Direct Support Worker Payroll Registration Packet: TA WAIVER

INSTRUCTIONS ON HOW TO FILL THIS PAPERWORK OUT IS OUTLINED BELOW IN ITEMS 1 THROUGH 6. PLEASE MAKE SURE YOU READ IT CAREFULLY AND UNDERSTAND IT BEFORE SIGNING IT. YOUR SIGNATURE WILL INDICATE YOU DID.

1. **WE ACCEPT PAPERWORK BETWEEN THE HOURS OF 8:00 AM TO 3:00 PM MONDAY TO THURSDAY – NO FRIDAYS!**
   - YOU MUST BE 18 YEARS OF AGE TO WORK.
   - MAKE A COPY OF THIS PAPERWORK FOR YOUR RECORDS.
   - YOU MAY SUBMIT COPIES OF YOUR TWO FORMS OF ID’S AS STATED ON THE LIST OF ACCEPTABLE DOCUMENTS PAGE, THEY MUST BE CURRENT AND UNEXPIRED AND AS LONG AS THE CUSTOMER HAS SIGNED I-9 FORM.
   - YOU MUST ALSO HAVE A COPY OF YOUR HIGH SCHOOL DIPLOMA OR EQUIVALENT (GED)
   - RETURN THESE ITEMS ONLY: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28

2. **THE “YELLOW” AREAS ARE FOR YOU TO FILL OUT WITH YOUR INFORMATION AS THE DSW/CAREGIVER/PERSONAL ASSISTANT.**

3. **THE “ORANGE” AREAS ARE FOR YOU TO FILL OUT WITH YOUR INFORMATION AS THE CUSTOMER/EMPLOYER/CLIENT.**

4. WHEN SUBMITTING THIS PAPERWORK IT MUST BE COMPLETE WITH NO ERRORS OR OMISSIONS, UPON REVIEW IF WE ILRC FIND ANY ERRORS OR OMISSIONS IT WILL BE GIVEN/MAILED BACK TO YOU WITH INSTRUCTIONS ON WHAT TO DO.

5. YOU ARE NOT ELIGIBLE TO WORK FOR A CUSTOMER UNTIL YOU HAVE PASSED ALL OF THE REQUIRED BACKGROUND CHECKS AND RECEIVED AN ID NUMBER TO CLOCK IN/OUT WITH USING THE MANDATORY KANSAS AUTHENTICARE CALL IN SYSTEM. ANY HOURS WORKED PRIOR TO THIS ARE NOT ELIGIBLE FOR PAYMENT BY ILRC AND IT WILL BE THE CUSTOMER’S RESPONSIBILITY TO PAY YOU.

6. YOU CAN SUBMIT PAPERWORK BY ONE OF THE FOLLOWING WAYS:
   - PLACE IT IN THE GREEN TIME SHEET DROP BOX UNDER THE CANOPY IN FRONT OF OUR BUILDING
   - SCAN AND EMAIL IT IN PDF FORM ONLY TO swlickery@ilrcs.org
   - MAIL IT TO ILRC 3033 W 2ND ST N STE 1, WICHITA, KS 67203
   - FAX IT TO 316-425-3720 OR 316-670-1424

If you have any questions about anything contained in this packet, please contact Sabrina in the Payroll Services Department at 316-942-6300 between the hours of 8am to 4:00pm Monday through Friday.
BACKGROUND CHECK REQUIREMENTS

PLEASE READ CAREFULLY BELOW BEFORE COMPLETING THIS APPLICATION. WE CAN'T STRESS THIS ENOUGH HOW IMPORTANT THIS IS WHEN APPLYING TO WORK FOR A CUSTOMER ON THE HCBS WAIVER(S).

THE BACKGROUND CHECK PROCESS CONDUCTED BY KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES (KDADS) AND HEALTH OCCUPATIONS CREDENTIALING (HOC) REVIEWS ANY AND ALL OFFENSES, REGARDLESS OF HOW LONG AGO IT HAPPENED.

PLEASE REVIEW THE "CURRENT AND NEW PROHIBITED OFFENSES" LIST ON THE NEXT FIVE (5) PAGES.

- **IF** YOU HAVE ANY OF THE LISTED OFFENSES PER K.S.A 39-970, K.S.A. 65-5117 AND SENTENCING REQUIREMENTS HAVE NOT BEEN COMPLETED YET, YOU ARE NOT ELIGIBLE TO WORK IN THIS HCBS WAIVER PROGRAM, **DO NOT FILL THIS PAPERWORK OUT**.

- **IF** YOU HAVE ANY OF THE LISTED OFFENSES PER K.S.A 39-970, K.S.A. 65-5117 AND IT HAS BEEN 6 YEARS SINCE YOU HAVE COMPLETED ALL OF THE SENTENCING REQUIREMENTS THEN YOU CAN FILL OUT THIS PAPERWORK. IF IT HAS NOT BEEN 6 YEARS DO NOT FILL THIS PAPERWORK OUT.

