EMPLOYER MUST SIGN/DATE THE PINK HIGHLIGHTED AREAS ONLY.

THE PERSONAL CARE SERVICE WORKER (PCA)THAT YOU HIRE MUST FILL OUT ALL THE YELLOW HIGHTLIGHTED AREAS ONLY.
Will need to provide 2 forms of identification and banking information. Banking information needs to be a **VOIDED check, a letter from your bank or a direct deposit form**.

***Please DO NOT fill out any areas that are NOT highlighted.

***EMPLOYEES (PCA WORKERS) – MUST check their JUNK/SPAM folder (for their employee number and information to work, if they use GMAIL. For some reason the emails we send go to the JUNK/SPAM folder for gmail users.

independence INC
for people with disabilities

PERSONAL CARE SERVICE WORKER

Date_____ Waiver _____

Employer Name (Consumer) _____

Personal Care Service Worker Name _____
(First name, Middle Initial, & Last Name)

Kansas AuthentiCare Worker Number _____

Social Security Number _____ Birth Date _____

Street Address _____

City, State, Zip Code _____

Cell/Home Phone Number _____

Email Address _____

Personal Care Service Worker Signature _____ Date_____

Employer/Consumer or Designee Signature _____ Date _____

****Personal Care Service hours cannot be turned in when the Consumer/Employer has been admitted into the hospital, either as an outpatient or inpatient. Please inform Independence, Inc. when the consumer has been admitted and released from the hospital.****

Office Use Only

Hourly Rate _____ Enhanced Service Rate _____

Date: _____ Initials: _____

Notes: _____

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2025

Step 1: Enter Personal Information

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

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

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

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

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

Step 3: Claim Dependent and Other Credits

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

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

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

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

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

General Instructions

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

Future Developments

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

Purpose of Form

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

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

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

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

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

2. Expect to work only part of the year;

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

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

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

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

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

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

Specific Instructions

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

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

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

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

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

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

Step 4 (optional).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

. . . . . 2 $

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

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

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

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

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

Single or Married Filing Separately

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

Head of Household

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

K-4
(Rev. 7-24)

KANSAS
EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

K-4 Attach 500524

Use the following instructions to accurately complete your K-4 form, then detach the lower portion and give it to your employer. For assistance, call the Kansas Department of Revenue at 785-368-8222.

Purpose of the K-4 form: A completed withholding allowance certificate will let your employer know how much *Kansas* income tax should be withheld from your pay on income you earn from Kansas sources. Because your tax situation may change, you may want to re-figure your withholding each year.

Exemption from Kansas withholding: To qualify for exempt status you must verify with the Kansas Department of Revenue that: **1)** last year you had the right to a refund of ***all*** STATE income tax withheld because you had ***no*** tax liability; and **2)** this year you will receive a full refund of ***all*** STATE income tax withheld because you will have ***no*** tax liability.

Basic Instructions: If you are not exempt, complete the **Personal Allowance Worksheet** that follows. The total on line F should ***not*** exceed the total exemptions you claim under "Exemptions and Dependents" on your Kansas income tax return.

NOTE*: Your status of "Single" or "Joint" may differ from your status claimed on your federal form W-4).*

Using the information from your **Personal Allowance Worksheet**, complete the **K-4** form below, sign it and provide it to your employer. If your employer does not receive a K-4 form from you, they must withhold Kansas income tax from your wages without exemption at the "Single" allowance rate.

Head of household: Generally, you may claim head of household filing status on your tax return only if you are **unmarried and pay more than 50% of the cost of keeping up a home for yourself and for your dependent(s).**

Non-wage income: If you have a large amount of non-wage Kansas source income, such as interest or dividends, consider making Kansas estimated tax payments on Form K-40ES. Without these payments, you may owe additional Kansas tax when you file your state income tax return.

Personal Allowance Worksheet (Keep for your records)

A Allowance Rate: If you are a single filer mark "Single"
If you are married and your spouse has income mark "Single"
If you are married and your spouse does not have income mark "Joint"
A ☐ Single ☐ Joint

B Enter "0" or "1" if you are married or single(entering "0" may help you avoid having too little tax withheld) ..... **B** _____

C Enter "0" or "1" if you are married and only have one job, and your spouse does not work (entering "0" may help you avoid having too little tax withheld) ..... **C** _____

D. Enter "2" if you will file head of household on your tax return (see conditions under Head of Household above) ..... **D** _____

E Enter the number of dependents you will claim on your tax return. **Do not** claim yourself or your spouse or dependents that your spouse has already claimed on their form K-4 ..... **E** _____

F **Add lines B through E** and enter the total here ..... **F** _____

▼ **Cut here and give the lower portion to your employer. Keep the top portion for your records.** ▼

K-4
(Rev. 7-24)

Kansas Employee's Withholding Allowance Certificate

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

1 Print your First Name and Middle Initial	Last Name	2 Social Security Number
Mailing address	3 Allowance Rate Mark the allowance rate selected in Line A above. ☐ Single ☐ Joint	

4	Total number of allowances you are claiming (from Line F above)	4	
5	Enter any additional amount you want withheld from each paycheck (this is optional)	5	$
6	I claim exemption from withholding. (You must meet the conditions explained in the "Exemption from withholding" instructions above.) If you meet the conditions above, write "Exempt" on this line **Note: The Kansas Department of Revenue will receive your federal W-2 forms for all years claimed *Exempt*.**	6	

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

SIGN HERE ▶ **Date**

7 Employer's Name and Address	8 EIN (Employer ID Number)

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. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

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

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

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

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

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

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)			**Additional Information**		
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)			☐ 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)

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

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

LISTS OF ACCEPTABLE DOCUMENTS

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

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

independence

Direct Deposit Agreement Form

Authorization Agreement

I hereby authorize Independence, Inc. to initiate automatic deposits to my account at the financial institution named below. I also authorize Independence, Inc. to make withdrawals from this account in the event that a credit entry is made in error.

Further, I agree not to hold Independence, Inc. responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until Independence, Inc. receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to the Payroll Department.

