete the information for your identification in the correct "list" (see sample or list of acceptable documents page)
- Please review the sample with the Responsible Party so they can complete the certification section EXACTLY like the sample and directions list.
- Responsible Party should sign and date the form using the date that is the same as the date you, as the employee signed in section 1.

Supplement A, included with the I-9 form, only needs to be completed if you have used a translator to help you complete this form.

O Employer/Employee Agreement/Job Description — Return this form

- Bring to the meeting with your Responsible party. Review and Sign together.

O Employee Acknowledgement of Proper Timesheet and Service Billing — Return this form

- Read the information. Sign and date this form.

O Family Paid Medical Leave Notice — Return this form

- Read the information. Sign and date this form.

O Employee Responsibilities Acknowledgment — Return this form

- Read each statement and initial, acknowledging responsibility.
- Sign and date

O Complete CFSS Worker Training — Send completion Certificate to Mains'l

- **Visit the DHS website to register for the training- https://registrationtraining.dhs.state.mn.us/?BusinessUnitID=16**
- Select the radio button next to the PCA/CFSS Support Worker Option
  Click the Next- Register button to open and complete the registration page. Watch your email for the next steps.

O Background Study — Return this form & a copy of your ID

- Complete the form making sure your full name matches your photo ID
- Sign and date the form. *Return with a copy of your photo ID.* The copy of your ID can be emailed/faxed/sent via text to your Mains'l Manager/contact.

O Individual Support Worker Enrollment Application — Return this form

- Complete the form. **If you don't know what a box means, leave it blank.**
- Sign and date under "Individual Support Worker Provider Statement"

O Provider Agreement – Individual Support Worker — Return this form

- Read form. Write your name at the bottom and Initial the box on the right.
- Write your name, sign and date on Page 2

The Individual Support Worker Enrollment Application and the Provider Agreement are used to enroll you as a provider with the Department of Human Services (DHS) and Minnesota Health Care Programs (MHCP). Please note that the state may take 2-3 months to process these forms. This will NOT delay your start date. Once this process is complete, DHS will send letters to you confirm your enrollment and containing your provider number (UMPI) for any MHCP. You should save these for your records. Mains'l will receive our own copy directly from DHS.

O Electronic Visit Verification (EVV) exemption form — Return this form if applicable

- **Fill out only if you live at the same address as the person you support.**
- Sign, date and responsible party signs and dates.
- Include proof of address (see list of acceptable documents)

CFSS-NEW EMPLOYEE INFORMATION

Employee Name: First _____ Middle _____ Last _____

Primary Phone #:_____ Email Address: _____

Date of Birth: _____ Social Security Number: _____

Address: _____ County: _____

City, State, Zip: _____ Gender _____

Pay Rate Per Hour: _____ Have you previously been employed by this employer? ☐ Yes ☐ No

Name of Person Receiving Services _____ Your Relation to them _____

Name of Employer (Not Mains'l) _____ Your Relation to them _____

Do you work with any other participants who use Mains'l as their FMS ☐ Yes ☐ No

Do you work with any other participants who use an FMS other than Mains'l ☐ Yes ☐ No

THIS SECTION WILL BE COMPLETED BY MAINS'L

Mains'l Manager: _____ Cost Center 505- _____

Is this employee employed by another employer? _____ RP Name: _____

Wage Type Needed: _____ Pay Rate: _____

Additional Wage Types Needed: _____ Pay Rate: _____

EVV Live in Caregiver ☐ Yes ☐ No PTO Status ☐ Accrue ☐ Opt Out

Additional Notes: _____ **CFSS**

Official Hire Date (date I-9 was signed) _____ Date Employee Notice Sent: _____

☐ New Employee Information ☐ Direct Deposit ☐ CFSS Worker Certificate

☐ Relationship Disclosure ☐ PTO Opt Out ☐ Background Study & ID

☐ Federal W-4 ☐ I-9 ☐ Provider Enrollment

☐ MN W-4 ☐ Employee Agreement ☐ Provider Agreement

☐ Proper Billing Form ☐ Acknowledgement ☐ EVV & Supporting Docs

☐ Paid Family Medical Leave Notice

Date UMPI Forms were submitted: _____

Start Date: (on/after BOTH BCA Clear date and Certificate Completion date _____

Job Title: FEA-CFSS

EMPLOYMENT RELATIONSHIP DISCLOSURE

Employee Name:_____ Date of Birth: _____

Name of your Household Employer/FEIN Holder (*not Mains'l*):_____

Your relationship to your employer, your student status, and your age are used to determine if FICA, FUTA, and SUTA taxes are required to be paid by the employee and employer. Because you are employed by a household employer, these taxes may not apply to you or your employer. If you are exempt based on the situations listed the taxes do not apply. There is not an option to choose to pay those taxes.

Definitions:

- **FICA**: Social Security and Medicare taxes. Both the employee and employer pay this tax. If you are exempt based on your relationship neither the employer nor employee will pay this tax. If you exempt, you will not be paying into Social or Medicare for wages earned in this job.
- **FUTA**: Federal unemployment tax. The employer pays this tax. If you are exempt, you may not be eligible for unemployment benefits for this job.
- **SUTA**: State unemployment tax. The employer pays this tax. If you are exempt, you may not be eligible for unemployment benefits for this job.
- **Please note** that your state and federal income tax withholdings are not addressed on this form. Income tax withholdings are determined by your form W-4.
- **Please note** that the program participant and the employer are not always the same. You must check the box that describes your relationship to your employer.

CHECK THE BOX THAT APPLIES TO YOUR RELATIONSHIP TO YOUR EMPLOYER

	RELATIONSHIP	If you check the box, you are exempt from:	
☐	**My spouse is my employer**		**FICA, FUTA, SUTA**
☐	**My child, stepchild, or adopted child is my employer**		**FICA, FUTA, SUTA**
☐	**My parent is my employer** **My current age is: _____**	under 18 years old	**FICA, FUTA, SUTA**
		age 18-20	**FICA, FUTA**
		age 21 and older	**No exemptions**
☐	**I am under 18 years old**		**FICA**
☐	**I am a non-resident alien temporarily in the USA on an F-1, J-1, M-1, or Q-1 Visa admitted to the USA for the purpose of providing domestic services**		**FICA, FUTA**
☐	**None of the above apply and I am 18 years or older**		**No exemptions**

_____ _____

Employee Signature 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

2025

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

TIP: Consider using the estimator at *www.irs.gov/W4App* to determine the most accurate withholding for the rest of the year if: you are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ _____

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

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

Employee's signature (This form is not valid unless you sign it.) **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2025 if you meet both of the following conditions: you had no federal income tax liability in 2024 **and** you expect to have no federal income tax liability in 2025. You had no federal income tax liability in 2024 if (1) your total tax on line 24 on your 2024 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2025 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 17, 2026.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

1. Are submitting this form after the beginning of the year;

2. Expect to work only part of the year;

3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;

4. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

5. Prefer the most accurate withholding for multiple job situations.

TIP: Have your most recent pay stub(s) from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

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

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work. Submit a separate Form W-4 for each job.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

Instead, if you (and your spouse) have a total of only two jobs, you may check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

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

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2025 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . **1** $

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . **2a** $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . **2b** $

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . **2c** $

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3**

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . **4** $

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1 Enter an estimate of your 2025 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $

2 Enter:
- $30,000 if you're married filing jointly or a qualifying surviving spouse
- $22,500 if you're head of household
- $15,000 if you're single or married filing separately

. . . . . **2** $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . **3** $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . **4** $

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . **5** $

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$700	$850	$910	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020
$10,000 - 19,999	0	700	1,700	1,910	2,110	2,220	2,220	2,220	2,220	2,220	2,220	3,220
$20,000 - 29,999	700	1,700	2,760	3,110	3,310	3,420	3,420	3,420	3,420	3,420	4,420	5,420
$30,000 - 39,999	850	1,910	3,110	3,460	3,660	3,770	3,770	3,770	3,770	4,770	5,770	6,770
$40,000 - 49,999	910	2,110	3,310	3,660	3,860	3,970	3,970	3,970	4,970	5,970	6,970	7,970
$50,000 - 59,999	1,020	2,220	3,420	3,770	3,970	4,080	4,080	5,080	6,080	7,080	8,080	9,080
$60,000 - 69,999	1,020	2,220	3,420	3,770	3,970	4,080	5,080	6,080	7,080	8,080	9,080	10,080
$70,000 - 79,999	1,020	2,220	3,420	3,770	3,970	5,080	6,080	7,080	8,080	9,080	10,080	11,080
$80,000 - 99,999	1,020	2,220	3,420	4,620	5,820	6,930	7,930	8,930	9,930	10,930	11,930	12,930
$100,000 - 149,999	1,870	4,070	6,270	7,620	8,820	9,930	10,930	11,930	12,930	14,010	15,210	16,410
$150,000 - 239,999	1,870	4,240	6,640	8,190	9,590	10,890	12,090	13,290	14,490	15,690	16,890	18,090
$240,000 - 259,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$260,000 - 279,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$280,000 - 299,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$300,000 - 319,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,170	19,170
$320,000 - 364,999	2,040	4,440	6,840	8,390	9,790	11,100	12,470	14,470	16,470	18,470	20,470	22,470
$365,000 - 524,999	2,790	6,290	9,790	12,440	14,940	17,350	19,650	21,950	24,250	26,550	28,850	31,150
$525,000 and over	3,140	6,840	10,540	13,390	16,090	18,700	21,200	23,700	26,200	28,700	31,200	33,700

