Mains'l has been selected by your employer to provide payroll-related services as the Fiscal Employer Agent (F/EA). **Mains'l is not your employer.** While you are employed by the participant (your employer), Mains'l is responsible for processing your hiring paperwork, approved timesheets, payroll, taxes, and year-end W-2. The participant, or their designated representative acting as the Responsible Party, remains responsible for directing your work, approving your schedule and time worked, and overseeing the services you provide as your employer.

Before you can begin working, you must complete all required hiring forms included in your application packet. Once your paperwork is submitted, Mains'l will begin processing your background study, which is required by the State of Minnesota.

After your background study is initiated, you will receive two emails:

- An informed consent form
- A link to schedule your fingerprinting appointment

Please watch your email closely (including your spam or junk folder) and complete both steps as soon as possible. These items must be completed within a short timeframe, and delays may impact your start date.

You may begin working only after:

- All hiring paperwork is completed
- Your background study has been approved
- You receive confirmation from Mains'l that you are cleared to work

Please note that Mains'l cannot issue payment for any time worked before your official start date. Any hours worked prior to receiving clearance will not be paid through Mains'l.

Once you are approved to begin working, you will receive instructions on how to submit your timesheets so you can be paid on schedule.

If you have any questions or need assistance during this process, please contact the Mains'l Self-Directed Services team.

Sincerely,

Mains'l Self-Directed Services Team

Please follow the instructions below. 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.

Please use the checklist below to ensure your employee packet is complete.

☐ New Employee Information

Complete this form.

☐ Employee Relationship Disclosure

Complete this form, indicating your relationship to the Employer.

☐ W4-MN MN Employee Withholding Allowance/Exemption Certificate

Complete either section 1 or section 2.

☐ Form W-4 Employee's Withholding Allowance Certification

Complete steps 1& 5, follow the directions to determine if you should complete steps 2-4.

☐ Payroll Direct Deposit Authorization Form

Complete the form- attach a voided check or banking information.

☐ Paid Time Off (PTO) Status Form

Read this form and choose one box.

☐ Employment Eligibility Verification / I-9 Form

Please follow the sample I-9 form included in your packet exactly when completing this document.

1. *You complete - Section 1 – Employee Information and Attestation*
   You will also need to provide acceptable forms of identification to your Employer/Responsible Party so they can complete Section 2.
2. *Your Employer/Responsible Party complete - Section 2 – Employer Review and Verification*
   A list of acceptable documents is included in your packet.
   Section 2 must be signed and dated on the same date that you completed Section 1.
3. *Return the I-9 form and copies of the required identification.*

☐ Background Study Submission Form

Complete this form. Ensure your full name matches your photo ID and include a copy of your photo ID with your completed employee packet.

☐ Provider Agreement- Individual Support Worker

Read the form, print your name at the bottom, and initial in the box on the right.

☐ Individual Support Worker Enrollment Application

Complete the form. If you are unsure what a box means, leave it blank. Mains'l will complete the Background Study Information section. Sign and date under "Individual CDCS or CFSS Worker Provider Statement."

☐ Employee Responsibilities Acknowledgment

Read each statement and initial to acknowledge your understanding and acceptance of responsibility.

☐ Employee/Employer Agreement – Job Description

Review this form and speak with your Employer if you have any questions.

☐ Minnesota Paid Leave Notice

Read the information, sign, and date the form.

☐ Electronic Visit Verification – Live-In Caregiver Form

Complete this form only if you live at the same address as the person you support. Be sure to include proof of address (see the list of acceptable documents at the bottom of the form).

☐ Workers' Compensation Exclusion Acknowledgement

Complete this form only if you are interested in being excluded from Workers' Compensation Coverage AND are the spouse, parent or child of the employer.

☐ Reference Materials

Review the attached reference materials:

- *Payroll in Self-Directed Services Policies and Procedures*
- *Mileage Reimbursement Policy and Procedure*
- *Workplace Injuries & Workers' Compensation Policy*
- *Payroll Calendar*
- *Responding to and Reporting Maltreatment Policy and Procedure*
- *Preventing Fraud, Abuse, and Waste of Medicaid and Other Insurance*

MAINS'L
FINANCIAL MANAGEMENT SERVICES

CDCS NEW EMPLOYEE INFORMATION

Employee Full Legal Name:

First _____ Middle _____ Last _____ Suffix _____

Date of Birth _____ Gender _____ Preferred Language _____

Street Address _____ Apartment/Unit # _____

City _____ State_____ Zip_____ County _____

Email Address _____ Phone Number _____

Social Security Number _____

Name of Participant(s) you will be working with _____

Your relationship to the Participant _____

Name of Household Employer (EIN Holder) -Not Mains'l _____

Your relationship to the Employer _____

Have you previously been employed by this employer? ☐ No ☐ Yes

This Section Will Be Completed by Mains'l

Mains'l Coordinator _____ Cost Center _____

Is this employee employed by another employer? ☐ No ☐ Yes _____

Primary Wage Type _____ Pay Rate _____

Additional Wage Type _____ Pay Rate _____

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

Workers' Comp Status ☐ Covered ☐ Opt Out

Additional Notes _____

Official Hire Date (date I-9 Signed) _____ Pay Tier Level Select

MAINS'L
FINANCIAL MANAGEMENT SERVICES

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

DEPARTMENT OF REVENUE

* 2 6 2 4 6 1 *

2026 W-4MN, Minnesota Employee Withholding Certificate

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 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 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 2026 Minnesota income tax return, you may also complete the Itemized Deductions and Additional Income Worksheet. . . . . **F** 0

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 2026 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 $1,300.
- 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 2026 Minnesota itemized deductions. For 2026, you may have to reduce your itemized deductions if your income is over $244,500($183,350 for Married Filing Separately). . . . . _____

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

a. $30,600 if Married Filing Jointly

b. $23,000 if Head of Household

c. $15,300 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 2026 additional standard deduction (from page 11 of the Form M1 instructions) . . . . . _____

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

6 Enter an estimate of your 2026 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 $5,300. 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 $1,300.
- 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 questions.

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 2026 Form W-4 will need to complete 2026 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 number 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.
- 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.

W-4 Quick Guide for Employees (General Information Only)

This guide is designed to help you understand how to complete your Federal Form W-4. **This form is titled "Form W-4 Employee's Withholding Certificate".**

Important Notes:

- The Federal W-4 no longer allows claims of 1, 2, etc. in any of the steps listed on the form. Please read the instructions carefully for Steps 3 and 4.
- Some sections ask for **dollar amounts**, but **not all employees need to complete every step**.
- You only need to fill out the steps that apply to your situation.

Disclaimer: This guide is for general information only and is not tax advice. For personalized help, use the IRS Tax Withholding Estimator or consult a tax professional.

Step 2: Multiple Jobs or Working Spouse (Optional)

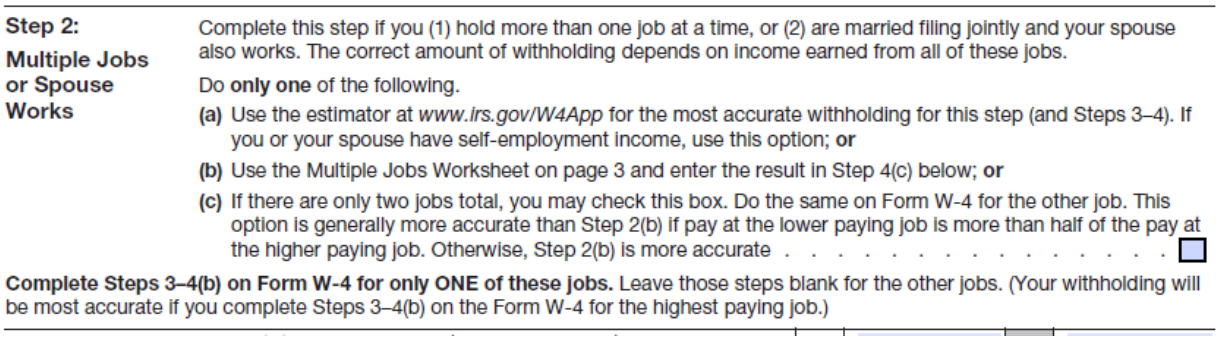
Complete this step **only if**:

- You have more than one job at the same time, or
- You're married filing jointly and your spouse also works

Options include:

- Using the IRS Tax Withholding Estimator: www.irs.gov/W4App
- Checking the box in Step 2(c) if jobs have similar pay

This step helps ensure enough tax is withheld.