Signature

Authorized Signature (Primary): _____ Date: _____

Authorized Signature (Joint): _____ Date: _____

Please attach a VOID CHECK or VERIFICATION from your bank and return this form to the Payroll Department. We CAN NOT accept a deposit slip.

STATE OF KANSAS
Department for Children & Families
Office of Background Investigations

ADULT ABUSE, NEGLECT, EXPLOITATION CENTRAL REGISTRY RELEASE OF INFORMATION

OBI 10400
REV 4/21

I, _____, give permission for the release of information concerning
(PRINT Full Name)

myself in the Adult Abuse, Neglect, Exploitation Central Registry to:

Contact Person(s)* Alisa Snyder **Phone** 785-841-0333

Agency name Independence, Inc.

Agency mailing address 2001 Haskell Ave., Lawrence, KS 66046

Email address: **Will return via Encrypted email unless marked otherwise** asnyder@independenceinc.org

Maiden Name and/or Other Names Known By: _____
(PRINT ONLY)

Address: _____
Street **City** **State** **Zip Code**

DOB: _____ **SS#:** _____ ☐ Male ☐ Female
(mm/dd/yyyy) **(mark one)**

I understand that all information released will be for the exclusive and confidential use of the above named organization/person. I have read and understand this form and information provided is true and correct to the best of my knowledge.

I give permission for the release of any information concerning myself in the Adult Abuse, Neglect, Exploitation Central Registry each year while I am employed or associated with the above agency. ☐ **Yes** ☐ **No**

Signature: _____ **Date:** _____
(An Ink Signature or a Verified E-Signature is Required for Processing) **(mm/dd/yyyy)**

RETURN TO:

Email: DCF.APSRegistry@ks.gov

Mail: Office of Background Investigations
Adult Abuse Registry
500 SW Van Buren St
Topeka, Kansas 66603
(Please allow 3-5 days for processing email requests and an additional 5-7 days if returning by US Postal Service)

For Official Use Only: Mark in this area if PROHIBITED	For Official Use Only: Mark in this area if CLEARED

Kansas Department for Children and Families

KANSAS DEPARTMENT FOR CHILDREN AND FAMILIES
Child Abuse and Neglect Central Registry
P.O. Box 2637 • Topeka, KS 66601 • DCF.CentralRegistry@ks.gov
Release of Information

Complete form by printing legibly in ink. Fee of $10.00 per Release of Information form may be required prior to processing.

All releases and fees are to be sent to the address or email listed above (see below for specifics)

CONFIDENTIALITY: *Kansas Department for Children and Family records are confidential. No individual, association, partnership, corporation, or other entity shall willfully or knowingly disclose, permit, or encourage disclosure of the contents of records or reports in violation of the confidentiality requirements of K.S.A. 38-2209. Violation of this statute is a class A nonperson misdemeanor and the court may impose a civil penalty of up to $1,000.*

Contact Person: Alisa Snyder — Agency/Org.: Independence Inc.

Phone #: 785 841 0333 x120 — Address: 2001 Haskell Ave

Email: ASNYDER@INDEPENDENCEINC.ORG — City/State/Zip: Lawrence KS 66046

Return Results by: ☒ Encrypted email (list if different than above): _____ ☐ Postal Mail

Payment/Account Information (check box which applies)

☐ *Fee included*	$10 per request. Check, Money Order (payable to DCF) or cash. ***Postal mail only.***
☐ *Online Payment**	www.dcf.ks.gov – 'Online DCF Payments' icon at bottom of page. Submit receipt with ROI form(s).
☒ *Pre-Pay Account**	Agency/Org. has Pre-Pay Account. FEIN: 48-0875993
☐ *Mentoring Account**	As listed in the Kansas Mentors' Partner Directory. http://mentorkansas.org/Find-a-Program
☐ *Exempt**	No fee for State government agencies (Sub-contracting agencies not included).

*Release of Information forms may be submitted via email to DCF.CentralRegistry@ks.gov

APPLICANT: *Instructions: PRINT CLEARLY. All requested information is required for processing. Incomplete or illegible information will result in processing delays for the Release of Information. Use 'N/A' rather than leaving a space blank.*

FIRST, MIDDLE, LAST NAME: _____

I give permission for the release of any of my information in the Child Abuse/Neglect Central Registry to the contact listed above. I understand the information released is for their exclusive and confidential use: ☐ *Yes* ☐ *No*

This organization/person/agency may check my information each year I am employed or associated with them: ☐ *Yes* ☐ *No*

OTHER NAMES USED: (Any/all aliases, married, maiden, nicknames, etc. 'N/A' if none used.): _____

DATE OF BIRTH: _____ **RACE:** _____

SOCIAL SECURITY #: _____ **GENDER:** ☐ *Male* ☐ *Female*

CURRENT ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE: _____ **EMAIL:** _____

SIGNATURE: _____ **DATE:** _____

DCF ONLY:

MATCH	CLEARED
This applicant is listed in the Child Abuse/Neglect Central Registry. ***Per KSA 65-504 and 65-516 this person prohibited from working, residing, or volunteering in a licensed child care home or facility.*** (see attached document for more info.)	

Kansas Central Repository

Certified Record Check Request Form

Regular name-based record checks are to be requested on-line at www.kansas.gov/kbi/criminalhistory

To: Kansas Bureau of Investigation
Attn: Central Repository
1620 SW Tyler
Topeka, KS 66612-1837

From: Independence Inc.
(Requestor's Full Name or Organization) (Please Print)
Alisa Snyder FMS/Business Manager
(Requestor's Point of Contact and Title)
2001 Haskell Ave
(Requestor's Mailing Address)
Lawrence KS 66046
(City, State or Country and Zip)
785 841 0333
(Requestor's Phone Number)

1. A criminal history record check of the Kansas Central Repository is requested for the following individual. The **Full Name** and **Date of Birth** are mandatory:

   Full Name: _____
   (Last Name) (First Name) (Middle Name)

   Maiden or
   Alias Name: _____
   (Last Name) (First Name) (Middle Name)

   Date of Birth: _____ Social Security Number: _____

   Sex: _____ Race: _____ Place of Birth: _____

2. A fingerprint card [is] [is not] included.

3. Purpose for the criminal history record check (Please be specific): _____

4. Mailing address for the results of the record check, if different from the "From" address, above:

   [ ] Same as the "From" address above.