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$200	$850	$1,020	$1,020	$1,020	$1,370	$1,870	$1,870	$1,870	$1,870	$1,870	$2,040
$10,000 - 19,999	850	1,700	1,870	1,870	2,220	3,220	3,720	3,720	3,720	3,720	3,890	4,090
$20,000 - 29,999	1,020	1,870	2,040	2,390	3,390	4,390	4,890	4,890	4,890	5,060	5,260	5,460
$30,000 - 39,999	1,020	1,870	2,390	3,390	4,390	5,390	5,890	5,890	6,060	6,260	6,460	6,660
$40,000 - 59,999	1,220	3,070	4,240	5,240	6,240	7,240	7,880	8,080	8,280	8,480	8,680	8,880
$60,000 - 79,999	1,870	3,720	4,890	5,890	7,030	8,230	8,930	9,130	9,330	9,530	9,730	9,930
$80,000 - 99,999	1,870	3,720	5,030	6,230	7,430	8,630	9,330	9,530	9,730	9,930	10,130	10,580
$100,000 - 124,999	2,040	4,090	5,460	6,660	7,860	9,060	9,760	9,960	10,160	10,950	11,950	12,950
$125,000 - 149,999	2,040	4,090	5,460	6,660	7,860	9,060	9,950	10,950	11,950	12,950	13,950	14,950
$150,000 - 174,999	2,040	4,090	5,460	6,660	8,450	10,450	11,950	12,950	13,950	15,080	16,380	17,680
$175,000 - 199,999	2,040	4,290	6,450	8,450	10,450	12,450	13,950	15,230	16,530	17,830	19,130	20,430
$200,000 - 249,999	2,720	5,570	7,900	10,200	12,500	14,800	16,600	17,900	19,200	20,500	21,800	23,100
$250,000 - 399,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$400,000 - 449,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$450,000 and over	3,140	6,490	9,160	11,660	14,160	16,660	18,660	20,160	21,660	23,160	24,660	26,160

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$450	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,870	$1,870	$1,870	$1,890
$10,000 - 19,999	450	1,450	2,000	2,200	2,220	2,220	2,220	3,180	4,070	4,070	4,090	4,290
$20,000 - 29,999	850	2,000	2,600	2,800	2,820	2,820	3,780	4,780	5,670	5,690	5,890	6,090
$30,000 - 39,999	1,000	2,200	2,800	3,000	3,020	3,980	4,980	5,980	6,890	7,090	7,290	7,490
$40,000 - 59,999	1,020	2,220	2,820	3,830	4,850	5,850	6,850	8,050	9,130	9,330	9,530	9,730
$60,000 - 79,999	1,020	3,030	4,630	5,830	6,850	8,050	9,250	10,450	11,530	11,730	11,930	12,130
$80,000 - 99,999	1,870	4,070	5,670	7,060	8,280	9,480	10,680	11,880	12,970	13,170	13,370	13,570
$100,000 - 124,999	1,950	4,350	6,150	7,550	8,770	9,970	11,170	12,370	13,450	13,650	14,650	15,650
$125,000 - 149,999	2,040	4,440	6,240	7,640	8,860	10,060	11,260	12,860	14,740	15,740	16,740	17,740
$150,000 - 174,999	2,040	4,440	6,240	7,640	8,860	10,860	12,860	14,860	16,740	17,740	18,940	20,240
$175,000 - 199,999	2,040	4,440	6,640	8,840	10,860	12,860	14,860	16,910	19,090	20,390	21,690	22,990
$200,000 - 249,999	2,720	5,920	8,520	10,960	13,280	15,580	17,880	20,180	22,360	23,660	24,960	26,260
$250,000 - 449,999	2,970	6,470	9,370	11,870	14,190	16,490	18,790	21,090	23,280	24,580	25,880	27,180
$450,000 and over	3,140	6,840	9,940	12,640	15,160	17,660	20,160	22,660	25,050	26,550	28,050	29,550

DEPARTMENT OF REVENUE

2025 W-4MN, Minnesota Withholding Allowance/Exemption Certificate

* 2 5 2 4 6 1 *

Employees

Complete Form W-4MN so your employer can withhold the correct Minnesota income tax from your pay. Consider completing a new Form W-4MN each year and when your personal or financial situation changes. If no Form W-4MN is in effect, the number of withholding allowances claimed will be zero.

First Name and Initial	Last Name	Social Security Number

Permanent Address

City | State | ZIP Code

Marital Status *(Check one):*

- ☐ Single; Married, but legally separated; or Spouse is a nonresident alien
- ☐ Married
- ☐ Married, but withhold at higher Single rate

Complete Section 1 OR Section 2, then sign the bottom and give the completed form to your employer.

☐ **Section 1 — Determining Minnesota Allowances**

A Enter "1" if no one else can claim you as a dependent . . . . . **A** _____

B Enter "1" if any of the following apply: . . . . . **B** _____

- You are single and have only one job
- You are married, have only one job, and your spouse does not work
- Your wages from a second job or your spouse's wages are $1500 or less

C Enter "1" if you are married. Or 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 the number of dependents (other than your spouse or yourself) you will claim on your tax return. . . . . **D** _____

E Enter "1" if you will use the filing status Head of Household *(see instructions)*. . . . . **E** _____

F Add steps A through E. If you plan to itemize deductions on your 2024 Minnesota income tax return, you may also complete the Itemized Deductions and Additional Income Worksheet. . . . . **F** _____

1 Minnesota Allowances. Enter Step F from Section 1 above or Step 10 of the Itemized Deductions Worksheet . . . . . **1** _____

2 Additional Minnesota withholding you want deducted for each pay period *(see instructions)* . . . . . **2** $_____

☐ **Section 2 — Exemption From Minnesota Withholding**

Complete Section 2 if you claim to be exempt from Minnesota income tax withholding *(see Section 2 instructions for qualifications)*. If applicable, check one box below to indicate why you believe you are exempt:

☐ **A** I meet the requirements and claim exempt from both federal and Minnesota income tax withholding

☐ **B** Even though I did not claim exempt from federal withholding, I claim exempt from Minnesota withholding, because:

- I had no Minnesota income tax liability last year
- I received a refund of all Minnesota income tax withheld
- I expect to have no Minnesota income tax liability this year

☐ **C** All of these apply:

- My spouse is a military service member assigned to a military location in Minnesota
- My domicile (legal residence) is in another state
- I am in Minnesota solely to be with my spouse. My state of domicile is _____

☐ **D** I am an American Indian that resides and works on a reservation for which I am enrolled *(see instructions)*.

Enter the reservation name: _____

Enter your Certificate of Degree of Indian Blood (CDIB)/Enrollment number: _____

☐ **E** I am a member of the Minnesota National Guard or an active-duty U.S. military member and claim exempt from Minnesota withholding on my military pay

☐ **F** I receive a military pension or other military retirement pay as calculated under U.S. Code, title 10, sections 1401 through 1414, 1447 through 1455, and 12733, and I claim exempt from Minnesota withholding on this retirement pay

I certify that all information provided in Section 1 ***OR*** *Section 2 is correct. I understand there is a $500 penalty for filing a false Form W-4MN.*

Employee's Signature | Date | Daytime Phone Number

Employees: Give the completed form to your employer.

Employers

See the employer instructions to determine if you must send a copy of this form to the Minnesota Department of Revenue. If required, enter your information below and mail this form to the address in the instructions. (Incomplete forms are considered invalid.) We may assess a $50 penalty for each required Form W-4MN not filed with us. Keep a copy for your records.

Name of Employer	Minnesota Tax ID Number	Federal Employer ID Number (FEIN)

Address | City | State | ZIP Code

DEPARTMENT OF REVENUE

Form W-4MN Instructions for Employees

Complete this form for your employer to calculate the amount of Minnesota income tax to be withheld from your pay.

When must I complete Form W-4MN?

Complete Form W-4MN if any of these apply:

- You begin employment
- You change your filing status
- You reasonably expect to change your filing status in the next calendar year
- Your personal or financial situation changes
- You claim exempt from Minnesota withholding (see Section 2 instructions for qualifications)

If you have not had sufficient Minnesota income tax withheld from your wages, we may assess penalty and interest when you file your state income tax return.

Note: Your employer may be required to submit a copy of your Form W-4MN to the Minnesota Department of Revenue. You may be subject to a $500 penalty if you provide a false Form W-4MN.

You must enter your Social Security Number for this Form W-4MN to be valid.

What if I have completed federal Form W-4?

If you completed a 2025 Form W-4, you must complete Form W-4MN to determine your Minnesota withholding allowances.

What if I am exempt from Minnesota withholding?

If you claim exempt from Minnesota withholding, complete only Section 2 of Form W-4MN and sign and date the form to validate it. If you complete Section 2, you must complete a new Form W-4MN by February 15 in each following year in which you claim an exemption from Minnesota withholding.

You cannot claim exempt from withholding if all of these apply:

- Another person can claim you as a dependent on their federal tax return
- Your annual income exceeds $1,100
- Your annual income includes more than $350 of unearned income

If you do not complete a new Form W-4MN to claim exempt from Minnesota withholding by February 15, your employer will withhold tax as if your filing status is single with zero withholding allowances.

What if I am a nonresident alien for U.S. income taxes?

If you are a nonresident alien, you are not allowed to claim exempt from withholding. You will check the single box for marital status regardless of your actual marital status and may enter one personal allowance on Step A of Section 1. Enter zero on steps B, C, and E of Section 1.

If you are resident of Canada, Mexico, South Korea, or India, and are allowed to claim dependents, enter the number of dependents on Step D.