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 Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(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 Dependents (Optional)

Before completing:

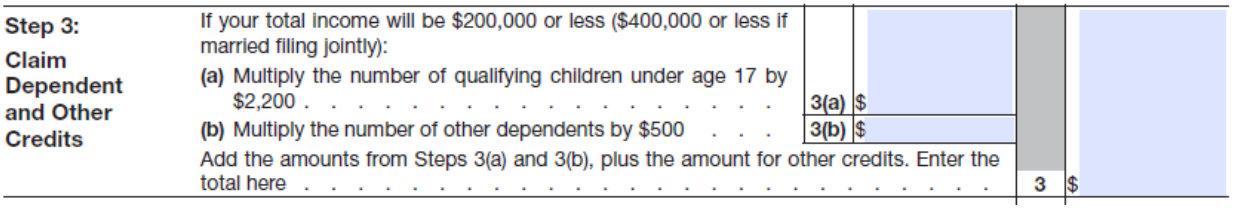
- Review the income limits listed in step 3 on the form

If eligible, enter:

- Number of qualifying children under age 17 × $2,200
- Other dependents × $500

W-4 Quick Guide for Employees (General Information Only)

This may reduce the amount of tax withheld. Remember, this section is no longer used to claim the number of dependents by writing a 1, 2, etc. This step asks for a dollar amount, using the calculation listed in the step 3 box.



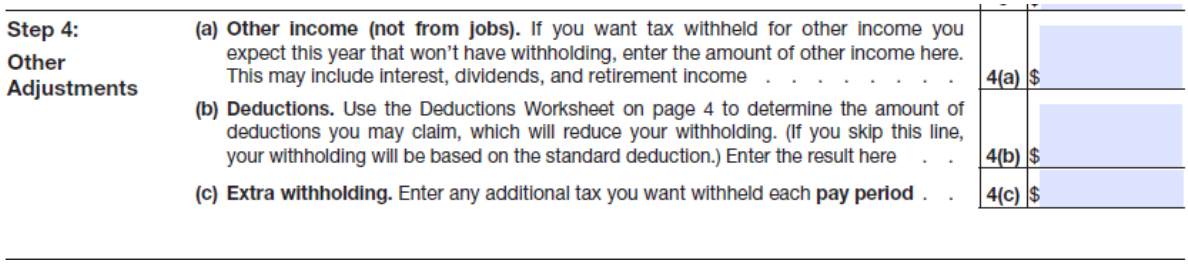
Step 3: **Claim Dependent and Other Credits**	If your total income will be $200,000 or less ($400,000 or less if married filing jointly):			
	(a) Multiply the number of qualifying children under age 17 by $2,200	**3(a)** $		
	(b) Multiply the number of other dependents by $500	**3(b)** $		
	Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here		**3**	$

Step 4: Other Adjustments (Optional)

Use this section if you want to adjust your withholding further:

- **4(a):** Other income (not from this job)
- **4(b):** Deductions (if you itemize)
- **4(c):** Extra tax withheld per paycheck

Many employees leave this section blank unless they have additional income or want extra withholding.



Step 4: **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. Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) Enter the result here	**4(b)**	$
	(c) Extra withholding. Enter any additional tax you want withheld each **pay period**	**4(c)**	$

Key Reminders

- You are **not required** to complete every section—only those that apply to you
- If you skip optional sections, your withholding will be based on basic information (Step 1)
- You can update your W-4 at any time if your situation changes

Need More Help?

Visit the Internal Revenue Service website or use the Tax Withholding Estimator for more guidance.

Reminder: Neither your employer or Mains'l can provide individualized tax advice. If you're unsure how to complete your W-4, consider speaking with a qualified tax professional.

_____ I understand that taxes will be withheld accordingly based on how I fill out my W-4's. I have read this reference guide and understand that if submit an invalid W-4, I will be asked to read instructions thoroughly and redo the form. I understand this can delay when I will be able to begin working.

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

2026

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.)

Caution: To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.

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 Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(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):

(a) Multiply the number of qualifying children under age 17 by $2,200 . . . . . **3(a)** $

(b) Multiply the number of other dependents by $500 . . . **3(b)** $

Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here . . . . . **3** $

Step 4: 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. Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) Enter the result here . . **4(b)** $

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

Exempt from withholding

I claim exemption from withholding for 2026, and I certify that I meet **both** of the conditions for exemption for 2026. See *Exemption from withholding* on page 2. I understand I will need to submit a new Form W-4 for 2027 . ☐

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 2026 if you meet both of the following conditions: you had no federal income tax liability in 2025 **and** you expect to have no federal income tax liability in 2026. You had no federal income tax liability in 2025 if (1) your total tax on line 24 on your 2025 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), 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 2026 tax return. To claim exemption from withholding, certify that you meet both of the conditions by checking the box in the *Exempt from withholding* section. 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 16, 2027.

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 of tax withheld 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 (and/or your spouse if married filing jointly) must have the required social security number to claim certain credits. 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.

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 15, if you expect to claim deductions other than the basic standard deduction on your 2026 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for qualified tips, overtime compensation, and passenger vehicle loan interest; student loan interest; IRAs; and seniors. You (and/or your spouse if married filing jointly) must have the required social security number to claim certain deductions. For additional eligibility requirements, see Pub. 501.

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 when you file your tax return.

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 5. 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 5 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 5 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 (plus any other additional amount you want withheld) . . . . . **4** $

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

See the Instructions for Schedule 1-A (Form 1040) for more information about whether you qualify for the deductions on lines 1a, 1b, 1c, 3a, and 3b.

1 Deductions for qualified tips, overtime compensation, and passenger vehicle loan interest.

- **a** **Qualified tips.** If your total income is less than $150,000 ($300,000 if married filing jointly), enter an estimate of your qualified tips up to $25,000 . . . **1a** $
- **b** **Qualified overtime compensation.** If your total income is less than $150,000 ($300,000 if married filing jointly), enter an estimate of your qualified overtime compensation up to $12,500 ($25,000 if married filing jointly) of the "and-a-half" portion of time-and-a-half compensation . . . **1b** $
- **c** **Qualified passenger vehicle loan interest.** If your total income is less than $100,000 ($200,000 if married filing jointly), enter an estimate of your qualified passenger vehicle loan interest up to $10,000 **1c** $

2 Add lines 1a, 1b, and 1c. Enter the result here . . . **2** $ $ 0.00

3 **Seniors age 65 or older.** If your total income is less than $75,000 ($150,000 if married filing jointly):

- **a** Enter $6,000 if you are age 65 or older before the end of the year . . . **3a** $
- **b** Enter $6,000 if your spouse is age 65 or older before the end of the year and has a social security number valid for employment . . . **3b** $

4 Add lines 3a and 3b. Enter the result here . . . **4** $ $ 0.00

5 Enter an estimate of your student loan interest, deductible IRA contributions, educator expenses, alimony paid, and certain other adjustments from Schedule 1 (Form 1040), Part II. See Pub. 505 for more information . . . **5** $