5. Enclosed is payment made payable to the **KBI Record Check Fee Fund** for the record check in the sum of:

   [ ] $30.00 for a certifed name-based check
   [ ] $45.00 for a certified Kansas fingerprint-based check
   [ ] $57.00 for a certified Kansas/national fingerprint-based check*
   * A state or federal statute allowing a national search is required

6. Dissemination of criminal history information is governed by statutes, laws and regulations. The Requestor will comply with and be subject to the provisions of both State and Federal law regulations, including, but not limited to Title 28 (Judicial Administration) of the Code of Federal Regulations and Kansas Statutes Annotated 22-4107 et seq.

7. Requestor agrees to limit disclosure of the information received to personnel who have a clear, distinct "need to know," and ensure that the information is used only for the purpose for which provided. Further, Requestor shall:
   a. Implement reasonable procedures to insure the confidentiality and security of any information received.
   b. Indemnify and hold harmless the KBI, their employees, including their heirs, executors, administrators, personal representatives, successors, and assigns, from and against any and all causes of actions, claims, demands, suits, rights and other proceedings of any nature which seek damages or ther remedies arising from the providing of criminal

8. The KBI has the right to demand return of all information provided to the Requestor when any rule, policy, procedure, regulation or law described in this request is violated or appears to be violated or for non-payment of any service.

9. I have read and understand my responsiblities when receiving record check information from the Kansas Central Repository, and I agree to safeguard and properly use all information I receive.

employee Signature _____
(Signature of Requestor)

Health Insurance Portability and

Accountability Act (HIPAA) Confidentiality Agreement

The HIPAA Privacy Rule applies to health care providers, health plans, health care clearinghouses, and any business associate that transmits health information in any form or media, including electronic, paper or oral. The Privacy Rule calls this information protected health information (PHI).

A Personal Care Service Worker (PCSW) performs various services for individuals with disabilities and may come in contact with protected health information. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that you ensure the integrity and confidentiality of all PHI you obtain or possess concerning individuals you assist.

Therefore as a Personal Care Service Worker:

1. I agree to protect all PHI against threats to the integrity of the information or unauthorized uses or disclosures of it.
2. I will not reproduce, disclose, or provide to third parties any confidential information relating to people with disabilities who receive services from Independence, Inc. (consumers), without written authorization from the consumer(s). I will only make available PHI in accordance with applicable law.
3. I will report to Independence, Inc. any use or disclosure of PHI not provided for by this agreement of which I become aware.
4. Upon termination for any reason, I will return or destroy all PHI received from Independence, Inc. or the consumer. I will not retain copies of the PHI and remain obligated not to use, disclose, or provide such information to third parties unless otherwise required to do so by law.
5. I will appropriately safeguard confidential information made available to me.

Signature _____ **Date** _____

independence INC
for people with disabilities

Safe Work Performance Expectations

PCSW Responsibilities

We expect our Personal Care Service Workers (PCSW's) to follow all objectives for safe work performance and be responsible for their own actions and conduct. OSHA requires that we furnish employees a place of employment "free from recognized hazards that are causing or are likely to cause death of serious physical harm to employees." Our Personal Care Service Workers also play a significant role in the success or failure of our program.

General Safety Expectation

All PCSW'S are expected to perform their jobs to the best of their ability as well as perform them in a safe manner. It is critical that employees do not circumvent safety features and safe work behaviors that can cause them or others to be at risk. All accidents are preventable. We must each carry out our safety responsibility. We each share a common goal and these are our expectations of each person working for our consumers.

- Follow the safe job procedures established by your consumer. Perform only those jobs to which you have been assigned and properly instructed.
- Wear the protective equipment (latex gloves, etc.) required for your job as established by your consumer.
- Report damaged equipment immediately for replacement or repair. Do not perform your task without the appropriate protection.
- Report unsafe work practices and/or unsafe conditions immediately.
- Report all incidents immediately. Summon first aid as soon as possible when injuries demand prompt attention. Contact your physician or "walk-in" clinic. Contact Independence, Inc. within 3 days of the incident at (785) 841-0333 x 113.
- When using a lift, keep all mechanical safeguards in position during operation.
- Under no circumstances should "assistive equipment" be used in an unsafe manner or with safety features missing, malfunctioning, or circumvented.

Lifting and/or Transferring

- Do not lift awkwardly.
- Never lift beyond your strength. If your consumer is too heavy, find help or utilize assistive equipment (Hoyer Life, etc.)
- Be sure you fully understand how to operate the lifting/hoisting equipment before you start.
- Avoid reaching as you lift or lower. If something is in your way, move it before beginning to lift. Set feet firmly, placing one foot alongside the person to be lifted, and the other slightly behind them. Keep the person close to your body. Position comfortably and then set muscles of your legs, hips, and back readying to take the strain.
- Lift gradually, avoid jerking, twisted motions.
- If a helper is needed, decide how the move will be handled. Keep in step and communicate stopping, placing, etc.
- For consumers with lifts, utilize only well maintained and appropriate slings and chains for the weight of the consumer. Check for defects and visual signs of fatigue in the slings and hoist components before attempting a lift. Report any problems to your consumer to obtain a replacement part, sling, or repairs.
- Do not compromise a safe lift by using damaged lifts even for a short time.

Housekeeping

- Make sure ovens/stoves are free of grease and clean before using. Turn off ovens/stove after use.
- Return all cleaning supplies to their proper storage place after use.
- Dispose of any blood, stool, and urine soiled items in the appropriate manner and do not let it accumulate.
- Do not use any defective equipment or appliances; notify the consumer of the need to repair or replace the equipment or appliance.
- Isolate all flammable/combustible materials from possible ignition sources (e.g., open flames, heated surfaces)
- Check appliances/ vacuum for frayed, defective cords or plugs; notify consumer of any findings.