Section 1 — Minnesota Allowances Worksheet

Complete Section 1 to find your allowances for Minnesota withholding tax. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

If you expect to owe more income tax for the year than will be withheld, you can claim fewer allowances or request additional Minnesota withholding from your wages. Enter the amount of additional Minnesota income tax you want withheld on line 2 of Section 1.

Nonwage Income

Consider making estimated payments if you have a large amount of "nonwage income." Nonwage income (other than tax-exempt income) includes interest, dividends, net rental income, unemployment compensation, gambling winnings, prizes and awards, hobby income, capital gains, royalties, and partnership income.

Two Earners or Multiple Jobs

If your spouse works or you have 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-4MN. Usually, your withholding will be more accurate when all allowances are claimed on the Form W-4MN for the highest paying job and zero allowances are claimed on the others.

Head of Household Filing Status

You may claim Head of Household as your filing status if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependents. Enter "1" on Step E if you may claim Head of Household as your filing status on your tax return.

What if I itemize deductions on my Minnesota return or have other nonwage income?

Use the Itemized Deductions and Additional Income Worksheet to find your Minnesota withholding allowances. Complete Section 1 on page 1, then follow the steps in the worksheet on the next page to find additional allowances.

Continued

Itemized Deductions and Additional Income Worksheet

1 Enter an estimate of your 2025 Minnesota itemized deductions. For 2025, you may have to reduce your itemized deductions if your income is over $238,950 ($119,475 for Married Filing Separately). . . . . _____

2 Enter one of the following based on your filing status: . . . . . _____

a. $29,900 if Married Filing Jointly

b. $22,500 if Head of Household

c. $14,950 if Single or Married Filing Separately

3 Subtract step 2 from step 1. If zero or less, enter 0 . . . . . _____

4 Enter an estimate of your 2025 additional standard deduction (from page 11 of the Form M1 instructions) . . . . . _____

5 Add steps 3 and 4 . . . . . _____

6 Enter an estimate of your 2025 taxable nonwage income . . . . . _____

7 Subtract step 6 from step 5. If zero, enter 0. If less than zero, enter the amount in parentheses. . . . . _____

8 Divide the amount on step 7 by $5,200. If a negative amount, enter in parentheses. Do not include fractions . . . . . _____

9 Enter the number on step F of Section 1 on page 1 . . . . . _____

10 Add step 8 and 9 and enter the total here. If zero or less, enter 0. Enter this amount on line 1 of page 1. . . . . _____

Section 2 — Minnesota Exemption

Your employer will not withhold Minnesota taxes from your pay if you are exempt from Minnesota withholding. You cannot claim exempt from withholding if all of these apply:

- Another person can claim you as a dependent on their federal tax return
- Your annual income exceeds $1,100
- Your annual income includes more than $350 of unearned income

Box A

Check box A of Section 2 to claim exempt if all of these apply:

- You meet the requirements to be exempt from federal withholding
- You had no Minnesota income tax liability in the prior year and received a full refund of Minnesota tax withheld
- You expect to have no Minnesota income tax liability for the current year

Box B

Check box B of Section 2 if you are not claiming exempt from federal withholding, but meet the second and third requirements for box A.

Box C

Check box C in Section 2 to claim exempt if all of these apply:

- You are the spouse of a military member assigned to duty in Minnesota
- You and your spouse are domiciled in another state
- You are in Minnesota solely to be with your active duty military spouse member

Boxes D-F

If you receive income from the following sources, it is exempt from Minnesota withholding. Your employer will not withhold Minnesota tax from that income when you check the appropriate box in Section 2.

- **Box D:** You receive wages as a member of an American Indian tribe living and working on the reservation of which you are an enrolled member. Enter the name of your reservation and your Certificate of Degree of Indian or Alaskan Blood (CDIB) number/enrollment number. **Members of the Minnesota Chippewa Tribe** can exclude income regardless of which Minnesota Chippewa Tribe reservation you live and work on. This affects members of these tribes:
  - Mille Lacs
  - Nett Lake (Bois Forte)
  - Fond du Lac
  - Leech Lake
  - White Earth
  - Grand Portage
- **Box E:** You receive wages for Minnesota National Guard (MNG) pay or for active duty U.S. military pay. MNG and active duty U.S. military members can claim exempt from Minnesota withholding on these wages, even if they are taxable federally. For more information, see Income Tax Fact Sheet 5, *Military Personnel*.
- **Box F:** You receive a military pension or other military retirement pay calculated under U.S. Code title 10, sections 1401 through 1414, 1447 through 1455, and 12733. You may claim exempt from Minnesota withholding on this income even if it is taxable federally.

Note: You may not want to claim exempt if you (or your spouse if filing a joint return) expect to have other forms of income subject to Minnesota tax and you want to avoid owing tax at the end of the year.

If you complete Section 2, you must complete a new Form W-4MN by February 15 in each following year.

Nonresident Alien

If you are a nonresident alien for federal tax purposes, do not complete Section 2. See IRS Publication 519, *U.S. Tax Guide for Aliens*.

Continued

Line 2 — Additional Minnesota Withholding

If you would like an additional amount of tax to be deducted per payment period, enter the amount on line 2. Do not enter a percentage of the payment you want to be deducted.

Use of Information

All information on Form W-4MN is private by state law. It cannot be given to others without your consent, except to the IRS, other states that guarantee the same privacy, or by court order. Your name, address, and Social Security Number are required for identification. Information about your allowances is required to determine your correct tax. We ask for your phone number so we can call if we have a question.

Questions?

- Website: www.revenue.state.mn.us
- Email: withholding.tax@state.mn.us
- Phone: 651-282-9999 or 1-800-657-3594 (toll-free)

Employer instructions are on the next page.

Form W-4MN Employer Instructions

Form W-4MN Requirement

Federal Form W-4 will not determine withholding allowances used to determine the amount of Minnesota withholding. Employees completing a 2025 Form W-4 will need to complete 2025 Form W-4MN to determine the appropriate amount of Minnesota withholding.

Lock-In Letters

IRS Letter 2800C tells you when the IRS believes your employee may have filed an incorrect federal Form W-4. If you receive this letter, you must provide the Minnesota Department of Revenue with a copy of the employee's Form W-4MN. We will verify the number of allowances that the employee may claim for Minnesota purposes. Continue using the Form W-4MN you were using at the time you received Letter 2800C from the IRS, until we notify you to change the amount of allowances on the employee's Form W-4MN. If the employee has not completed a Form W-4MN, have them complete the form and use the allowances calculated on that form until notified by the department.

Use the amount on line 1 of page 1 for calculating the withholding tax for your employees.

When does an employee complete Form W-4MN?

Employees complete Form W-4MN no later than when they begin employment or when their personal or financial situation changes.

How should I determine Minnesota withholding for an employee that does not complete Form W-4MN?

If an employee does not complete Form W-4MN and they have a federal Form W-4 (from 2019 or prior years) on file, use the allowances on their federal Form W-4. Otherwise, withhold Minnesota tax as if the employee is single with zero withholding allowances.

What if my employee claims to be exempt from Minnesota withholding?

If your employee claims exempt from Minnesota withholding, they must complete Section 2 of Form W-4MN. They must provide you with a new Form W-4MN by February 15 of each year. If they claimed exempt the prior year and do not provide you with a new Form W-4MN by February 15, then withhold Minnesota tax as if the employee is single with zero withholding allowances. If you are paying an employee for wages that are exempt from withholding, such as Medicaid Waiver Payments or wages to H-2A visa workers, do not send us Form W-4MN.

When do I need to submit copies of a Form W-4MN to the department?

You must send copies of Form W-4MN to us if any of these apply:

- The employee claims more than 10 Minnesota withholding allowances
- The employee checked box A or B under Section 2, and you reasonably expect the employee's wages to exceed $200 per week
- You believe the employee is not entitled to the number of allowances claimed

You do not need to submit Form W-4MN to us if the employee is asking to have additional Minnesota withholding deducted from their pay.

We may assess a $50 penalty for each Form W-4MN you do not file with us when required.

Mail Forms W-4MN to:

Minnesota Department of Revenue
Mail Station 6501
600 N. Robert St.
St. Paul, MN 55146-6501

What if my employee is a resident of a state that has a reciprocity agreement with Minnesota?

Your employee must complete Form MWR, Reciprocity Exemption/Affidavit of Residency if both of these apply:

- They are a resident of North Dakota or Michigan, and
- They do not want you to withhold Minnesota tax from their wages

Your employee must complete a Form MWR by February 28 of each year, or within 30 days after they begin working or change their permanent residence. See Withholding Fact Sheet 20, *Reciprocity - Employee Withholding*, for more information.

What is an invalid Form W-4MN?

A Form W-4MN is considered invalid if any of these apply:

- There is any unauthorized change or addition to the form, including any change to the language certifying the form is correct
- The employee indicates in any way the form is false by the date they provide you with the form
- The form is incomplete or lacks the necessary signatures
- Both Section 1 and Section 2 were completed
- The employer information is incomplete

What if I receive an invalid form?

Do not use the invalid form to calculate Minnesota income tax withholding. Have the employee complete and submit a new Form W-4MN. If the employee does not give you a valid form, and you have an earlier Form W-4MN from them, use the earlier form to calculate their withholding.

If a valid Form W-4MN is not completed by the employee, withhold taxes as if the employee is single and claiming zero withholding allowances.

What if my employee is a nonresident alien of the United States?