6 **Itemized deductions.** Enter an estimate of your 2026 itemized deductions from Schedule A (Form 1040). Such deductions may include qualifying:

- **a** **Medical and dental expenses.** Enter expenses in excess of 7.5% (0.075) of your total income . **6a** $
- **b** **State and local taxes.** If your total income is less than $505,000 ($252,500 if married filing separately), enter state and local taxes paid up to $40,400 ($20,200 if married filing separately) . **6b** $
- **c** **Home mortgage interest.** If your home acquisition debt is less than $750,000 ($375,000 if married filing separately), enter your home mortgage interest expense (including mortgage insurance premiums) . . . **6c** $
- **d** **Gifts to charities.** Enter contributions in excess of 0.5% (0.005) of your total income . . . **6d** $
- **e** **Other itemized deductions.** Enter the amount for other itemized deductions . . . **6e** $

7 Add lines 6a, 6b, 6c, 6d, and 6e. Enter the result here . . . **7** $ $ 0.00

8 **Limitation on itemized deductions.**

- **a** Enter your total income . . . **8a** $
- **b** Subtract line 4 from line 8a. If line 4 is greater than line 8a, enter -0- here and on line 10. Skip line 9 **8b** $

9 Enter:
- $768,700 if you're married filing jointly or a qualifying surviving spouse
- $640,600 if you're single or head of household
- $384,350 if you're married filing separately

. . . **9** $

10 If line 9 is greater than line 8b, enter the amount from line 7. Otherwise, multiply line 7 by 94% (0.94) and enter the result here . . . **10** $

11 **Standard deduction.**

Enter:
- $32,200 if you're married filing jointly or a qualifying surviving spouse
- $24,150 if you're head of household
- $16,100 if you're single or married filing separately

. . . **11** $

12 **Cash gifts to charities.** If you take the standard deduction, enter cash contributions up to $1,000 ($2,000 if married filing jointly) . . . **12** $

13 Add lines 11 and 12. Enter the result here . . . **13** $ $ 0.00

14 If line 10 is greater than line 13, subtract line 11 from line 10 and enter the result here. If line 13 is greater than line 10, enter the amount from line 12 . . . **14** $

15 Add lines 2, 4, 5, and 14. Enter the result here and in Step 4(b) of Form W-4 . . . **15** $ $ 0.00

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	$480	$850	$850	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020
$10,000 - 19,999	0	480	1,480	1,850	2,050	2,220	2,220	2,220	2,220	2,220	2,220	2,620
$20,000 - 29,999	480	1,480	2,480	3,050	3,250	3,420	3,420	3,420	3,420	3,420	3,820	4,820
$30,000 - 39,999	850	1,850	3,050	3,620	3,820	3,990	3,990	3,990	3,990	4,390	5,390	6,390
$40,000 - 49,999	850	2,050	3,250	3,820	4,020	4,190	4,190	4,190	4,590	5,590	6,590	7,590
$50,000 - 59,999	1,020	2,220	3,420	3,990	4,190	4,360	4,360	4,760	5,760	6,760	7,760	8,760
$60,000 - 69,999	1,020	2,220	3,420	3,990	4,190	4,360	4,760	5,760	6,760	7,760	8,760	9,760
$70,000 - 79,999	1,020	2,220	3,420	3,990	4,190	4,760	5,760	6,760	7,760	8,760	9,760	10,760
$80,000 - 99,999	1,020	2,220	3,420	4,240	5,440	6,610	7,610	8,610	9,610	10,610	11,610	12,610
$100,000 - 149,999	1,870	4,070	6,270	7,840	9,040	10,210	11,210	12,210	13,210	14,210	15,360	16,560
$150,000 - 239,999	1,870	4,100	6,500	8,270	9,670	11,040	12,240	13,440	14,640	15,840	17,040	18,240
$240,000 - 319,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,780	14,980	16,180	17,380	18,580
$320,000 - 364,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,860	15,860	17,860	19,860	21,860
$365,000 - 524,999	2,720	5,920	9,390	12,260	14,760	17,230	19,530	21,830	24,130	26,430	28,730	31,030
$525,000 and over	3,140	6,840	10,540	13,610	16,310	18,980	21,480	23,980	26,480	28,980	31,480	33,990

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	$90	$850	$1,020	$1,020	$1,020	$1,070	$1,870	$1,870	$1,870	$1,870	$1,870	$1,970
$10,000 - 19,999	850	1,780	1,980	1,980	2,030	3,030	3,830	3,830	3,830	3,830	3,930	4,130
$20,000 - 29,999	1,020	1,980	2,180	2,230	3,230	4,230	5,030	5,030	5,030	5,130	5,330	5,530
$30,000 - 39,999	1,020	1,980	2,230	3,230	4,230	5,230	6,030	6,030	6,130	6,330	6,530	6,730
$40,000 - 59,999	1,020	2,880	4,080	5,080	6,080	7,080	7,950	8,150	8,350	8,550	8,750	8,950
$60,000 - 79,999	1,870	3,830	5,030	6,030	7,100	8,300	9,300	9,500	9,700	9,900	10,100	10,300
$80,000 - 99,999	1,870	3,830	5,100	6,300	7,500	8,700	9,700	9,900	10,100	10,300	10,500	10,700
$100,000 - 124,999	2,030	4,190	5,590	6,790	7,990	9,190	10,190	10,390	10,590	10,940	11,940	12,940
$125,000 - 149,999	2,040	4,200	5,600	6,800	8,000	9,200	10,200	10,950	11,950	12,950	13,950	14,950
$150,000 - 174,999	2,040	4,200	5,600	6,800	8,150	10,150	11,950	12,950	13,950	14,950	16,170	17,470
$175,000 - 199,999	2,040	4,200	6,150	8,150	10,150	12,150	13,950	15,020	16,320	17,620	18,920	20,220
$200,000 - 249,999	2,720	5,680	7,880	10,140	12,440	14,740	16,840	18,140	19,440	20,740	22,040	23,340
$250,000 - 449,999	2,970	6,230	8,730	11,030	13,330	15,630	17,730	19,030	20,330	21,630	22,930	24,240
$450,000 and over	3,140	6,600	9,300	11,800	14,300	16,800	19,100	20,600	22,100	23,600	25,100	26,610

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	$280	$850	$950	$1,020	$1,020	$1,020	$1,020	$1,560	$1,870	$1,870	$1,870
$10,000 - 19,999	280	1,280	1,950	2,150	2,220	2,220	2,220	2,760	3,760	4,070	4,070	4,210
$20,000 - 29,999	850	1,950	2,720	2,920	2,980	2,980	3,520	4,520	5,520	5,830	5,980	6,180
$30,000 - 39,999	950	2,150	2,920	3,120	3,180	3,720	4,720	5,720	6,720	7,180	7,380	7,580
$40,000 - 59,999	1,020	2,220	2,980	3,570	4,640	5,640	6,640	7,750	8,950	9,460	9,660	9,860
$60,000 - 79,999	1,020	2,610	4,370	5,570	6,640	7,750	8,950	10,150	11,350	11,860	12,060	12,260
$80,000 - 99,999	1,870	4,070	5,830	7,150	8,410	9,610	10,810	12,010	13,210	13,720	13,920	14,120
$100,000 - 124,999	1,870	4,270	6,230	7,630	8,900	10,100	11,300	12,500	13,700	14,210	14,720	15,720
$125,000 - 149,999	2,040	4,440	6,400	7,800	9,070	10,270	11,470	12,670	14,580	15,890	16,890	17,890
$150,000 - 174,999	2,040	4,440	6,400	7,800	9,070	10,580	12,580	14,580	16,580	17,890	18,890	20,170
$175,000 - 199,999	2,040	4,440	6,400	8,510	10,580	12,580	14,580	16,580	18,710	20,320	21,620	22,920
$200,000 - 249,999	2,720	5,920	8,680	10,900	13,270	15,570	17,870	20,170	22,470	24,080	25,380	26,680
$250,000 - 449,999	2,970	6,470	9,540	12,040	14,410	16,710	19,010	21,310	23,610	25,220	26,520	27,820
$450,000 and over	3,140	6,840	10,110	12,810	15,380	17,880	20,380	22,880	25,380	27,190	28,690	30,190