I have read and understood the above expectations and agree to comply with them fully.

PCSW Signature_____ **Date**_____

Employer Signature_____ **Date**_____

The Safe Work Performances Expectations are established in the interest of protecting lives and property. All Personal Care Service Workers are asked to follow these rules to help safeguard themselves and their consumers.

Notice of Injury

As provided in K.S.A. 44-520 it is the duty of all employees to notify Independence, Inc. FMS/PASS Department within three (3) days of any accident that occurs during the scope of that employee's duties.

Such notice shall be in writing, shall contain the name and address of the employee and a statement of the time, place, nature and cause of the injury or death. The notice shall be signed by the employee not by some person on his/her behalf.

Notice shall be given to Independence, Inc. FMS/PASS Department in writing by delivering it or by sending it by mail addressed to:

Independence, Inc.
Attn: FMS/PASS Department
2001 Haskell Avenue
Lawrence, KS 66046

Failure to provide such notice may prevent compensation for the employee's injury.

We have read and understand the above notice.

PCSW's full name_____ Date_____

Employer's Signature_____ Date_____

Employment Termination Notification Policy

As a Personal Care Service Worker being paid by Independence, Inc., it is my responsibility to follow the policies and procedures stated in the Personal Care Service Worker application package. If, for any reason, my employment should end with a consumer, I will contact the FMS/PASS Department at 785-841-0333 within 3 days. Failure to do so will indicate that I am no longer interested in providing personal services through this payroll agency.

I understand that an Employment Termination Form will be mailed to me so that Independence, Inc. can have a written explanation of the reason for my termination. Before receiving my last paycheck, I will complete this form and return it to:

Independence, Inc.
Attn: FMS/PASS Department
2001 Haskell Avenue
Lawrence, KS 66046

I have read and understand the above employment notification policy. I agree to notify Independence, Inc. within 3 days of my employment termination.

We have read and understand the above notice.

PCSW's full name _____ Date _____

Employer's Signature _____ Date _____

EMPLOYMENT AGREEMENT

THIS EMPLOYMENT AGREEMENT (the **"Agreement"**) is effective on this _____ day of _____, 20___, between _____ (the **"Employer"**), an individual, and _____, (the **"Caregiver"**), an individual.

WITNESSETH:

WHEREAS, the Employer is a participant in a Home and Community Based Services waiver program under Medicaid (the **"Program"**) administered by the Kansas Department of Aging and Disability Services (**"KDADS"**) through KanCare and has elected to self-direct his/her services under the Program by employing one or more direct support workers;

WHEREAS, the purpose of a direct support worker (or caregiver) under the Program is to provide assistance and support to a Program participant in accordance with the participant's integrated service plan under the Program (the **"ISP"**);

WHEREAS, the Employer desires to hire the Caregiver to be his/her direct support worker under the Program;

WHEREAS, the Caregiver desires to be employed by the Employer as a direct support worker under the Program; and

WHEREAS, the Employer uses Independence, Inc. (the **"FMS Provider"**) to provide financial management services (**"FMS"**) under the Program to the Employer, including but not limited to (i) processing of time worked by the Caregiver, (ii) billing KanCare on the Employer's behalf, (iii) distributing pay checks or electronic deposits for services rendered by the Caregivers under the ISP, (iv) withholding, filing and paying appropriate taxes for Caregiver services under the ISP, and (v) information and assistance services to assist the Employer in understanding his/her role and requirements as the employer of the Caregiver and his/her responsibilities under participant-direction.

NOW, THEREFORE, in consideration of the premises and of the mutual covenants and agreements hereinafter contained, the parties hereto agree as follows:

Section 1. **Employment.** The Employer hereby employs the Caregiver, and the Caregiver hereby accepts employment with the Employer, upon the terms and conditions hereinafter set forth.

Section 2. **"At-Will" Employment.** The Caregiver is an "at-will" employee of the Employer, which means that the Caregiver's employment may be terminated by the Employer, with or without notice, and with or without cause, at any time, for any reason not prohibited by law.

Section 3. **Duties under this Agreement.** The duties of the Caregiver under this Agreement shall be as set forth in the Employer's ISP (the **"Covered Duties"**). The Caregiver agrees to use his/her best efforts in performing his/her Covered Duties for the Employer and to comply with all Employer directives, both written and oral. The Caregiver understands and agrees that his/her assignment, duties, and responsibilities may be changed at any time by the Employer, subject to the limitations in the ISP.

Section 4. Compensation for Covered Duties.

(a) The Employer shall pay the Caregiver for performing Covered Duties, in such amount as is agreed upon between the Employer and the Caregiver from time to time. Compensation for Covered Duties shall be made using Medicaid funds exclusively, in accordance with Kansas regulation 30-5-308.

(b) The Caregiver understands and agrees that although payment for Covered Duties will be made by the FMS Provider, on behalf of and as payroll agent for the Employer, the FMS Provider shall not be liable to the Caregiver for payment of any compensation. The FMS Provider is a third party beneficiary of this Section 4(b).

(c) If the Caregiver has concerns or questions about his/her compensation, the Caregiver is required to contact the Employer (not the FMS Provider) immediately in order to resolve those concerns or questions.

Section 5. Non-Covered Duties are Outside this Agreement. This Agreement does not prohibit the Employer from employing the Caregiver to perform duties that are not Covered Duties (**"Non-Covered Duties"**). To the extent that the Caregiver performs Non-Covered Duties, the parties agree that the Employer is obligated to pay the Caregiver directly for those Non-Covered Duties, with no involvement by the FMS Provider, in such amount as is agreed upon between the Employer and the Caregiver from time to time, and that the Employer is responsible for paying any overtime wages that are not properly payable under the Program. The parties understand that the Program does not provide funds to pay for any Non-Covered Duties.

Section 6. Work Schedule and Overtime.