If the wages to this employee are subject to income tax withholding, you will use Table 1 and the procedure under **Withholding Adjustment for Nonresident Alien Employees** in IRS Publication 15-T to determine the correct Minnesota withholding tax. Do not use this procedure for nonresident alien students from India and business apprentices from India. Also do not use this procedure for certain nonresident aliens who are residents of South Korea. See IRS Notice 1392 for special instructions and withholding exceptions.

PAYROLL DIRECT DEPOSIT AUTHORIZATION FORM

Employee Name: _____

Email Address:_____

Check the appropriate item: (more than one box may be checked)

☐ **Direct Deposit- Primary**

I hereby request and authorize the entire amount of my paycheck each pay period to be deposited into:

☐ Checking* ☐ Savings ☐ Pay Card (not provided by Mains'l)

Bank Name/Branch:_____

Account Number: _____

Routing Number: _____

☐ **Direct Deposit- Secondary Account**

I hereby request and authorize the sum of $_____ to be deducted from my paycheck each pay period and to be deposited directly into the account indicated below with the remaining balance going into my primary account.

☐ Checking* ☐ Savings ☐ Pay Card (not provided by Mains'l)

Bank Name/Branch:_____

Account Number: _____

Routing Number: _____

☐ ***rapid! PayCard*** *–Provided by Mains'l*

I hereby request and authorize the entire amount of my paycheck each pay period to be deposited onto a *rapid! PayCard*. *(A rapid! PayCard will be mailed to your address on file with Mains'l before pay day)*

☐ **I would like to cancel my deposit**

I hereby cancel the authorization for direct deposit or payroll deduction effective (date)_____.

I authorize Mains'l Services, Inc. and the financial institution named above to automatically deposit my net pay to my account and to reverse any entries made in error. This authority will remain in effect until I give written notice to cancel it. **I understand that changes not received at least one week before pay day will not go into effect until the following pay date.**

_____ _____

SIGNATURE **DATE**

* Attach voided check or bank notification of account information here

Paid Time Off (PTO) Status Form

Information about Paid Time Off (PTO)

All employees working in the state of Minnesota are entitled to Earned Sick and Safe Time, a form of paid leave. Paid Time Off (PTO) is a richer benefit to Workers than Sick and Safe Leave.

Employees who do not opt out earn 1 hour of PTO for every 30 hours worked. Workers can carry over up to 80 hours of PTO from one State fiscal year to the next. The State's fiscal year is July 1 to June 30.

Employees can choose to waive the right to earn Paid Time Off (PTO) for their work in CDCS, CSG, or CFSS. When they waive PTO, it means that

- They will no longer accrue PTO and will stop earning additional PTO.
- They cannot retroactively waive PTO. This change will take effect beginning with the first date of the next pay period after the form is submitted, unless they are a new hire then effective date will be the same as their start date.
- They will not be able to choose to earn PTO again until the next service plan year of the person they support. If they have questions about that date, they can contact their employer or Mains'l manager.
- This waiver will stay in effect until the employee completes a new PTO status form that they have chosen to begin earning PTO again AND the new service plan year for the person they support begins.
- If a current employee is opting out. any PTO they have already earned will be paid out. This means, after an employee opts out of PTO, they will not have any PTO available for such things as vacations, hospitalizations, or sick days.
- To be eligible to waive PTO, they must meet one of the following criteria. .

  (1) A family member is defined as:

  - A child, foster child, adult child, child for whom the employee is legal guardian, or child to whom the employee stands.
  - Spouse or registered domestic partner.
  - Sibling, step sibling, or foster sibling
  - Biological, adoptive, or foster parent, stepparent, or a person who stood in loco parentis when the employee was a minor child.
  - Grandchild, foster grandchild, or step grandchild
  - Grandparent or step grandparent
  - A child of a sibling of the employee
  - A sibling of the parents of the employee; or
  - A child-in-law or sibling-in-law

  (2) Any of the family members listed in clause (1) of a spouse or registered domestic partner.

  (3) Any other individual related by blood or whose close association with the employee is the equivalent of family relationship; and

  (4) Up to one individual annually designated by the employer.

Paid Time Off (PTO) Status Form

Employee Name: _____ Employee Number:_____

Name of Employer (Not Mains'l): _____

Paid Time Off (PTO) Selection

*Please read the information sheet above before making your selection.

☐ I want to retain my right to earn PTO

☐ I do NOT want to have PTO

I voluntarily chose to waive the right to earn Paid Time Off (PTO) for my work. I have read the above definition of a family member and by signing this form I acknowledge that my relationship falls within the definition of a family member as listed above. I understand when I opt out of PTO, all remaining PTO I have available to me will be paid out to me.

Employee Signature:_____ Date: _____

Mains'l Use

Manager Completing This Form: _____ Date PTO Form Received:

Date Employee Notice Was Sent (attach copy and proof that it was sent) New Hire

How many participants does this employee work with under this employee number?_____

Effective Date (unless new employee, this needs to be the start of a payroll cycle):
New Hire

*If other employees use the same current wage type, ensure their PTO status is the same. If PTO status is not the same,

New wage type(s) assigned: _____

N/A new wage type NOT needed ☐

Will there be a PSCF-Payrate Form? _____

Changes Made in ISS ☐ or Calendar Reminder Set to Update ISS When Able ☐

Other Notes:

Review CSP, Budget Template, ISS, Nav Plus and then send to Payroll and Navigation Plus Email

IMPORTANT INFORMATION FOR EMPLOYMENT ELIGIBILITY VERIFICATION FORM I-9-COMPLETION

Before writing anything on the Employment Eligibility Verification Form I-9, please read the information on this document and the instructions carefully. **This form was recently updated and likely looks different if you've completed this form before. It is now on one page. Read the instructions carefully.** A sample is also included for you. If your Employment Eligibility Verification Form is not completed correctly, it may delay the start of your employment. ***Please contact us with any questions about this form or process!***

INSTRUCTIONS TO THE EMPLOYEE:

- Read this important information and look at the Sample form provided. U.S. Citizenship and Immigration has also provided detailed instructions online at: https://www.uscis.gov/i-9
- Choose which documents you will show from the List of Acceptable Documents (page 2 of 4).
  - If you provide a document from list A, that is all that is required.

    OR
  - If you provide one document from List B, you **must also** provide one document from List C.
- Meet with your Employer/Responsible Party (the person who hired you)
- At the meeting you Complete Section 1 Employee Information and Attestation (page 1 of 4).
- Sign and date Section 1 on the same date the Responsible party signs and dates Section 2. **An original signature in ink is required. This form may not be signed electronically.**
  - **This must be within 72 hours of your hire date.**
- At the meeting the Responsible party completes Section 2 (page 1 of 4).
  - Provide **original** forms of identification to your Responsible Party.
- Send the original I-9 form, complete with all required signatures, back with your other employment paperwork to Mains'l.

COMMON ERRORS TO AVOID:

- Do not write the date wrong. Use the correct format for the date of 2-digit month, 2-digit day, 4-digit year (mm/dd/yyyy).
- Do not white out mistakes. Put a line through the error, initial it and write the correct information. The best option is to start over on a new clean form.
- Do not use pencil or marker. Write clearly, neatly, and legibly with blue or black pen.
- Do not leave blanks on the form. Write N/A instead of leaving an item blank.

PHOTOCOPIES OF DOCUMENTS ARE NOT ACCPETABLE. You cannot provide photocopies of identity or employment eligibility documents to fulfill I-9 requirements. *Only the original documents,* meaning the actual document issued by the issuing authority, are satisfactory, with the single exception of a certified photocopy of a birth certificate.

✓ Please bring these instructions along with meeting with the Responsible Party. Their instructions are on the reverse side of this page.

Please see the sample Employment Eligibility Verification Form I-9 and the Instructions to help with questions you have when completing the form. If you have further questions, please contact your Mains'l Manager.
We are happy to help so that errors can be avoided and the start of employment is not delayed.

IMPORTANT INFORMATION FOR EMPLOYMENT ELIGIBILITY VERIFICATION FORM I-9-COMPLETION

INSTRUCTIONS TO THE EMPLOYER/RESPONSIBLE PARTY:

- Review the documentation the employee provides you.
  - You must view the **original** forms of identification of the employee. The options for acceptable documents are listed on the List of Acceptable Documents (page 2 of 4).
  - The employee must provide one document from List A, and that is all that is required.

    OR
  - The employee must provide one document from List B **as well as** one document from List C.
  - You are not required to be a document expert. In reviewing the genuineness of the documents presented by the employee, employers are held to reasonableness standards.
- Complete Section 2. Employer or Authorized Representative Review and Verification (page 1 of 3)
  - Write the exact document title as listed on the List of Acceptable Documents
  - Write the issuing authority as it is listed on the document. If you are not sure, you can look at http://www.uscis.gov/sites/default/files/files/form/m-274.pdf
  - Write the document number as listed on the document.
  - Write the expiration date if there is one. If none, leave blank..
    - Write the date in the correct format (2 digit month, 2 digit day, 4 digit year mm/dd/yyyy)

Example if using one document from List A:

	List A	OR	List B	AND	List C
Document Title 1	U.S. Passport				
Issuing Authority	Department of State				
Document Number (if any)	98765432				
Expiration Date (if any)	02/23/2025				
Document Title 2 (if any)		Additional Information			

Example if using one document from List B AND one from List C:

	List A	OR	List B	AND	List C
Document Title 1			Driver's License		Social Security Card
Issuing Authority			Minnesota		Social Security Administration
Document Number (if any)			X123456789		555-44-3333
Expiration Date (if any)			04/13/2024		N/A
Document Title 2 (if any)		Additional Information			

- Complete all information under Certification. The date you sign must be the same as the date the employee signs in Section 1 on page 1 and must be within 72 hours of their hire date. **An original signature in ink is required. This form may not be signed electronically.**
- Do not write anything in Section 3. Reverification and Rehires

COMMON ERRORS TO AVOID:

- Do not write the date wrong. Please use the format show in the example. (mm/dd/yyyy).
- Do not use pencil or marker. Write clearly, neatly, and legibly using blue or black pen
- Do not accept photocopies of identity or employment eligibility documents with the exception of a certified photocopy of a birth certificate.