PAYROLL DIRECT DEPOSIT AUTHORIZATION FORM

Employee Name _____ Employee Number _____
(new employees leave blank)

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

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 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. A child, foster child, adult child, child for whom the employee is legal guardian, or child to whom the employee stands.
     b. Spouse or registered domestic partner.
     c. Sibling, step sibling, or foster sibling
     d. Biological, adoptive, or foster parent, stepparent, or a person who stood in loco parentis when the employee was a minor child.
     e. Grandchild, foster grandchild, or step grandchild
     f. Grandparent or step grandparent
     g. A child of a sibling of the employee
     h. A sibling of the parents of the employee; or
     i. 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 (existing employees only): _____

Name of Employer (Not Mains'l): _____

Name of Participants you work with: _____

Paid Time Off (PTO) Selection

**Please read the information sheet on the previous page before making your selection.*

☐ I want to retain my right to accrue/earn PTO

☐ I do not want to earn PTO. I voluntarily choose to waive the right to earn Paid Time Off (PTO) for my work. I understand that when I opt out of PTO, I will not accrue PTO when I work. I understand if I opt out of PTO sometime after I have already worked, any earned PTO will be paid out to me.

Employee Signature: _____ **Date**: _____

Mains'l Use:

Date PTO Form Received: _____ Effective Date/Payroll Start Date: Upon Hire

Additional Information: _____

Coordinator Completing Process: _____

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/Managing 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 managing 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 managing party completes Section 2 (page 1 of 4).
  - Provide **original** forms of identification to your Managing 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 Managing 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/MANAGING 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.**

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.

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, sex, 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, sex, 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.
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		**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		

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.

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 05/31/2027

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 Fo… employees for documentation to verify information in **Section 1**, or specify which acceptable documentation empl… **2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration … illegal.

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

Section 1. Employee Information and Attestation: Employees must complete and sign Section 1 … **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
01/01/1987	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. An alien 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 Numb…

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	08/01/2025

The date the employee signs is the date they are hired. This is the same date the employer/MP signs the bottom

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator …

If Translator is used, complete separate document

Review and Verification: Employers or their authorized representative must complete and sign … employee's first day of employment, and must physically examine, or examine consistent with an alter… …ary of DHS, documentation from List A OR a combination of documentation from List B and List C. E… …itional Information box; see Instructions.

	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)			12/01/2027		N/A
Document Title 2 (if any)			Additional Information		
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

If using documents from List A, no other info is needed. (Do NOT write in List B & C)

If using documents from List B AND C do NOT write anything in List A

List the correct title for the person signing. Example: Managing Party, Responsible Party or Employer

The MP/Employer need to sign & date on same date that the employee used

☐ 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): 08/01/2025

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)
Jones, Amanda-Managing Party	Signature of MP or Employer	08/01/2025

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 5555

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 05/31/2027

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. An alien 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)
Managing 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.

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 05/31/2027

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

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 ** Please ensure the information you complete below matches your photo ID* * Provide your full legal name**

_____ (Initial): After Mains'l receives your completed background study form and ID, Mains'l will enter your background study in the DHS website. Once we do this, you will receive two emails: an informed consent and a link to schedule your fingerprinting. These items have to be completed in a timely manner. Please ensure the email address you provided is checked daily to meet timelines.

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 (*If United States, list state of birth. If outside of US, list country of birth):*

_____

Primary Telephone _____ Secondary Telephone _____

Email address _____

BACKGROUND STUDY SUBMISSION FORM

Driver's License/ I.D. Number _____ Issuing Authority _____

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

Form of ID: ☐ State ID ☐ Driver's License ☐ Other Select _____

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

Other First Names You Have Used _____

Other Middle Names You Have Used _____

Other Last Names You Have Used _____

Have you resided in another country in the last 5 years? ☐ Yes ☐ No

Have you resided in any state other than Minnesota in the last 5 years?

☐ Yes ☐ No

If **yes**, please list the prior out-of-state address (City, State) 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_____

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

Signature_____ Date _____

Clear Form

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 Worker
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.

Clear Form

DEPARTMENT OF HUMAN SERVICES

DHS-4469A-ENG 7-24

MINNESOTA HEALTH CARE PROGRAMS (MHCP)

Individual CDCS or CSG Worker Enrollment Application

Complete all fields to enroll an individual CDCS or CSG Worker. Complete this form, print and then fax it 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 for CDCS only)
- ( ) Rehire (requires new background study for CDCS only) PREVIOUS EMPLOYMENT END DATE: _____
- ( ) Revalidation

Individual Direct Support Worker Information

PROVIDER TYPE **38 - Individual (COS 021 & 105)**		
SOCIAL SECURITY NUMBER (Print 9 digits clearly. No dashes required.)	**UMPI (IF REQUESTING REINSTATEMENT or REVALIDATING)**	
LEGAL NAME (FIRST)	FULL MIDDLE NAME	LAST NAME
DATE OF BIRTH	PHONE NUMBER	

Individual Direct Support Worker Background Study Information

PROGRAM TYPE. **CDCS (C4) (You must submit and have the individual pass a background check.)**		
BGS number (required only for CDCS)	**Application number**	**Facility ID**

Individual Direct Support Worker Address

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

Individual Direct Support Worker Training Information

Did this worker take Qualified Enhanced Rate training? (optional training) ☐ Yes ☐ No

OPTIONAL TRAINING COMPLETION DATE	OPTIONAL TRAINING EXPIRATION DATE (if applicable)

Individual CDCS or CSG 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 MHCP 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 Data 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 INDIVIDUAL DIRECT SUPPORT WORKER (PRINT OR TYPE)	SIGNATURE OF INDIVIDUAL DIRECT SUPPORT WORKER	DATE SIGNED

Organization Affiliation Information

You may affiliate or enroll the individual DSW named on this form with another Financial Management Services (FMS) agency or location you directly own without completing another application and agreement. Do you want to affiliate this individual DSW with any other agency or location you own?

◯ Yes ◯ No

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 NAME		FACILITY NPI OR UMPI
Mains'l Fiscal Support Entity LLC		A784457500
ORGANIZATION PERSONNEL COMPLETING FORM	ORGANIZATION PERSONNEL SIGNATURE	ORGANIZATION FAX NUMBER
		763-416-9193

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 your enrollment using the MPSE portal and upload the Individual Support Worker (CDCS, CSG, PCA, CFSS) Provider Agreement (DHS-4611) (PDF).

MHCP will process only complete requests.

EMPLOYEE RESPONSIBILITES ACKNOWLEDGEMENT

Employee Name: _____

Job Title: Direct Support Professional _____

- **Review all policies, procedures, and materials in your new employee packet prior to working your first shift.**
- **Ask questions if anything is unclear.**
- **The items below are especially important and are covered in further detail in your new employee packet.**

Initial each statement indicating that you understand and agree to each responsibility.

Reporting Responsibilities in Consumer Directed Programs

_____ I will report workplace-related injury to my Mains'l Coordinator 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 any suspected maltreatment as soon as possible, but no later than 24 hours after becoming aware of it. 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 and 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 for work I did not actually do 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.