(a) The Caregiver's work schedule shall be set by the Employer (not the FMS Provider). The Caregiver understands that he/she is expected to adhere to the work schedule and to provide the Employer with advance notice of any absence or requests for schedule changes.

(b) The Caregiver understands and agrees not to work more than forty hours in any workweek for the Employer without advance approval from the Employer. The Caregiver's workweek shall be the 7-day period starting at 12:01 A.M. on Sunday and ending at midnight on the following Saturday.

Section 7. Time Records. The Caregiver shall report all time worked on Covered Duties using the AuthentiCare® KS IVR system and shall *not* report any time worked on Non-Covered Duties using the AuthentiCare® KS IVR system. Time worked on Non-Covered Duties (if any) shall be reported to the Employer, in the manner directed by the Employer (not by the FMS Provider).

Section 8. Supervision, Cooperation, and Compliance with ISP, the Program, Instructions, Policies, Rules, Regulations, and Laws.

(a) The Caregiver shall be directly supervised and managed by the Employer or the Employer's "Designated Representative" (if any) set forth in the ISP.

(b) The Caregiver agrees to adhere to all rules, policies, and regulations of the Employer.

(c) The Caregiver and the Employer agree to strictly comply with the ISP, the Customer Service Worksheet (if any), and any and all other Program requirements.

(d) The Caregiver and the Employer agree to strictly comply with any instructions, rules, or policies maintained by the FMS Provider with regard to the billing and payment for Covered Duties services rendered by the Caregiver.

(e) The Caregiver and Employer agree to strictly comply with any and all Kansas statutes, regulations, or policies (including, but not limited to, the KDADS's Field Services Manual, as amended) relating or pertaining to Covered Duties services to the Employer and for payment for such services.

(f) The Caregiver agrees to cooperate fully with the FMS Provider and with KDADS, the Employer's case manager, case management agency (if any) from whom the Employer receives case management services under the Program, and the Case Management Entity (if any) from whom the Employer receives case management services under the Program (the **"CME"**), regarding any questions and/or inquiries about the Employer's case and services provided by the Caregiver under the Program.

Section 9. FMS Provider is Not the Common Law Employer for Purposes of Patient Protection and Affordable Care Act. The parties hereby understand and agree that ***the FMS Provider is not the "common law employer" of the Caregiver for purposes of the Patient Protection and Affordable Care Act ("PPACA") or under any other law and that the FMS Provider has no legal obligation to offer health care coverage to any Caregiver.*** The parties further agree and understand that, under the legal standards established by the Internal Revenue Service, the "common law employer" for purposes of PPACA compliance is the Employer. The parties agree never to argue or raise as a defense in any legal proceeding that the FMS Provider is the "common law employer" of the Caregiver for purposes of PPACA or for any other purpose. The FMS Provider is a third-party beneficiary of Section 9 of this Agreement.

Section 10. FMS Provider is Not the "Employer" for Purposes of the Fair Labor Standards Act. The parties hereby understand and agree that ***the FMS Provider is not the "employer" of the Caregiver for purposes of the Fair Labor Standards Act or under any other law that uses the "economic reality test" to determine employer/employee status.*** The parties agree never to argue or raise as a defense in any legal proceeding that the FMS Provider is the "employer" of the Caregiver for purposes of the Fair Labor Standards Act or for any other purpose. The FMS Provider is a third-party beneficiary of Section 10 of this Agreement.

Section 11. Changes in Information. The Caregiver agrees to notify the Employer of any change in the Caregiver's name, address, telephone number, e-mail address, emergency contact information, and/or Form W-4 and Form K-4 elections.

Section 12. Safety. The Caregiver is expected to follow generally accepted safety procedures while performing Covered Duties and must promptly report all safety concerns to the Employer.

(a) If an accident results in injury to the Employer and the Employer has a Designated Representative, the Caregiver must report the accident to the Designated Representative as soon as possible.

(b) If a work-related accident results in injury to the Caregiver, the Caregiver must report such accident to the Employer as soon as possible, but no later than 24 hours after such injury

Section 13. **Driving.** The Caregiver is prohibited from providing transportation services to the Employer unless the duties specified in the Employer's ISP include providing transportation services. If the Caregiver's duties under the ISP include providing transportation services, the Caregiver (a) must have a current, valid driver's license and must have automobile insurance in the minimum amount required by the State of Kansas or in such greater amount as the Employer otherwise requires and (b) must notify the Employer immediately if the status of the Caregiver's driver's license or automobile insurance changes.

Section 14. **Medicaid Fraud.** The parties agree and understand that if either of them submits false or inaccurate information to the FMS Provider or through the AuthentiCare® KS IVR system regarding the work times or duties performed by the Caregiver under the Program, it will be considered Medicaid fraud and exploitation of benefits, which the FMS Provider is required to report to the State of Kansas.

Section 15. **Consent to Release of Confidential Information.** The Caregiver consents and authorizes the FMS Provider and the Employer to release and exchange information related to the services provided by the Caregiver to the following agencies and individuals: the Employer's case manager; the Employer's case management agency or CME (as applicable), including, but not limited to, a Managed Care Organization ("MCO") that is a CME; the Employer's Community Developmental Disability Organization ("CDDO"); KDADS; the Division of Health Care Finance of the Kansas Department of Health and Environment; HP Enterprises/KS Medicaid Fiscal Agent; the KDADS's Quality Assurance Department; AuthentiCare® KS; and any other governmental agency as required by law and Kansas FMS requirements.

Section 16. **Termination of the Agreement.** This Agreement shall remain in effect while the Caregiver is employed by the Employer. The Caregiver understands and agrees that his/her employment, and this Agreement, will terminate upon the earliest occurrence of one of the following events:

(a) Denial of the Employer's Medicaid and/or KanCare eligibility;

(b) Termination/closure of the Employer's applicable HCBS case;

(c) Termination of the Employer's right to self-direct his/her care; or

(d) A decision of either party to terminate the employment relationship.

Section 17. **Third Party Beneficiary.** Though KDADS and the CME (if any) are not parties to this Agreement, the parties specifically intend that KDADS and the CME (if any) each be a third-party beneficiary and, as a result thereof, further acknowledge and agree that KDADS and/or the CME (if any) may, at their option, enforce the terms of this Agreement.