Please see the sample Employment Eligibility Verification Form I-9 and the Instructions to help with questions you have when completing the form. If you have further questions, please contact your Mains'l Manager. We are happy to help so that errors can be avoided.

SAMPLE DOCUMENT ONLY

Employment Eligibility Verification

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

USCIS Form I-9
OMB No.1615-0047
Expires 07/31/2026

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

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to presen not ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentati **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immi may be illegal.

Do not leave spaces
Write N/A if an item doesn't apply

Section 1. Employee Information and Attestation: Employees must complete and sign Se han the **first day of employment**, but not before accepting a job offer.

Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	Other Last Names Used (if any)
Sample	Sam	S	N/A

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code
123 Main Street	N/A	Fake City	MN	12345

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number
01/01/1986	1 2 3 4 5 6 7 8 9	sam.sample@gmail.com	(987) 654-3210

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

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

- [X] 1. A citizen of the United States
- [ ] 2. A noncitizen national of the United States (See Instructions.)
- [ ] 3. A lawful permanent resident (Enter USCIS or A-Number.)
- [ ] 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

Check the appropriate box of the 4 choices

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number a

If Box 4 is checked, fill in one of the 3 options

Signature of Employee	Today's Date (mm/dd/yyyy)
SAM SAMPLE - EMPLOYEE NEEDS TO SIGN	08/01/2023

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

If Translator used, complete separate document

Review and Verification: Employers or their authorized representative must complete and sign **S** mployee's first day of employment, and must physically examine, or examine consistent with an altern ary of OHS, documentation from List A OR a combination of documentation from List B and List C. En ditional Information box; see Instructions.

List A	OR	List B	AND
Document Title 1		Drivers License	SS Card
		Minnesota	SSA
		X123456789	123-45-7891
		12/01/2027	
Document Number (if any)			

If using documents from **List A**, no other information is needed ***(DO NOT WRITE ANYTHING IN COLUMN B OR C).***

If using documents from **list B and C**, list information in the proper columns ***(DO NOT WRITE ANYTHING IN COLUMN A).***

Employee needs to sign and date on the day they are hired. The Employer/ Responsbile Party signs the bottom of this document.

Additional Information

List the correct title for the person signing the I9. Example of titles: Responsible Party and Employer.

The MP or Employer need to sign and date on the day the employee is hired. This needs to be the same date the employee used.

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

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

First Day of Employment (mm/dd/yyyy): 08/01/2023

Last Name, First Name and Title of Employer or Authorized Representative	SiJnature of (mployer or $uthorized 5epresentative	Today's Date (mm/dd/yyyy)
Jones, Amanda - Responsible Party	Signature of RP or Employer	08/01/2023

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
Mary Jones	812 1st Ave N, Springfield, MN 55555

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

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 07/31/2026

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

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

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

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

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

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

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

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

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

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

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Acceptable Receipts

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

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

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

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

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

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 07/31/2026

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

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

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

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

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

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

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

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

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

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

EMPLOYER/EMPLOYEE AGREEMENT AND JOB DESCRIPTION
CFSS Support Worker

Employee Name _____ Date of Birth:_____

Person Receiving Services _____

This agreement/job description should be completed by you and your employer to establish the terms of employment. Both the employer and employee should maintain copies before submitting to Mains'l. We ask that the employee and employer review this together.

OVERVIEW OF THE EMPLOYER-EMPLOYEE RELATIONSHIP

Based on the services chosen, this support worker is employed by the person receiving services or their authorized representative (called the responsible party). The responsible party can be the individual receiving services, or a person designated on their behalf to manage services. Mains'l has been hired by the employer to act as the Fiscal Employer Agent, or Payroll Agent.

The responsible party is responsible for selecting the employee, providing on the job training as needed, determining the employee's schedule, and the employee's job responsibilities. The responsible party is also responsible for reviewing and approving timesheets. The responsible party and or individual receiving services can determine that an employee no longer work with them. If an employee resigns their position, the responsible party is to be contacted by the employee. The responsible party is responsible for notifying Mains'l in writing if an employee will no longer be working with them.

As our business partners, we expect the employer and their employees to follow Mains'l policies and procedures related to participant directed services. If a responsible party asks you to do something that is: not in your job description; not approved in the CFSS Individual Service Delivery Plan or goes against instruction from Mains'l, you can contact the Mains'l manager to receive clarification.

ESSENTIAL JOB DUTIES AND RESPONSIBILITIES:

Provide services to support the outcomes identified by the person in his or her CSP, under limited supervision, in a person-centered manner, considering the choices and preferences of the individual, thereby ensuring the well-being of the person supported and promoting his or her dignity as an individual.

- Work assigned shifts, arriving on time and staying until the end of the shift.
- Complete assigned tasks during the time of the shift.
- Monitor the safety of the individual receiving services and the environment.
- Ensure the health and safety of the individual receiving services.
- Responds to crises following the guidelines of the plan, Maltreatment Reporting, and the guidelines provided by the responsible party.
- Act according to mandated reporter's responsibilities defined in Statute and policy and procedure.
- **Employees (including family members, spouses, and parents) may not be paid for providing nursing tasks. These include administering medications and treating complex medical needs.**

REPORTING REQUIREMENTS AND EXPECTATIONS

- Report directly to the responsible party.
- Notify the responsible party when you need to miss a shift, will be late, or need to re-schedule.
    - Not showing up for work and not calling can be grounds for termination.
- Provide the responsible party written notice if you decide to terminate your employment.
- Report any suspected verbal, emotional, physical, or financial abuse, as well as any suspected. neglect, to MAARC within 24 hours of initial knowledge of the suspected. abuse or neglect situation.
- Contact the Mains'l manager as soon as possible if there is a MAARC report, serious injury, or hospitalization of the person you work with so we can ensure the proper individuals are notified.
- Report to the Mains'l manager and the responsible party any injuries or accidents that occur to you while you are working as soon as possible.
- The Mains'l manager can also be contacted if you have other questions, comments or concerns that are not able to be address by the responsible party.

TIMESHEETS

Timesheets must be entered, following the EVV Mandate, which includes clocking in and out at the start/end if your shift on our Mains'l EVV App. Timesheet guides can be found on our website: https://www.mainsl.com/fms-mn/

- Timesheets must be approved by the responsible party by the due dates on the payroll calendar.
- Time must be entered correctly. If time is not entered correct, your shift must be edited on our website and then approved by the responsible party before the due date and time listed on the payroll calendar to be paid on time.
- Time entered by the employee creates a legal and permanent timesheet record.
- Entering false information on a timesheet will result in a fraud report and potentially termination or criminal charges. Only the actual dates and times you work with the individual receiving the services can be submitted on a timesheet. **REVIEW YOUR TIMESHEET CLOSELY**
- Review the Payroll Policy and Timesheet System user guide before you begin working.

SCHEDULE AND PAY RATE

- The pay rate and scheduled hours are determined by the responsible party.
- A support worker can not work more than 310 hours in a calendar month with all participants receiving services no matter what agency or FMS the person receiving services uses. The employee is responsible for keeping track of their hours and not submitting time over the 310-hour limit. If time is submitted, the employee will be required to pay back the funds related to the overage.
- Changes to pay rates must be requested in writing by the responsible party and approved in the plan.
- Employees are not permitted to work overtime (more than 40 hours per week) unless given permission from the responsible party.
- Employees are not permitted to work when the person receiving services is not eligible for services. This includes while admitted to the hospital, while in jail, and when Medicaid/Medical Assistance is not active.

TRANSPORTATION

- An employee providing transportation to the individual receiving services must: have a valid driver's license; be insured; use a vehicle that is safely maintained; and follow all traffic laws.

ADDITIONAL INFORMATION FOR FAMILIES AND THOSE LIVING WITH THE PARTIPANT

- For employees who are supporting a family member or someone living in their home, only time spent completing the tasks/activities in the plan are considered worked time. Additional time would be considered normal family time or as a natural support and isn't paid or considered work time. Also, family members may only work up to the number of hours authorized in the individual's plan.
- Parents of Minors and Spouses should follow the schedule listed in the plan. Parents of Minors and Spouse are not paid for time spent doing activities that a parent or spouse would normally do and time spent doing those activities should not recorded on the timesheet.

Employer: I agree to treat all employees in a professional, business-like manner and to recognize the value of their services. I understand and I agree to follow the policies and procedures of this program that are provided by Mains'l.

Responsible Party Name (Printed): _____

Responsible Party/Employer Signature _____ Date: _____

Employee: I agree to carry out my duties and responsibilities as explained in this agreement/job description and my orientation. I understand and agree that any activities I engage in outside the realm of direct care responsibilities as described in this agreement/job description, I do at my own risk. I have reviewed, fully understand, and agree to the responsibilities of this job.

Employee Signature: _____ Date: _____

Employee Acknowledgement of Proper Timesheet and Service Billing Information

Did you know?
"It is a federal crime to provide materially false information on service billings for medical assistance or services provided under a federally approved waiver plan as authorized under Minnesota Statutes, sections 256B.0913, 256B.0915, 256B.092, and 256B.49."