EMPLOYEE RESPONSIBILITES ACKNOWLEDGEMENT

_____I understand my timesheet must be entered on the date the shift is worked to comply with the federal EVV guidelines. If I make a mistake on my timesheet entry, I will correct it on the timesheet website or contact my Mains'l Coordinator 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.

_____By initialing this line, 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."

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.

_____I have read and understand the Health and Safety Plan provided to me by the individual receiving services or the Responsible Party and understand the health and safety needs of the person I will be working with.

Work Limitations for Self- Directed Programs

_____I am responsible for informing Mains'l and the Participant/ Responsible Party if I resign from 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 with me at all times while I am working unless I have received written notice from Mains'l that it is okay to do work without the person being with me. *This is because almost all services require the person be present in order 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 and can never be used outside of the country (includes vacations)*.

_____ _____

Employee Signature Date

EMPLOYER / EMPLOYEE AGREEMENT & JOB DESCRIPTION
CDCS Support Worker

Employee Name: _____

Person Receiving Services: _____

This agreement outlines job duties and expectations. The employee and employer (responsible party) must review this together and keep copies before submitting to Mains'l.

Employer–Employee Relationship

- The employee is hired by the person receiving services or their responsible party
- Mains'l serves as the Fiscal/Payroll Agent (not the employer)
- The responsible party:
    - Hires, trains, and supervises the employee
    - Sets the schedule and job duties
    - Approves timesheets
    - Can end employment at any time

Employees must notify the responsible party if they resign. The responsible party must notify Mains'l in writing if employment ends.
If you are asked to do something outside your job duties, not in the Community Support Plan (CSP), or against Mains'l policies, contact your Mains'l Coordinator.

Job Duties

- Support the individual based on their Community Support Plan (CSP)
- Work scheduled shifts (arrive on time and stay for the full shift)
- Complete assigned tasks
- Ensure the individual's health and safety
- Monitor the environment for safety
- Respond to emergencies as directed
- Follow mandated reporter requirements

Note: Employees (including family members) cannot be paid to perform nursing tasks (e.g., medication administration or complex medical care).

Reporting & Expectations

- Report directly to the responsible party
- Notify them if late, absent, or needing schedule changes
- No call/no show may result in termination
- Provide written notice if resigning

You must report:

- Suspected abuse or neglect within 24 hours
- Serious incidents (injury, hospitalization) to the responsible party and Mains'l
- Work-related injuries or accidents as soon as possible

Contact your Mains'l Coordinator with any additional questions or concerns.

Timesheets

- Enter time using the Mains'l EVV system (clock in/out each shift)
- Timesheets must be approved by the responsible party by payroll deadlines
- Time entries are legal records—ensure accuracy
- Incorrect entries must be corrected and reapproved before deadlines
- False time reporting may result in termination and legal action

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EMPLOYER / EMPLOYEE AGREEMENT & JOB DESCRIPTION
CDCS Support Worker

Schedule & Pay
- Pay rate and schedule are set by the responsible party
- Changes to pay must be requested in writing and approved in the CSP
- Overtime (over 40 hours/week) requires approval and must be authorized in the CSP
- No work is allowed when the participant is ineligible (e.g., hospital stay, incarceration, inactive MA)

Transportation (if applicable)
Employees providing transportation must:
- Have a valid driver's license
- Maintain auto insurance
- Use a safe vehicle
- Follow all traffic laws

Family / Live-In Employees
- Only time spent completing CSP-approved tasks is paid
- Additional time is unpaid natural support
- Family employees may only work authorized hours
- Parents of minors and spouses:
    - Must follow the approved schedule
    - Cannot bill for typical parental/spousal responsibilities

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Agreement
Employer / Responsible Party:
I agree to follow program policies and treat employees professionally.

Signature: _____ Date: _____

Employee:
I understand and agree to the duties and expectations outlined above.

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	

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.

Do you live with _____?

☐ No, *Stop-This form does not need to be completed.* ☐ Yes, Complete form.

Employee Name _____

Name of Participant _____

Responsible Party Name _____

Home address of Employee and Participant:

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: _____

Responsible 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.

Workers' Compensation Exclusion Acknowledgement

MAINS'L FINANCIAL MANAGEMENT SERVICES

Employer & Worker Information

EIN Holder/Employer: _____
Business Structure: Sole Proprietorship
Worker Name: _____
Relationship to EIN Holder (Employer): ☐ Spouse ☐ Parent ☐ Child
(If none apply, **STOP — coverage is required**)

Reason for Exclusion (Required Disclosure)

Workers' compensation coverage does not apply to:
"A sole proprietor, or the spouse, parent, and child, regardless of age, of a sole proprietor."
The Minnesota Department of Labor & Industry confirms that sole proprietors and their immediate family members are excluded from mandatory workers' compensation coverage.

Acknowledgements by Family Member (Worker)

By signing below, I acknowledge and agree that:

_____ I am the spouse/parent/child of the employer listed above.
_____ I understand that **I am excluded** from mandatory workers' compensation coverage under Minnesota law.
_____ If I suffer a work-related injury or illness, **I will not have workers' compensation benefits**, including:

- Medical treatment coverage
- Wage-loss benefits
- Permanent disability benefits
- Vocational rehabilitation services

_____ I have been given the opportunity to ask questions before signing.
_____ I understand that I may request the Employer to **elect to provide** workers' compensation coverage for me (optional), and that such coverage:

- Requires the business to notify its workers' compensation insurer
- If coverage is requested, the employer must submit an Election of Coverage form for workers' compensation. Coverage will not be in effect until the application has been reviewed and approved. This process may take up to four weeks, and the worker will not be covered during that time. Coverage will resume at the beginning of a pay period.

_____ I understand that this form does not waive rights for any individuals **who are not legally exempt**.

Signatures

Worker Signature: _____
Date: _____

Employer/Authorized Representative: _____
Date: _____

Internal Use (Mains'l/Fiscal Employer Agent)
☐ Verified statutory relationship
☐ Maintained in employee personnel records

Payroll in Self-Directed Services Policies and Procedures

Payroll Policy

Mains'l is committed to ensuring that all employees paid through the Financial Management Services (FMS) Program are compensated accurately, timely, and in compliance with all applicable federal, state, and local wage and hour laws. Employees are required to accurately record all time worked and submit time records in accordance with established payroll procedures. Employers are responsible for reviewing and approving employee time records and ensuring that work performed is authorized and accurately documented.

Mains'l maintains processes to support timely payroll administration, proper application of overtime, leave, and prompt correction of payroll errors when identified. Falsification of time records, or any attempt to misrepresent hours worked is strictly prohibited and may result in disciplinary action up to and including termination. All employees and employers share responsibility for maintaining accurate payroll records and promptly reporting payroll questions, concerns, or discrepancies.

Payroll Procedure

Employment Category

All employees who work in a participant-directed program are classified as non-exempt (hourly) from the Fair Labor Standards Act. Hourly Employees are paid for their time actually worked and are subject to overtime pay. Any Employee who works more than 40 hours in one workweek receives overtime pay of one- and one-half times their regular rate of pay.

Overtime

No overtime may be worked without prior approval from the employer or their representative. All employees working in self-directed services are paid overtime at the rate of one and one-half times their regular rate of pay for hours worked in excess of 40 hours per work week.

Based on the Department of Human Services regulations, parents of minors and paid spouses cannot work overtime (more than 40 hours per week), unless this is approved in the participant's plan prior to the hours being worked.

Overtime pay is based on actual hours worked. PTO, Sick, or any leave of absence is not considered hours worked for purposes of calculating overtime.

Pay Period

Each pay period consists of two (2) weeks, for a total of fourteen (14) days. Each week starts on Sunday at 12:00 a.m. and ends the following Saturday at 11:59 p.m.