Section 18. **Assignment.** The parties shall not assign, subcontract, or delegate any duties or obligations required by this Agreement to any other individual, agency, or organization. Subject to that limitation, this Agreement shall be binding upon and inure to the benefit of the parties and their heirs, personal representatives, successors, and assigns.

Section 19. **Amendment.** This Agreement may only be modified by a written agreement signed by the parties hereto. No failure by either party to insist upon the strict performance of this Agreement on one or more occasions shall constitute a waiver of any right or remedy hereunder.

Section 20. **Severability.** The invalidity or unenforceability of any provision of this Agreement shall not affect the other provisions hereof and this Agreement shall be construed in all respects as if such invalid or unenforceable provision were omitted.

Section 21. **Entire Agreement.** This Agreement has been entered into in good faith by the parties. This Agreement sets forth the entire agreement and understanding of the parties with respect to the subject matter hereof and supersedes any and all prior and contemporaneous negotiations, understandings, and agreements with regard to the subject matter hereof, whether oral or written. In entering into this Agreement, none of the parties have made or relied upon any representation or provision not set forth herein.

Section 22. **State Law.** The terms and provisions of this Agreement shall be construed in accordance with and governed by the laws of the State of Kansas. The titles of the Sections, Subsections, Paragraphs, and Subparagraphs in this Agreement have been inserted for convenient reference only and shall not affect the construction of this Agreement.

Section 23. **Venue.** For any action to enforce this Agreement by KDADS or CME (if any), venue shall solely be in the District Court of Shawnee County, Kansas. For all other actions to enforce this Agreement, venue shall solely be in the District Court of Douglas County, Kansas.

Section 24. **Compliance with Program.** It is the intent of the parties that this Agreement be interpreted to comply with the Program requirements.

Section 25. **Signatures.** This Agreement (and any amendments, modifications, or waivers in respect hereof) may be executed in any number of counterparts, each of which shall be deemed to be an original, but all of which shall constitute one and the same document. Facsimile signatures or signatures emailed in portable document format (PDF) shall be acceptable and deemed binding on the parties hereto as if they were originals.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the day and year first above written.

CAREGIVER

_____
Signature

_____
Print name

EMPLOYER

_____
Signature

_____
Print name

_____
If Employer does not sign, the relationship of the person signing to the Employer

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name			4. Employer Identification Number (EIN)
5. Employer address			6. Employer phone number
7. City		8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?			
11. Phone number (if different from above)	12. Email address		

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:

DO NOT FILL OUT

  - ☐ Some employees. Eligible employees are:

- With respect to dependents:
  - ☐ We do offer coverage. Eligible dependents are:
  - ☒ We do not offer coverage.

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

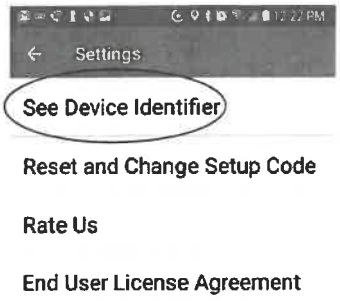
Keep

Instructions for AuthentiCare 2.0 app

1. Download Apple/Android users please download "AuthentiCare 2.0" app from the play/app store.
2. Enter the set-up code "kansasprd". Press submit.

3. You will see this screen. Click on settings.

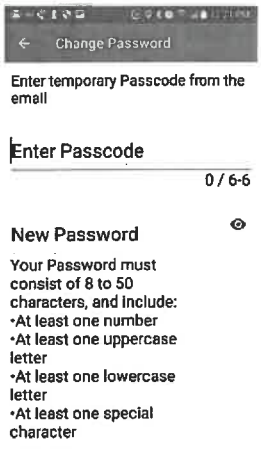
4. Click "see device identifier."

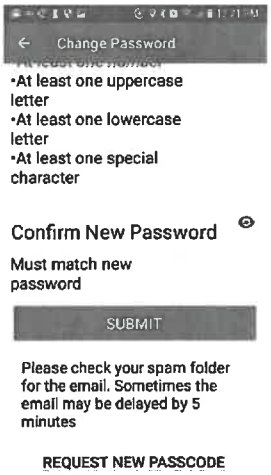


5. It will open a box that looks like this. You will need to copy the device ID number and email it to your consumer's FMS provider so they can set you up to use the app. You will need to email the device ID to Alisa Snyder at asnyder@independenceinc.org.

6. Once the FMS provider gets you set up in AutnentiCare to use this app. They will reply to your email with a temporary password.
7. Once you get that temporary password you will need to go back to the home screen that has the worker ID & password. You will enter your worker ID number that the FMS provider has assigned you and the temporary password they gave you.

8. After you have done that, it will ask you to change your password. You will enter the temporary password that was provided to you as the current password. You will then change your password. You will need to confirm your password by entering it a second time. At this time, you cannot use facial recognition or fingerprints. It will keep locking you out.





9. If you enter your password wrong three times you will be prompted to contact your provider to have your password reset. You can use the "forgot password" to reset your password. Please make sure you check your spam folder for an email that will give you a temporary password.