What does this mean?
When you enter your time worked, it not only creates a timesheet to pay you, it also gets processed to create a bill for the service that you provided while working.

If you enter your time incorrectly, it could lead to an incorrect billing claim. People getting paid correctly and medical assistance (Medicaid) getting billed correctly is very important.

Minnesota Statues are the rules related to the following programs that provide supports and services to people:

- 256B.0913 are the rules related to the Alternative Care Program,
- 256B.0915 are the rules related to the Medicaid Waiver for Elderly Services
- 256B.092 are the rules related to Services for People with Developmental Disabilities
- 256B.49 are the rules related to Home and Community Based Services for People with Disabilities

Why are we talking about this and why am I signing this sheet?
We are informing you of this information up front because it is required. Starting July 1, 2019 employers, like the person you work for, are required to have documentation that staff have reviewed and attested to the statement listed at the top and bottom of this page. Employees will do this when they are hired and again they acknowledge this with each timesheet entry. We are also informing you because we believe that most people who know better, do better.
We want you to clearly understand that it is illegal to put false information on a service billing and/or a timesheet. It is also known as fraud.

What if I have questions?
In your hiring packet you received information on preventing insurance waste, abuse. We've also provided a training guide on how to enter your time worked so that you can be confident your timesheet documentation creates accurate payroll and billing.

If you have more questions, please talk to your employer or contact the Mains'l Coordinator.

Employee Attestation
By signing this form, I understand and confirm that I know that "It is a federal crime to provide materially false information on service billings for medical assistance or services provided under a federally approved waiver plan as authorized under Minnesota Statutes, sections 256B.0913, 256B.0915, 256B.092, and 256B.49."

Employee Name_____ Employee # _____

Employee Signature_____ Date_____

MINNESOTA PAID LEAVE

Minnesota Paid Leave

Minnesota Paid Leave provides payments and job protections when you need time off to care for yourself or your family.

You can take leave for the following qualifying events:

Medical Leave:

- To care for your own serious health condition, including care related to pregnancy, childbirth, and recovery

Family Leave:

- Bonding Leave – to care for and bond with a child welcomed through birth, adoption, or foster placement
- Caring Leave – to care for a family member with a serious health condition
- Military Family Leave – to support a family member called to active duty
- Safety Leave – to respond to issues related to domestic violence, sexual assault, or stalking for yourself or a family member

Am I covered by Paid Leave?

Most workers in Minnesota are covered by Paid Leave. You are covered no matter the size of your employer, or the hours or days you work. Independent contractors and self-employed individuals are not automatically covered, but may opt in. You may qualify for payments if you've been paid a minimum amount for work in Minnesota in the last year ($3,900 for the start of Paid Leave in 2026).

What are my employment protections?

- **Job protections:** Generally, you must be restored to your job or an equivalent position when returning from leave. Job protections take effect 90 days after your date of hire.
- **Health insurance continuation:** Generally, employers must continue to fund their portion of healthcare insurance and other group insurance premiums while you are on leave. You will be responsible for any portion of health insurance and other group insurance premiums that you pay.
- **No retaliation or interference:** Employers must not interfere with or retaliate against you if you apply for or use Paid Leave. Employers cannot take your Paid Leave payments.

MINNESOTA PAID LEAVE

For inquiries related to Paid Leave, please contact Minnesota Paid Leave at 651-556-7777 or visit our website. If you think your employer is violating employment protections, contact the Labor Standards Division at the Minnesota Department of Labor and Industry.

Who pays for Paid Leave?

Paid Leave is funded by premiums paid by employees and employers. **The initial premium rate is 0.88% of wages** up to the cap set by Social Security's Old-Age, Survivors, and Disability Insurance program (currently $176,000). Your employer **may deduct up to 0.44% of your wages** to fund your portion of the premium. This total premium covers both Medical Leave (0.61%) and Family Leave (0.27%). **The additional 0.44% will be deducted from the Participant's budget that you work with.**

Employers are responsible for sending premiums to Paid Leave on behalf of all employees.

Your premium contributions are:

Medical Leave				
	Total Medical Leave Premium: 0.61%			
	The budget of the participant you work with	will contribute	.305 %	of the Medical Leave contribution
		and the remaining	**.305 %**	**will be deducted from your wages**

Family Leave				
	Total Family Leave Premium: 0.27%			
	The budget of the participant you work with	will contribute	.135 %	of the Family Leave contribution
		and the remaining	**.135 %**	**will be deducted from your wages**

Total deducted from your wages	****Beginning with wages paid 1/1/26**	**.44%**

MINNESOTA PAID LEAVE

How do I take Paid Leave?

1. Notify your employer / the Participant you work with.
2. Apply with Paid Leave. You will be able to apply for Paid Leave at **paidleave.mn.gov.** You can also apply over the phone if needed.

After you apply, you will receive a determination from Paid Leave, which is the official decision from the program about whether your application was approved or denied.

If you are approved for Paid Leave payments, they will be sent to the bank account or prepaid debit card selected in your application.

Learn more

Visit **paidleave.mn.gov** to apply or for more information about Paid Leave, including calculators to help you estimate your premium costs and the payments you could receive under Paid Leave.

Other ways to reach us

Phone: 651-556-7777 or 844-556-0444 (toll free). E-mail: paidleave@state.mn.us

Mail: Department of Employment and Economic Development, Paid Leave Division
180 E 5th Street, 12th Floor, Saint Paul, MN

Information is available in alternative formats for people with disabilities by using the contact information listed above.

Employer Information:

Employer Name:	This is listed on your paystub, under "Agent for"
Mailing Address:	Please contact the Managing Party of the individual you work with to receive the address of the Employer you work with.
Employer Identification Number (FEIN):	This is listed on your W2. If you do not have a copy of your W2, please contact either the Managing Party of the individual you work with or your Mains'l Coordinator, and they can provide the FEIN number for you.

Employee Acknowledgement:

	By signing below, I acknowledge receipt of this notification.
Name	
Signature	
Date	

EMPLOYEE RESPONSIBILITES ACKNOWLEDGEMENT

Employee Name: _____

Job Title: Direct Support Professional / CFSS Worker

- To help you learn your role and responsibilities in this job, we ask that you review the policies, procedures, and other paperwork in your new employee paperwork within the first week of work.
- Please ask questions if you do not understand or need more information about anything.
- While all of the information is important, below are some very important things to know. All of these are covered in your new employee paperwork.

We ask for you to initial each statement to tell us that you know and agree to each responsibility.

Reporting Responsibilities in Consumer Directed Programs

_____ I will report workplace related injury to my Mains'l contact as soon as possible, but no later than 24 hours. I understand a delay in notification and in returning documentation may impact my Worker's Compensation.

_____I understand that paid and unpaid caregivers, including myself, are required to report to the Common Entry Point (CEP) any suspected maltreatment as soon as possible, but no longer than 24 hours from becoming aware of the suspected maltreatment. If I do not report, I know I may get into serious trouble. *Details are in Reporting and Responding to Maltreatment Policy and Procedure*.

_____I understand that I am required to report to any suspected fraud as soon as possible, but no longer than 24 hours from becoming aware of the suspected fraud. If I do not report, I know I may get into serious trouble. *Details are in Preventing Insurance Waste, Abuse, and Fraud Policy and Procedure*

_____I will notify Mains'l or the Case Manager by phone or email within 24 hours of knowing about any of the following situations involving the individual receiving services;

1. Any serious injury to the individual receiving services.
2. Hospitalization, nursing home placement, or jail of the individual receiving services.
3. The person leaving the state or country for more than 30 days.
4. Any change of my contact information including my phone, email, and mailing address.
5. Significant changes in the person's need for services (needing more or less).

Timesheets, Payroll, and Billing

_____I understand that timesheets are legal documents used to bill Medicaid or other funding sources. I cannot put any date or time on my timesheet that I was not actually doing the work myself. Only the actual dates and times I work can be submitted for payment and the time must be entered accurately.

_____If I put false information on a timesheet or other document, I am at risk of being charged with Medicaid fraud or other fraud and I am jeopardizing the person's services and my position.

_____I understand my timesheet must be entered on the date the shift is worked to be compliant with the

federal EVV guideline. If I make a mistake on my timesheet entry, I will correct it on the timesheet website or contact my Mains'l Manager right away to help me. I understand I must use the Mains'l EVV app to clock in and clock out at the start/end of each shift I work.

Job Description and Health and Safety

_____I have read and agreed to the job description provided to me by the individual receiving services or the Responsible Party.

Work Limitations for Consumer Directed Programs

_____I am responsible for communicating to Mains'l if I resign my position. Depending on the circumstances, the I may be entitled have my PTO paid out. This also helps Mains'l maintain accurate records of who is currently employed.

_____I understand that the individual receiving services must be always with me while I am working. *This is because almost all services require the person be present to receive the service*.

_____I understand that I am not able to work with the person receiving services if they are in the hospital, a nursing home, or in jail. *This is because the services I provide cannot be used while a person is in the hospital, nursing home, or in jail*.

_____If a person leaves the state of Minnesota; I cannot work until they return to Minnesota, unless I have received written notice from Mains'l that it is okay. *This is because the services I provide require special permission before being used in another state or country (includes vacations)*.

_____ I understand as a Support Worker I can only work up to 310 hours per month. This hour limit includes all participants I work with over any agency or FMS in the state of Minnesota. Combined hours worked, with all participants, can not exceed 310 hours in a calendar month. I understand I am responsible to keep track of this and if I exceed it, I will be required to pay back Mains'l for the funds related to the hours worked over the limit.