Paydays

Refer to the Payroll Calendar for exact pay periods, when timesheets are due and pay dates. All Employees are paid via electronic direct deposit unless they opt to receive manual checks. Employees may choose to have their Pay Stubs mailed or e-mailed. Paycheck stubs will include earnings for all work performed through the end of the previous payroll period. Advances of pay are not made for any reason.

Employees are responsible for notifying Mains'l of any changes in their bank account numbers and address. If an Employee requests a change in the direct deposit, a manual check may be issued the pay period following the request.

Mains'l is not responsible for any delays in mail service or electronic deposits in the Employee's designated bank account. A manual replacement check will not be processed until verification is completed by payroll.

Holidays

As part of the SEIU collective bargaining agreement, employees are entitled to holiday pay at their regular rate plus one-half for specific holidays. These holidays are: New Year's Day, Martin Luther King Jr Day, Memorial Day, Juneteenth, Independence Day, Labor Day, Veterans Day, Thanksgiving Day, and Christmas Day. All employees who work these days will automatically receive pay at their holiday rate.

Paid Time Off (PTO)

Employees will accrue one (1) hour of PTO for every thirty (30) hours worked. Employees may use PTO hours in any pay period after the pay period in which they were accrued. Employees may waive PTO so that those funds are returned to the Participant's budget for alternative use by the Participant at any time during the Participant's service plan year. Once an Employee has waived PTO, they will not be eligible to accrue PTO until the start of the Participant's next service plan year.

Employees may enter PTO at any time to cash out their accrued PTO, with the approval of their Employer. However, when an Employee is no longer employed by the Participant, the Employee is no longer required to receive approval from the Participant to cash out their accrued PTO. An Employee may carry over up to eighty (80) hours of PTO from one State fiscal year to the next (July 1 – June 30). Up to one hundred twenty (120) hours of accrued PTO shall be cashed out and paid to the Employee by an FMS upon termination of all employment managed by that FMS.

How to Raise a Question or Concern about Pay or a Payroll Deduction

If an Employee has questions about pay (over or under payment) or any deduction from pay, they should immediately contact a Mains'l representative. State, Federal, Social Security, Medicare taxes, garnishments and levies (if applicable), are deducted automatically per regulations. No other deductions are made unless required or allowed by law or prior authorization.

The Employee will contact Mains'l to look into reports. If an Employee has been paid incorrectly, or if Mains'l determines that a deduction was improperly made, Mains'l will reimburse the Employee as promptly as possible. If an Employee has been overpaid, the Employee will be required to return overpayment immediately.

Keeping Your Information Current

Employees are responsible for ensuring that their personal and payroll information remains accurate and up to date. Changes to contact information or banking information should be reported to Mains'l as soon as possible to avoid delays in communication, payroll processing, or receipt of tax documents.

Employees must promptly notify Mains'l of changes to:

- Mailing address
- Telephone number
- Email address
- Direct deposit or banking information
- Tax withholding elections

Requests to change direct deposit information must be submitted to Payroll using the required Direct Deposit Authorization Form at least one week prior to the applicable pay date. Changes received after that deadline may not be processed in time for the upcoming payroll. In such cases, payment may be deposited into the account currently on file or issued by paper check, as applicable.

Timekeeping, Electronic Visit Verification (EVV), and Timesheet Integrity

Employees are responsible for accurately recording all time worked and submitting a complete, accurate, and truthful record of services provided. Time records must accurately reflect the actual date, time, location, and duration of services performed. Accurate timekeeping is essential for payroll processing, service billing, regulatory compliance, and program integrity.

Electronic Visit Verification (EVV)

In accordance with federal law and State of Minnesota requirements, all employees providing self-directed services must comply with the Electronic Visit Verification (EVV) mandate. EVV is a federally required system that verifies the delivery of home and community-based services by electronically capturing service information at the time services are provided.

Employees are required to:

- Clock in at the beginning of each shift using the approved EVV system.
- Clock out at the end of each shift using the approved EVV system.
- Use a location-enabled device when recording the start and end of services, as required by the EVV system.
- Ensure all information entered into the EVV system is accurate and complete.
- Review recorded shifts promptly and report discrepancies as soon as they are identified.
- Submit all time worked by established payroll deadlines.

Employees must not enter time before services are provided, delay recording services already completed, or allow another person to record time on their behalf. Employees may not falsify, alter, or misrepresent EVV records, including the date, time, location, duration, or nature of services provided.

Employees who experience technical difficulties with the EVV system or who are unable to record their time electronically must notify their Employer and Mains'l as soon as possible so that appropriate corrective action and documentation can be completed.

Failure to comply with EVV requirements may result in delayed payroll processing, claim denials, repayment obligations, corrective action, disciplinary action, termination of employment, interruption of services, or other consequences required by state or federal regulations.

Timesheet Submission and Approval

Employees are responsible for ensuring that all timesheet entries are complete, accurate, and submitted by the established deadline. Resources, including user guides and training materials, are available to assist employees with proper use of the timekeeping system. Employees may also request additional assistance or training from Mains'l.

A payroll calendar is provided and available through Mains'l resources. The payroll calendar identifies:

- The dates included in each pay period
- Timesheet submission and approval deadlines
- Scheduled pay dates

The Employer or designated representative is responsible for reviewing and approving submitted timesheets. Employees will generally receive payment on the scheduled pay date when time is entered accurately, submitted on time, and approved by the required payroll deadline.

Authorized Work Time

Employees may perform only work that has been authorized by their Employer or designated representative. Employees are expected to work within their assigned schedules and authorized hours and should not perform services outside those parameters without prior approval.

Unauthorized work includes, but is not limited to:

- Beginning work before the scheduled start time
- Continuing work after the scheduled end time
- Working overtime without prior approval
- Working more hours than authorized for the participant
- Performing duties unrelated to the approved service needs of the participant
- Providing services after being instructed not to work by the Employer or Mains'l

Unauthorized work may result in disciplinary action, up to and including termination of employment.

Timesheet Errors and Corrections

Employees are responsible for correcting any timesheet errors as soon as they are identified. Because timesheets are used for both payroll processing and billing of services, errors, omissions, or late submissions may result in delayed payment and may affect the timely processing of claims.

Employees should take reasonable care to ensure shifts are entered correctly at the time services are provided. Edits to EVV records should be minimized whenever possible. Any modification to a recorded shift generates an EVV exception or non-compliance record that may require additional review, documentation, and follow-up.

Payment may be delayed if:

- Required shift information is missing.
- Timesheet information is incomplete or inaccurate.
- Hours entered overlap with another employee's recorded time.
- Time worked is not entered by the established submission deadline.
- The Employer or designated representative does not approve the timesheet by the payroll processing deadline.

Employees are responsible for correcting inaccurate information on their timesheets. Once a timesheet has been corrected, approved, and received by the applicable payroll deadline, payment will be processed according to the established payroll schedule. Corrections received after payroll deadlines may not be processed until the next available payroll cycle.

Timesheet Integrity and Fraud Prevention

Accurate reporting of time worked is required by Mains'l policy and by applicable state and federal laws. Any falsification, misrepresentation, or alteration of time records is strictly prohibited.

Prohibited conduct includes:

- Falsifying or misrepresenting hours worked.
- Recording time for services not provided.
- Submitting inaccurate EVV information.
- Altering another employee's timesheet or time record.
- Directing or encouraging another person to inaccurately report time worked.
- Instructing an employee to alter time records or submit false information.
- Failing to report hours worked.
- Knowingly submitting incomplete or inaccurate time records.

Employees who are instructed by any person to falsify a timesheet, alter a time record, or misrepresent hours worked must immediately report the situation to Mains'l.

Mains'l may make limited administrative corrections when sufficient documentation exists to verify the change. Such corrections may include:

- Correcting an incorrect participant number.
- Correcting an incorrect pay code.