Keep

AuthentiCare App Clock-In Instructions

Worker Check-In at Client Location

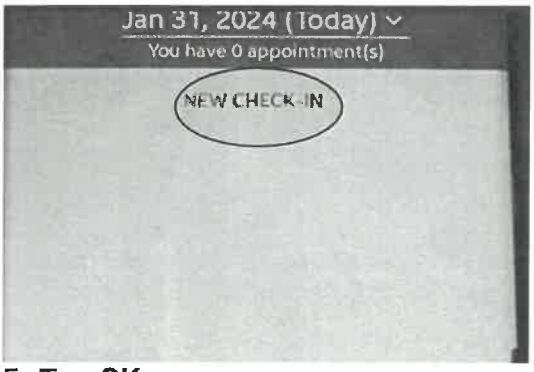
When the worker arrives at the client location, the worker will:

1. Open the AuthentiCare Mobile

2. Input **Worker ID** and App **Password** to begin the session.

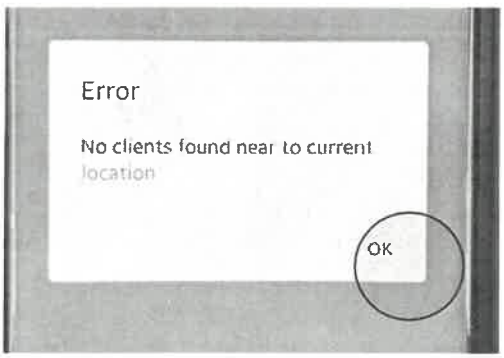
3. Tap **DONE** on the keyboard or simply tap **SIGN IN.**

4. "You have 0 appointments" displays in the date banner. The worker will tap **NEW CHECK-IN**.

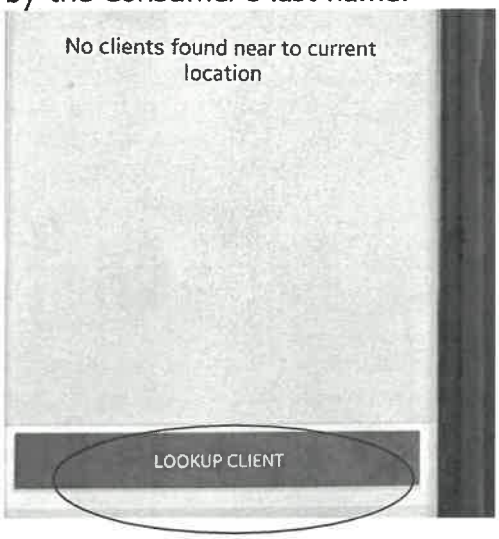


5. Tap **OK.**

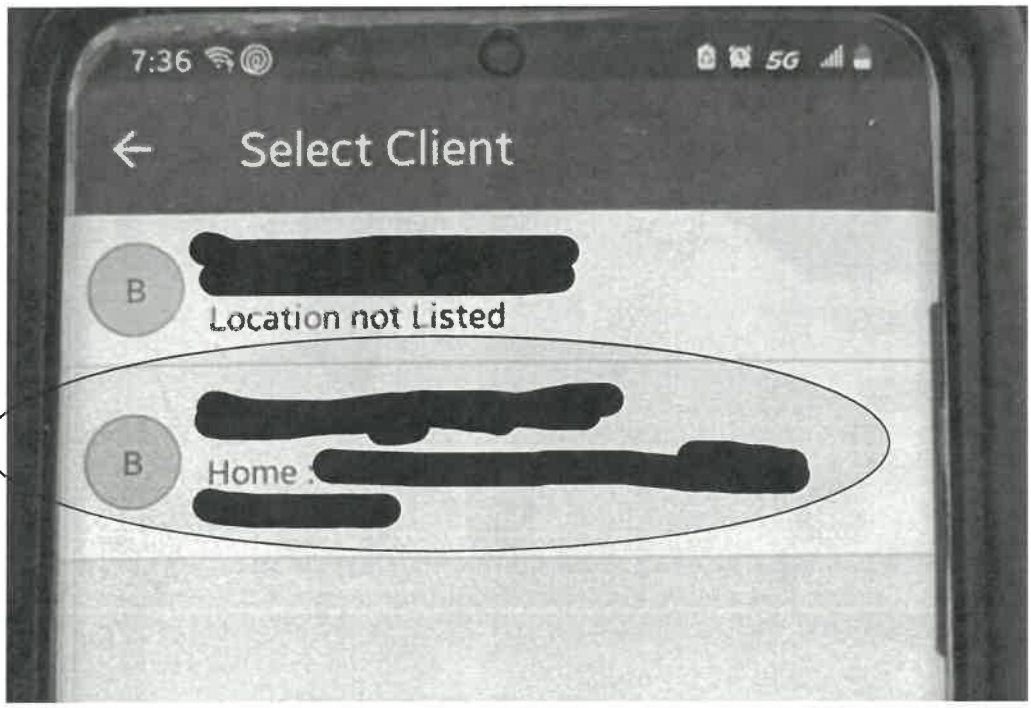
6. You may get this error message. Please click **OK**



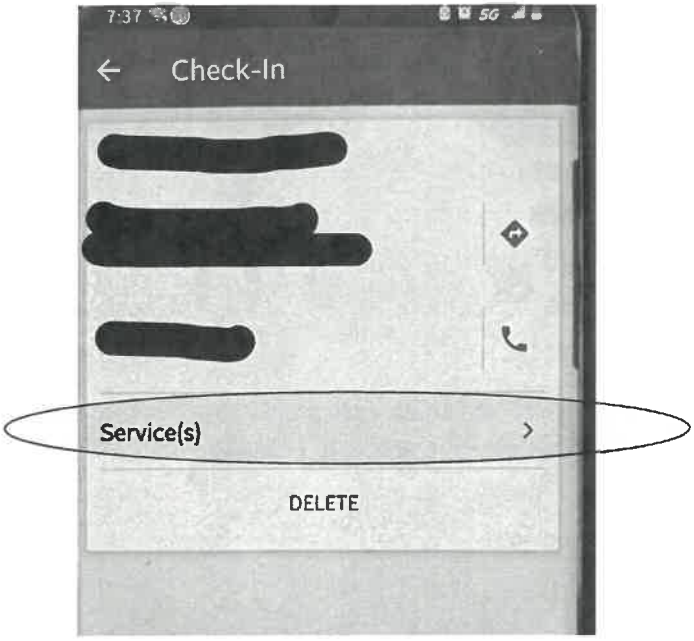
7. Tap **LOOKUP CLIENT** found at the bottom of the screen to process the Check-In. You will search by the Consumer's last name.