_____ I understand that my hours worked will be reported to the State of Minnesota and tracked in a database that will recognize if I submit time worked with multiple participants over different agencies. The State of Minnesota only allows you to work with a participant at one agency at a time. I understand, if I submit hours that overlap with multiple agencies my hours will be considered fraudulent and I will be required to pay the hours back to Mains'l that I was paid.

_____ _____

EMPLOYEE SIGNATURE DATE

INSTRUCTIONS COMPLETING CFSS WORKER TRAINING

Minnesota Law requires all individual CFSS Workers take the Department of Human Services (DHS) Individual PCA/CFSS Training and pass a one-time online test. Workers may take the training and test as often as they like.

This training is intended for anyone wanting to be paid to provide services to an individual who is receiving services through Community First Services and Supports (CFSS). All workers must complete this training before they are able to work and be paid to provide services. This online training is free.

Upon completion of the training, workers will be able to:

- Describe the CFSS program and the role the worker plays in them.
- Understand how to provide CFSS services in a person-centered manner.
- Respond appropriately in the event the person's health and safety are at risk.

People taking this training must have:

- A computer, tablet or phone with internet access. If you do not have a personal device, contact your Mains'l Manager to schedule a time to complete this training at our Mains'l office in Brooklyn Park.
- A valid email address.

Register or the training through the DHS website / online training registration page. This link will also be posted on our website in the event it is changed. www.mainsl.com/fms-mn/

DHS Training Registration Page https://registrationtraining.dhs.state.mn.us/?BusinessUnitID=16

- Select the button next to the CFSS Support Worker Option
- Click the Next- Register button to open and complete the registration page and submit your registration.
- Check your email for the next steps.

After passing the test, please print the certificate of successful completion and send this to Mains'l. DHS will also send a copy to the email address you used to register for the test and you are able to forward that to Mains'l as well.

If you lose your certificate, the directions to get a copy of it can be found on the DHS website https://mn.gov/dhs/partners-and-providers/training-conferences/minnesota-health-care-programs/provider-training/pca.jsp

BACKGROUND STUDY SUBMISSION FORM

The information you provide on this form will be used to run a background study through the Minnesota Department of Human Services. They will mail the results of your background study to you.

Privacy Notice: Your background study privacy rights are outlined in a separate notice entitled "Background Study Notice of Privacy Practices" (dated 2/12/2015).

Instructions: Please print clearly. Items marked with an asterisk (*) are optional. All other information is required.

Completion of this form is not intended as an offer of employment

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Instructions: Please print clearly and legibly

CFSS Worker Training Certificate Number (Must include copy of certificate):_____

First Name _____

Middle Name _____

Last Name _____

Social Security Number (provide for background to be transferable)* _____

Birth Date _____

Address_____

City _____ State _____

Zip Code _____ County: _____

Race _____ Sex _____

Eye Color_____ Hair Color_____

Height_____ Weight_____

Citizen of the United States? : ☐ Yes ☐ No Place of Birth_____

Primary Telephone_____ Phone Type: _____

Secondary Telephone_____ Phone Type: _____

Email address: _____

Items marked with an asterisk (*) are optional. All other information is required. *(Rev. 12/9/2024)*

BACKGROUND STUDY SUBMISSION FORM

Driver's License/State I.D.Number _____Which State? _____

Expiration Date of Driver's License/ State I.D.: _____

** ** **You must include a copy of your ID with your forms** ** **

Other First Names You Have Used _____

Other Last Names You Have Used _____

Have you resided outside the state of Minnesota within the last 5 years?

☐ Yes ☐ No

If **yes**, please list the prior out of state address within the last 5 years:

1._____

Year From:_____ Year To:_____

2._____

Year From:_____ Year To:_____

3._____

Year From:_____ Year To:_____

4._____

Year From:_____ Year To:_____

5._____

Year From:_____ Year To:_____

I hereby certify that the facts stated above are true and complete to the best of my knowledge.

Signature: _____ Date:_____

Items marked with an asterisk (*) are optional. All other information is required. *(Rev. 12/9/2024*

DEPARTMENT OF HUMAN SERVICES

To: Agency representatives

RE: Individual Community First Services and Supports (CFSS) Worker Enrollment Application

As an agency that provides services to Minnesota Health Care Programs (MHCP) members, you must submit this enrollment application and provider agreement for each individual Community First Services and Supports (CFSS) worker. When MHCP approves your application, we will:

- Assign a Unique Minnesota Provider Identifier (UMPI) to the CFSS worker.
- Affiliate the CFSS worker to your agency.
- Allow you to bill MHCP for the services the CFSS worker provides to members.

To enroll CFSS workers with MHCP, the CFSS worker must:

1. Read and understand the Data Privacy Notice (DHS-6287) (PDF).
2. Complete and pass the Minnesota Department of Human Services (DHS) background study under each agency facility ID number. The CFSS worker must complete a new background study if the CFSS worker ends employment with your agency or your agency ends the CFSS worker's affiliation and you rehire the CFSS worker.
3. Successfully complete and pass the required Individual PCA and CFSS training and test.
4. Complete and sign this application or use the Minnesota Provider Screening and Enrollment (MPSE) portal to complete an organization to direct support worker affiliation request. There is a DSW affiliation video that can help guide users through the MPSE portal affiliation request process. Providers should choose between the fax option or the MPSE portal, and do not need to do both.
5. Read and sign the Individual Direct Support Worker (CDCS, CSG, PCA, CFSS) Provider Agreement (DHS-4611) (PDF).

Optional training

The CFSS worker may choose to complete the Qualified Enhanced Rate training. Additional information related to enhanced rates and CFSS agency responsibilities are on the Enhanced rate/budget page in the CFSS Manual.

Background study

Complete a background study by logging in to the NETStudy website. Follow the directions on the NETStudy website.

More information is on the MHCP provider Background studies webpage.

DEPARTMENT OF HUMAN SERVICES

DHS-4469B-ENG 8-24

MINNESOTA HEALTH CARE PROGRAMS (MHCP)

Individual Community First Services and Supports (CFSS) Worker Enrollment Application

Complete all fields to enroll a CFSS worker or complete your request using the Minnesota Provider Screening and Enrollment (MPSE) portal. If faxing, complete this form online, print and then fax to Minnesota Health Care Programs (MHCP). An incomplete form will delay processing of this application. Check one of the following:

- (●) New hire (requires new background study and completion of CFSS worker training)
- ( ) Rehire (requires new background study and certificate number from the CFSS worker training) – previous employment end date: _____
- ( ) Revalidation

CFSS Worker Information

PROVIDER TYPE **38 - Individual**	**SOCIAL SECURITY NUMBER**	**UMPI** (IF REQUESTING REINSTATEMENT or REVALIDATING)
LEGAL NAME (FIRST)	**FULL MIDDLE NAME**	**LAST NAME**
DATE OF BIRTH	PHONE NUMBER	

CFSS Worker Address

STREET ADDRESS (RESIDENTIAL ADDRESS ONLY – DO NOT ENTER A PO BOX)			
CITY	**STATE**	**ZIP CODE**	**COUNTY OF RESIDENCE**

CFSS Worker Training Information

INDIVIDUAL PCA/CFSS TRAINING COMPLETION DATE	INDIVIDUAL PCA/CFSS TRAINING CERTIFICATION NUMBER

CFSS Worker Background Study Information

BACKGROUND STUDY NUMBER	APPLICATION NUMBER	FACILITY ID

Individual CFSS Worker Provider Statement

I have reviewed and certify the information provided on this form is true and correct to the best of my knowledge. **I will notify the MHCP Provider Eligibility and Compliance of any additions or changes to the information.**

By signing this form, I acknowledge I have read and understand the Data Privacy Notice (DHS-6287) (PDF). I also authorize MHCP to use the information you collect about me according to the Privacy Notice.

Check if signing electronically:

☐ I am signing this form electronically. My name as typed in the signature field is my legally binding signature. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (Minnesota Statutes, 325L.02(h), 325L.05 and 325L.08)

NAME OF CFSS WORKER (print or type)	**SIGNATURE OF CFSS WORKER**	**DATE SIGNED**

Organization Affiliation Information

You may affiliate or enroll the CFSS worker named on this form with other agencies you directly own without completing another application and agreement. Do you want to affiliate this CFSS worker with any other agencies you own?

☐ No ☐ Yes

Organization Information

Check if signing electronically:

☐ I am signing this form electronically. My name as typed in the signature field is my legally binding signature. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (Minnesota Statutes, 325L.02(h), 325L.05 and 325L.08)

ORGANIZATION OR AGENCY NAME		FACILITY NPI OR UMPI
Mains'l Services		A784457500
ORGANIZATION FAX NUMBER	**ORGANIZATION PERSONNEL COMPLETING FORM (first and last name)**	**ORGANIZATION PERSONNEL SIGNATURE**
763-416-9195		

Next Steps

Read, sign and date the Individual Direct Support Worker (CDCS, CSG, PCA, CFSS) Provider Agreement (DHS-4611) (PDF), and fax it with this application to MHCP Provider Eligibility and Compliance at **651-431-7465**.

Or, complete the organization to direct support worker affiliation request in the MPSE portal and upload DHS-4611 in MPSE.

MHCP will process only complete requests.