These administrative corrections do not constitute timesheet falsification or fraud.

Violations of this policy may result in delayed payment, disciplinary action up to and including termination of employment, repayment obligations, referral to regulatory agencies, and any additional civil or criminal penalties permitted under applicable law.

Health Insurance and Benefits

Except as required by law, no health insurance or other benefits are available through Mains'l to Employees sole-employed in a Self-Directed Services Program.

Questions or Concerns

If there are questions or concerns about this Payroll Policy and Procedure, please contact Mains'l.

Mileage Reimbursement Policy

The Employer determines when mileage reimbursement will be allowed, subject to applicable legal requirements and Program Rules, not to exceed the reimbursement rate as determined by the IRS.

Mileage reimbursement for transportation to any type of medical or dental appointment is prohibited.

The Employer must ensure that people providing transportation must:

- Be a legally licensed driver
- Submit reimbursement only for driving their own vehicle
- Have automobile insurance covering their vehicle as required by law

Mains'l will reimburse mileage based on the details included in the Participant's Community Support Plan (CSP).

Once the funds allocated for mileage reimbursement have been used, no additional mileage expense can be reimbursed until the Participant or Managing Party make a change to the CSP allocating additional dollars to mileage. Mains'l is unable to reimburse additional mileage until the revised plan has been approved by the Lead Agency.

Mileage Reimbursement Procedure

Mileage will be recorded on a mileage log and submitted to Mains'l at least once per month or as incurred by the Employer's Employees. The log must include:

- ✓ the date
- ✓ daily start and stop odometer readings
- ✓ where the transportation for the Participant is from and to (name of locations - street addresses not required)
- ✓ total miles driven per entry
- ✓ total miles for the month
- ✓ reimbursement rate
- ✓ total due

The complete mileage log should be submitted to Mains'l for processing. If the Employee is submitting the mileage log directly to Mains'l, the form must include the Employee's signature and the Employer's signature. If the Employee is unable to obtain the Employer's signature, the Employee may sign their form and submit to the Employer via email. The Employer will forward the emailed form to Mains'l as their indication of approval.

Mileage reimbursement requests received by 5pm on Mondays when timesheets are due, will be processed and paid on the following Friday's pay date. Completed and approved mileage logs should be submitted to MNFMSPayments@mainsl.com

Workplace Injuries & Workers' Compensation Policy
If a work-related injury occurs, Employees should contact their Mains'l Support Specialist immediately. It is extremely important that any injury or illness occurring during or arising out of an Employee's employment be reported as soon as reasonably possible after the Employee becomes aware of the injury or illness, regardless of how minor it may appear. ***Employees should be told that failure to timely report any accident, illness or injury may affect their eligibility for any workers' compensation benefits to which they may be entitled, and that Employees who file fraudulent claims may be subject to termination.***

Mains'l will provide the Employee with the required forms to document the injury and submit a claim. Mains'l will provide instruction to the Employee in completing these forms, if necessary and requested, and Mains'l will submit the forms.

Employees are responsible for responding to requests from Mains'l, our claims adjusters or other consultants in a timely manner.

Mains'l MN FMS
2026 Payroll Calendar

To ensure employees are paid on the dates listed, timesheets must be approved by the Responsible/Managing Party in Navigation Plus by 5pm on the listed due date. Late timesheets will not be paid until the following pay date.

As a reminder, you are required to enter your time as you work it; clock in at the start of your shift and clock out when your shift is finished

*** indicates a paid holiday within that pay period. All employees who work on this paid holiday are required to be paid time and a half*

	Pay Period (Pay Period Starts		to Pay Period Ends)	Approval Deadline (Even when that day is a holiday)		Pay Date (Every Other Friday)
1	12/14/25	to	12/27/25	12/29/25	5:00 PM	**01/09/26 ****
2	12/28/25	to	01/10/26	01/12/26	5:00 PM	**01/23/26****
3	01/11/26	to	01/24/26	01/26/26	5:00 PM	**02/06/26****
4	01/25/26	to	02/07/26	02/09/26	5:00 PM	**02/20/26**
5	02/08/26	to	02/21/26	02/23/26	5:00 PM	**03/06/26**
6	02/22/26	to	03/07/26	03/09/26	5:00 PM	**03/20/26**
7	03/08/26	to	03/21/26	03/23/26	5:00 PM	**04/03/26**
8	03/22/26	to	04/04/26	04/06/26	5:00 PM	**04/17/26**
9	04/05/26	to	04/18/26	04/20/26	5:00 PM	**05/01/26**
10	04/19/26	to	05/02/26	05/04/26	5:00 PM	**05/15/26**
11	05/03/26	to	05/16/26	05/18/26	5:00 PM	**05/29/26**
12	05/17/26	to	05/30/26	06/01/26	5:00 PM	**06/12/26****
13	05/31/26	to	06/13/26	06/15/26	5:00 PM	**06/26/26**
14	06/14/26	to	06/27/26	06/29/26	5:00 PM	**07/10/26****
15	06/28/26	to	07/11/26	07/13/26	5:00 PM	**07/24/26****
16	07/12/26	to	07/25/26	07/27/26	5:00 PM	**08/07/26**
17	07/26/26	to	08/08/26	08/10/26	5:00 PM	**08/21/26**
18	08/09/26	to	08/22/26	08/24/26	5:00 PM	**09/04/26**
19	08/23/26	to	09/05/26	09/07/26	5:00 PM	**09/18/26**
20	09/06/26	to	09/19/26	09/21/26	5:00 PM	**10/02/26****
21	09/20/26	to	10/03/26	10/05/26	5:00 PM	**10/16/26**
22	10/04/26	to	10/17/26	10/19/26	5:00 PM	**10/30/26**
23	10/18/26	to	10/31/26	11/02/26	5:00 PM	**11/13/26**
24	11/01/26	to	11/14/26	11/16/26	5:00 PM	**11/27/26****
25	11/15/26	to	11/28/26	11/30/26	5:00 PM	**12/11/26****
26	11/29/26	to	12/12/26	12/14/26	5:00 PM	**12/24/26**

2027 Payroll Calendar

1	12/13/26	to	12/26/26	12/28/26	5:00 PM	**01/08/27****
2	12/27/26	to	01/09/27	01/11/27	5:00 PM	**01/22/27****

RESPONDING TO AND REPORTING MALTREATMENT POLICY & PROCEDURE

Policy

Mains'l employees, including those employed directly by participants under the Fiscal Management Services (FMS) model, are mandated reporters under Minnesota law. This means that all such employees must report suspected maltreatment of minors and vulnerable adults in accordance with Minnesota Statutes §§ 245A.65, 245A.66, 626.556, and 626.557.

It is the policy of Mains'l to:

1. Protect individuals receiving services from maltreatment.
2. Comply with all state reporting requirements.
3. Ensure all personnel are trained on mandated reporting obligations.

Procedure

1. **Immediate Response**
   - If assault is in progress: Call 911 immediately.
   - For Vulnerable Adults:
     - Report to Minnesota Adult Abuse Reporting Center (MAARC) at 1-844-880-1574 or Adult Protection Online.
   - For Children:
     - Contact local child welfare agency or law enforcement: County Contacts.
2. **Timeframe**
   - Report immediately, no later than 24 hours after first knowledge of suspected maltreatment.
3. **What to Report**
   - Adults: Abuse, neglect, financial exploitation.
   - Children: Physical abuse, sexual abuse, neglect.
   - Any unexplained injury.
4. **Reporter Information**
   - Provide all known details: names, dates, locations, nature of concern, and any immediate safety needs.
   - Do not investigate before reporting.
5. **Internal Notification (Optional, not required by law)**
   - Leave a voicemail or send an email to the assigned Mains'l representative, who will notify the case manager and guardian (if applicable).
   - Identifying information about the reporter is not shared without consent.