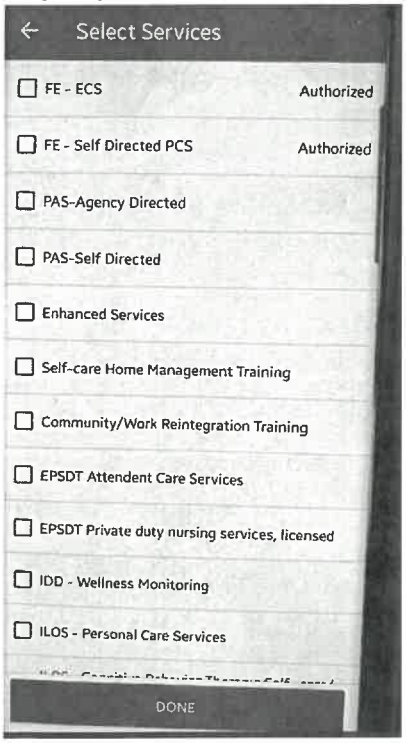
8. Select the Client name that has the address.



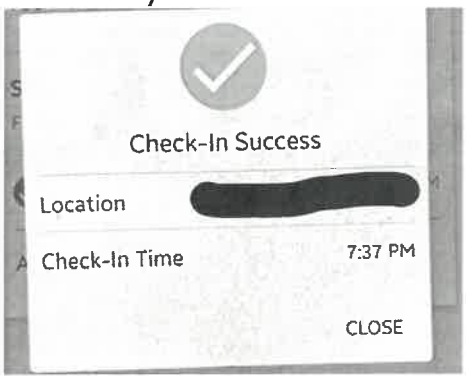
10. You will need to click on "service".



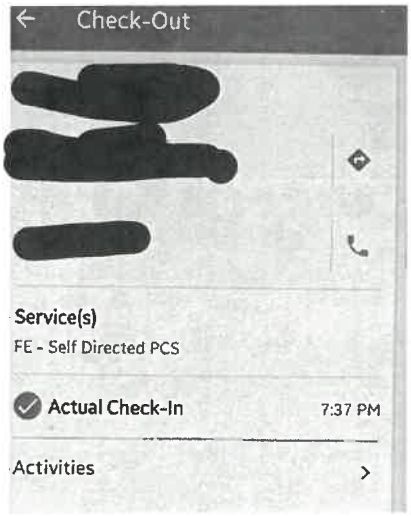
11. You should see a list of services. The services that your employer is authorizes for should say "authorized" by the service you need to select. If not, you will need to look through the list of services and select one of the following FE self-directed, IDD self-directed, PD self-directed or BI(TBI) self-directed. Click **Done** at the bottom.



11. When you have clocked in successfully you should see.



12. Once you have seen the successful check-in this is what you should see.



Keep

AuthentiCare App Clock-Out Instructions

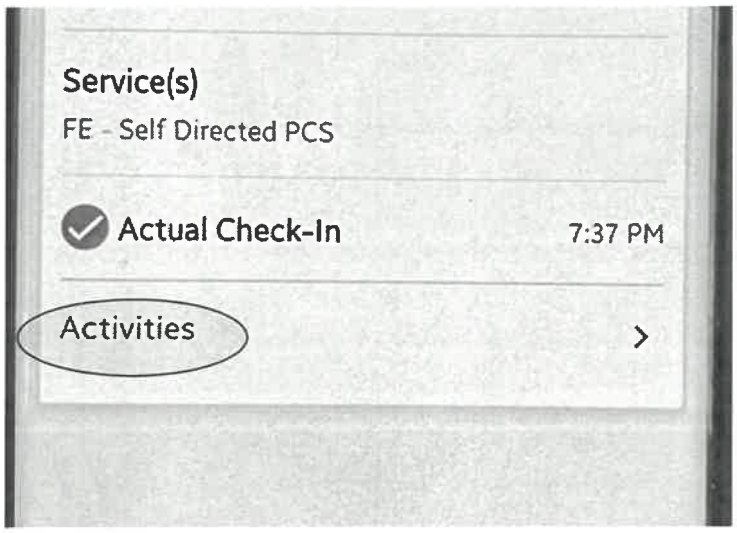
Worker Check-Out at Client Location
When the worker has completed their shift at the client location, the worker will:

1. Open the AuthentiCare Mobile
2. Input **Worker ID** and App **Password** to begin the session.

3. Tap **DONE** on the keyboard or simply tap **SIGN IN.**

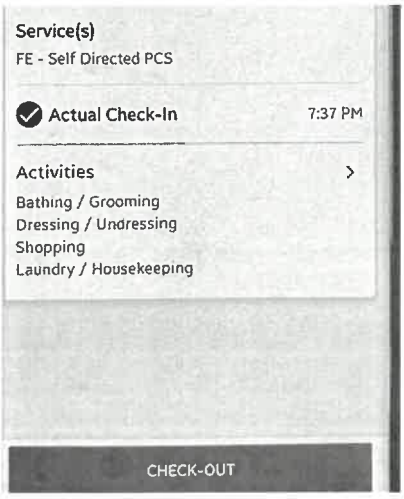
If you work a night shift, you will need to change the date at the top back to the previous day to clock out.

4. Select the activities you have performed for the day by clicking activities.



5. Check each activity that you have performed for the day by clicking on it. Once you have selected all activities that you have performed click **Done** at the bottom of the screen.

6. Below is what you should see once you have clicked done.

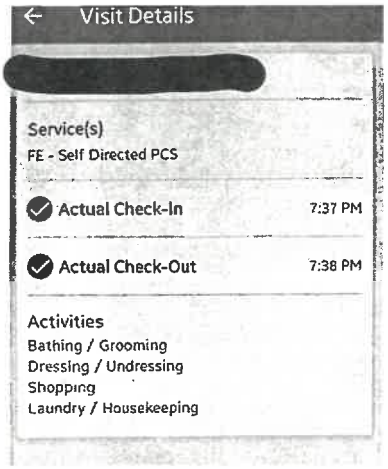


7. You will need to select the service location

8. Now click Check-out at the bottom. You should see the following.

9. click close.

10. This should be the next screen you see. Click visit details.



11. Then you should see this.