DEPARTMENT OF HUMAN SERVICES

DHS-4611-ENG 8-24

MINNESOTA HEALTH CARE PROGRAMS (MHCP)

Individual Direct Support Worker (CDCS, CSG, PCA, CFSS) Provider Agreement

As a participating provider in Minnesota Health Care Programs (MHCP) administered by the Minnesota Department of Human Services (DHS), the provider agrees to:

A. Submit documentation to your affiliated agency that fully discloses the extent of services provided to individuals under these programs. The documentation must be legible and meet the requirements of Minnesota Statutes, 256B.0659, subdivision 12 for all individual support workers in Consumer Directed Community Supports (CDCS), Consumer Support Grant (CSG), Personal Care Assistance (PCA), and Minnesota Statutes, 256B.85, subdivision 16 for Community First Services and Supports (CFSS).

B. Provide DHS, the secretary of the U.S. Department of Health and Human Services (DHHS), or the Minnesota Medicaid Fraud Control Unit such information as it may request regarding payments claimed for services provided under these programs.

C. Comply with all federal and state statutes and rules relating to the delivery of services to individuals and to the submission of claims for such services.

D. Accept as payment in full, amounts paid in accordance with schedules established by DHS, except where payment by the member has been authorized by DHS.

E. Make full disclosure of any conviction(s) of program crimes as required by the Code of Federal Regulations, title 42, section 455.106.

F. Comply with all federal statutes, implementing regulations and guidance prohibiting discrimination on the basis of race, color, national origin, sex, age, religion and disability in any program or activity receiving federal financial assistance from DHHS; and to comply with the Minnesota Human Rights Act.

G. Provide services to members of the same scope and quality as would be provided to the general public, within MHCP guidelines.

H. Comply with the provisions of any fully executed agreement or addendum required by DHS, which is incorporated herein by reference.

I. Comply with the advance directive requirements as required by the Code of Federal Regulations, title 42, sections 489.100 and 417.436.

J. Properly handle and safeguard protected information collected, created, used, maintained, or disclosed on behalf of DHS. For purposes of this agreement, “protected information” means data subject to any of the following laws:

1. The Minnesota Government Data Practices Act (MGDPA), Minnesota Statutes, chapter 13, section 13.46 ("welfare data");
2. The Minnesota Health Records Act, sections 144.291 and 144.298;
3. The Health Insurance Portability and Accountability Act (“HIPAA”), including but not limited to the requirements of the Privacy Rule and the Security Regulations, the Code of Federal Regulations, title 45, parts 160 and 164, subparts A and E.
4. Federal law and regulations that govern the use and disclosure of substance abuse treatment records, the United States Code, title 42, section 290dd-2 and the Code of Federal Regulations, title 42, sections 2.1 to 2.67; and

Electronic initials accepted.

DIRECT SUPPORT WORKER INITIALS

NAME OF SUPPORT WORKER (TYPE OR PRINT)	UMPI

5. Any other applicable state and federal statutes, rules, and regulations affecting the collection, storage, use and dissemination of private or confidential information.

K. Comply with the laws described in section J. This includes the provider:

1. Not using or further disclosing protected information created, collected, received, stored, used, maintained or disseminated in the course or performance of this agreement other than as necessary to perform its obligations under this Provider Agreement, or as required by law, either during the period of this agreement or after. See, respectively, the Code of Federal Regulations, title 45, sections 164.502(b) and 164.514(d), and Minnesota Statutes, 13.05, subdivision 3.
2. Using appropriate administrative, physical, and technical safeguards to prevent use or disclosure of the protected information other than as provided for by this agreement and to ensure the confidentiality, integrity, and availability of any electronic protected health information (PHI) that it creates, receives, maintains, or transmits on behalf of DHS. The provider will not transmit PHI over the Internet or any other unsecure or open communications channel unless such information is encrypted or otherwise safeguarded using procedures no less stringent than those described in the Code of Federal Regulations, title 45, section 164.312. If the provider stores or maintains PHI in encrypted form, the provider shall, at DHS' request, promptly provide DHS with the key or keys to decrypt such information. The provider shall not forward previously encrypted data to any other party, unless otherwise required by this agreement.
3. Mitigating, to the extent practicable, any harmful effects known to the provider of a use, disclosure, or breach of security with respect to protected information by the provider in violation of this agreement.

L. Agree that this agreement may be immediately terminated at the discretion of DHS if it determines that the provider has violated a material term of the agreement, including but not limited to, non-compliance by the provider with the HIPAA Privacy Rule and Security Standards. If termination is not feasible, DHS shall report the breach to the Secretary of DHHS.

Upon termination of this agreement, all of the protected information provided by DHS to the provider, or created or received by the provider on behalf of DHS, that the provider still maintains in any form, including information that is in the hands of subcontractors or agents of the provider, shall be destroyed or returned to DHS, and the provider shall retain no copies of such information. If it is infeasible to return or destroy the information, the provider shall provide DHS notification of the conditions that make return or destruction infeasible, and shall extend the protections of this agreement to such information and limit further use and disclosure of such information to those purposes that make return or destruction infeasible, for as long as the provider maintains the information.

M. Agree that any ambiguity in this agreement shall be resolved to permit DHS to comply with HIPAA, MDGPA, and other applicable state and federal statutes, rules, and regulations affecting the collection, storage, use and dissemination of private or confidential information and other state and federal laws and regulations.

Upon signature, this Provider Agreement supersedes and replaces all former Provider Agreements the provider has with DHS.

An individual applicant must personally sign the Provider Agreement. Sign and date this form, initial page 1, and return both page 1 and page 2 of this agreement.

Check if signing electronically:

☐ I am signing this form electronically. My name as typed in the signature field is my legally binding signature. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (Minnesota Statutes, 325L.02(h), 325L.05 and 325L.08)

NAME OF SUPPORT WORKER (TYPE OR PRINT)	TITLE Direct Support Professional
SIGNATURE OF SUPPORT WORKER	DATE

Keep a copy of the Provider Agreement for your files and upload the original form using the online **Minnesota Provider Screening and Enrollment (MPSE) portal**, or fax to 651-431-7465.

Agreement Summary

As an individual support worker, you are providing health care services to individuals. We require your enrollment in the Minnesota Health Care Programs (MHCP) and to be listed as the rendering provider on the claim so that you are represented as the person who provided the services. Knowing that a qualified individual provided the service ensures the safety of the people that the Minnesota Department of Human Services (DHS) serves. It also allows DHS to perform auditing and tracking of services which protects against double-billing and other types of fraud. Before enrollment is approved, MHCP must make certain that:

1. There is no legal or other reason why you shouldn't provide these services,
2. You understand what is necessary to properly provide these services, and
3. You understand the need to protect the privacy of the people you care for.

To help ensure that each of these conditions is met, MHCP requires that you agree to the terms in the attached Provider Agreement. In general, this agreement requires that you:

A. Provide documents to your employer about the services you provide.

B. Provide documents to MHCP or other state and federal agencies related to the services you provide, when requested.

C. Comply with federal and state laws about the services you provide.

D. Accept payment made to your employer as payment in full for the services you provide. You cannot ask for nor accept additional payment from the member.

E. Disclose any criminal convictions you have related to Medicare, Medicaid, or title XX services.

F. Not discriminate against individuals because of their race, color, national origin, sex, age, religion or disability when you provide these services.

G. Provide the same quality of service to persons receiving public assistance as those who don't receive such assistance.

H. If you are enrolled to provide and bill for other services, you must continue to follow the requirements of the agreement you signed when you enrolled for those services. The terms of that agreement are different than the terms in the attached agreement.

I. Comply with federal requirements about advance directives. An advance directive is written instruction, such as a living will, to give a patient control over medical treatment decisions.

J. Properly protect private information about the people to whom you provide services, especially their health information.

K. Don't disclose the private information of someone for whom you provide services, unless it is needed for your work. This includes not discussing someone's private information unless your job requires it. Also, ensure that the information could not be accessed by someone who does not have permission to see it. This includes not leaving paperwork out where others can see it, and not sending private information over the internet.

L. Understand that this agreement may be canceled if you violate its terms. If this agreement is canceled, you must properly dispose of any private information you have about the people you serve so that it is not discovered by someone who does not have permission to see it.

M. Understand that by signing this agreement, you are agreeing to protect any private information you come in contact with in your job. When you protect private information, you are complying with federal and state laws, and you help DHS comply with these laws, as well.

This is a basic description of the terms of this agreement.

By signing this agreement, you are agreeing to be legally bound by all its terms. If you have questions about it, you should get answers to them before signing this agreement. If you need or want legal advice, you should contact your own attorney. For more information, call 651-431-2700.

Electronic Visit Verification (EVV) Live In Caregiver Form

This form should only be completed if you live at the same address as the person you support.

Employee Name:_____Employee Number_____

Name of Person Receiving Services:_____

Managing Party Name: _____

Home address of Employee and Person Receiving Services:

Address: _____

City:_____State:_____Zip Code: _____

Is this a permanent or temporary living arrangement?

Permanent ☐ Temporary ☐

If Temporary, what are the dates of this temporary living arrangement?

Start Date_____ End Date _____

_____(Initial) I understand, as a live-in caregiver, that I must continue to enter my shift on the date it was worked. Completing this form does not exempt me from being required to enter the hours worked on the day they were worked.

We attest that the above-named employee and person using services live at the same address listed above and the information provided is accurate.

Employee Signature:_____ Date: _____

Managing Party Signature:_____ Date: _____

FMS Agencies are required to collect documentation of the live in caregiver status. Documentation must show the caregiver's name and current address matching the person receiving services. This documentation will be collected yearly. As documentation, please include one of the following items with your form:

- Copy of your current MN Driver's License or ID Card
- Residential Lease
- Tax Statement
- At least two consecutive months of utility bills with the address matching the person receiving services.