Version No	2	**Status**	Active
Author	Kelsey Kostohryz	**Revision Date**	08/14/2025
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Service Line	FMS	**State**	MN

POLICY: PREVENTING FRAUD, ABUSE AND WASTE OF MEDICAID AND OTHER INSURANCE

Most of the services Mains'l provides are funded by Medicaid (also known as Medi-Cal in California and Medical Assistance in Minnesota). So, you play a vital role in protecting the integrity of the Medicaid Program. To reduce waste, abuse, and fraud you need to know what to watch for and when to report if you suspect that waste, abuse, or fraud is occurring.

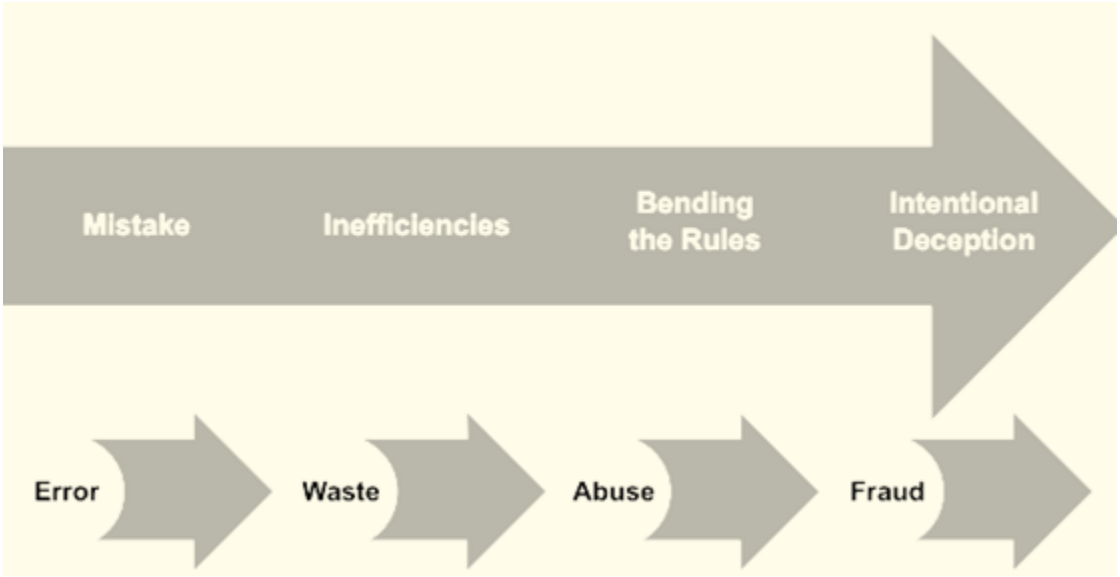
Although the terms Medicaid and Medicare fraud and abuse have slightly different meanings, depending on individual state law, they mean the same thing: any violations of the state and federal requirements related to the delivery of services to Medicaid or Medicare recipients.

Waste is a broad term referring to care that is not effective or delivered efficiently.

Abuse is when a provider does not follow good medical practices, resulting in unnecessary costs, improper payment, or services that are not medically necessary.

Fraud is when Medicaid or other insurance is billed for services or supplies a person who uses services never received. It is when a person knowingly cheats or is dishonest. The dishonesty results in a benefit such as payment or coverage that the person would not have been entitled to otherwise.

Examples of Fraud, Abuse and Waste include but are not limited to:



Using the wrong billing code	Buying too many goods or supplies occasionally	Providing more services than a person needs Buying excessive goods or supplies that are not needed or used on a regular basis	Submitting a timesheet with time you did not work Using or taking goods or services from the intended recipient

Multiple State and federal laws make it illegal for a person to bill Medicaid, Medicare or other insurance providers for goods or services that he or she knows are false.

Any person who submits a claim to Mains'l that he or she knows or should know is false will be held responsible and his or her action may be punishable by law.

Suspected fraud, abuse, and violations of this policy must be immediately reported. Any report of fraud or abuse, received by Mains'l will be investigated. Suspected waste should also be reported to reduce or prevent waste from continuing.

Failure of an employee to report suspected fraud, abuse or a violation of this policy will result in employee discipline, up to and including separation.

PROCEDURE: PREVENTING FRAUD, ABUSE AND WASTE OF MEDICAID AND OTHER INSURANCE

Any suspicions of fraud, abuse, and waste should be directly reported to our Public Funds Compliance Officer, the Chief Human Resources Officer.

The Public Funds Compliance Officer conducts an internal investigation. If our Public Funds Compliance Officer, the Chief Human Resources Officer, is suspected or alleged to be involved in fraud, the Director of Human Resources completes the investigation. The investigation will include at least the following:

1. Whether fraud, abuse, or waste occurred;
2. Whether written policies and procedures were adequate;
3. Whether written policies and procedures were followed;
4. Whether there is a need for additional staff training;
5. Whether there is a need for external reporting.

If it is determined after a thorough investigation that any employee has committed fraud, their employment will end immediately.

If it is determined that a vendor, person who uses services, or other business partner has committed fraud, Mains'l reserves the right to end the relationship.

While Mains'l prefers that reports of suspected fraud and abuse are made internally, you have the right to report suspicions of Medicaid abuse or fraud to a state agency:

In California: Department of Health Care Services/Health Care Programs at 800-822-6222 or
http://www.dhcs.ca.gov/individuals/pages/stopmedi-calfraud.aspx
Office of the Attorney General 800-722-0432 or http://www.ag.ca.gov/bmfea/medical.htm

In Minnesota: Department of Human Services Provider Fraud: 800-657-3750 Recipient Fraud: 800-627-9977
http://mn.gov/dhs/general-public/licensing/report-fraud/index.jsp

Mains'l will not discharge, discipline, threaten, or discriminate against, or penalize an employee, who in good faith reports or participates in an investigation of fraud, abuse, or waste internally or externally. However, failure to report suspicions of fraud, abuse, and waste will result in disciplinary action, up to and including separation.

(Rev. 4/18/2025)

Employee Acknowledgment & Certification

Employee Name _____ Participant Name _____

I acknowledge that I have received, reviewed, and understand the information contained in this Employee Onboarding Packet. I understand that it is my responsibility to ask questions if I do not understand any portion of these materials.

By signing below, I acknowledge and certify that:

☐ I have completed all required hiring forms to the best of my knowledge.

☐ I understand that I may not begin working until all required hiring documents are complete, my background study has been approved (when required), and I have received authorization from Mains'l to begin work.

☐ I understand that I am employed by the participant (or household employer) and not by Mains'l. I understand Mains'l's role is to provide Fiscal Employer Agent (F/EA) payroll-related services.

☐ I understand that I am responsible for accurately reporting all hours worked and for complying with all payroll and timesheet requirements.

☐ I understand that my tax withholding is based on the information I provide on my federal and state withholding forms, and that neither Mains'l nor the participant can provide me with individual tax advice.

☐ I acknowledge that I have reviewed the Employee Responsibilities, Provider Agreement, Job Description, and other employment-related documents included in this packet.

☐ I acknowledge receipt of the following policies and reference materials included in this packet:

- Payroll Policies & Procedures
- Mileage Reimbursement Policy
- Workplace Injuries & Workers' Compensation Policy
- Payroll Calendar
- Responding to and Reporting Maltreatment Policy
- Preventing Fraud, Abuse, and Waste of Medicaid and Other Insurance

☐ I understand that failure to comply with applicable policies, reporting requirements, or program requirements may result in disciplinary action, including termination of employment or removal as an approved worker.

I certify that the information I have provided throughout this onboarding packet is true, complete, and accurate to the best of my knowledge.

Employee Signature _____ **Date** _____