- **IF** YOU HAVE NEVER BEEN CONVICTED OF ANY OF THE LISTED OFFENSES PER K.S.A 39-970, K.S.A. 65-5117 THEN YOU CAN FILL THIS PAPERWORK OUT.
## Current and New Prohibited Offenses

<table>
<thead>
<tr>
<th>Adult Care Homes &amp; Home Health Agencies KSA 39-970, 65-5117</th>
<th>HCBS X = existing prohibition KSA 39-2009</th>
<th>OFFENSE</th>
<th>PROHIBITED</th>
<th>Does Not Expire</th>
<th>Expires 6 Yrs. *</th>
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<tbody>
<tr>
<td>21-5301 21-3301</td>
<td>X</td>
<td>Attempt to commit a prohibited offense</td>
<td>See Key</td>
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<tr>
<td>21-5302 21-3302</td>
<td>X</td>
<td>Conspiracy to commit a prohibited offense</td>
<td>See Key</td>
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<tr>
<td>21-5303 21-3303</td>
<td>New</td>
<td>Criminal solicitation to commit a prohibited offense</td>
<td>See Key</td>
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<tr>
<td>21-5401 21-3409</td>
<td>X</td>
<td>Capitol Murder (Felony)</td>
<td>Yes</td>
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<tr>
<td>21-5402 21-3401</td>
<td>X</td>
<td>First degree murder (Felony)</td>
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<tr>
<td>21-5403 21-3402a 21-3302</td>
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<td>Second degree murder (Felony)</td>
<td>Yes</td>
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<td>21-5404 21-3403</td>
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<td>Voluntary manslaughter (Felony)</td>
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<td>21-5405 21-3404</td>
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<td>21-5407 21-3406</td>
<td>X</td>
<td>Assisting suicide (Felony)</td>
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<td>21-5412(b) 21-3410</td>
<td>X</td>
<td>Aggravated assault (Felony)</td>
<td>6 Years*</td>
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<td>21-5412(d) 21-3411</td>
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<td>Aggravated assault on a law enforcement officer (Felony)</td>
<td>6 Years*</td>
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<td>21-5414 21-3412a</td>
<td>X</td>
<td>Domestic Battery (Felony)</td>
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<tr>
<td>21-5413(c) 21-3413</td>
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<td>Battery against a law enforcement officer (Felony)</td>
<td>6 Years*</td>
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<tr>
<td>21-5413(d) 21-3415</td>
<td>X</td>
<td>Aggravated battery against a law enforcement officer (Felony)</td>
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<tr>
<td>21-5415(a) 21-3419</td>
<td>X</td>
<td>Criminal threat (Felony)</td>
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<tr>
<td>21-5415(b) 21-3419(a)</td>
<td>X</td>
<td>Aggravated criminal threat (Felony)</td>
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<tr>
<td>21-5408(a) 21-3420</td>
<td>X</td>
<td>Kidnapping (Felony)</td>
<td>6 Years*</td>
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<tr>
<td>21-5408(b) 21-3421</td>
<td>X</td>
<td>Aggravated kidnapping (Felony)</td>
<td>6 Years*</td>
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1. Note: Green shading denotes a new prohibition for this type of facility.
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<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Sentence</th>
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<tbody>
<tr>
<td>21-5409(a)</td>
<td>Interference with parental custody (Felony)</td>
<td>6 Years*</td>
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<tr>
<td>21-5409(b)</td>
<td>Aggravated interference with parental custody (Felony)</td>
<td>6 Years*</td>
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<tr>
<td>21-5420(a)</td>
<td>Robbery (Felony)</td>
<td>6 Years*</td>
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<tr>
<td>21-5420(b)</td>
<td>Aggravated robbery (Felony)</td>
<td>6 Years*</td>
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<tr>
<td>21-5428</td>
<td>Blackmail (Felony)</td>
<td>6 Years*</td>
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<tr>
<td>21-5424</td>
<td>Exposing another to a life threatening communicable disease (Felony)</td>
<td>6 Years*</td>
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<tr>
<td>21-5417</td>
<td>Mistreatment of a dependent adult or Mistreatment of an elder person. (Misdemeanor or Felony)</td>
<td>Yes</td>
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<tr>
<td>21-5427</td>
<td>Stalking (Felony)</td>
<td>6 Years*</td>
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<tr>
<td>21-5405(a)(3)</td>
<td>Involuntary manslaughter while driving under the influence (Felony)</td>
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<tr>
<td>21-5426(a)</td>
<td>Human Trafficking (Felony)</td>
<td>Yes</td>
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<td>21-5426(b)</td>
<td>Aggravated Human Trafficking (Felony)</td>
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<td>21-5413(f)</td>
<td>Battery against a mental health employee (Felony)</td>
<td>6 Years*</td>
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<tr>
<td>21-5421</td>
<td>Terrorism (Felony)</td>
<td>6 Years*</td>
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<tr>
<td>21-5422</td>
<td>Illegal use of weapons of mass destruction (Felony)</td>
<td>6 Years*</td>
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<tr>
<td>21-5423</td>
<td>Furtherance of Terrorism or Illegal Use of Weapons of Mass Destruction (Felony)</td>
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<td>21-5503</td>
<td>Rape (Felony)</td>
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<tr>
<td>21-5506(a)</td>
<td>Indecent liberties with a child (Felony)</td>
<td>Yes</td>
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<td>21-5506(b)</td>
<td>Aggravated indecent liberties with a child (Felony)</td>
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<tr>
<td>21-5504(a)</td>
<td>Criminal sodomy (felony)</td>
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<tr>
<td>21-5504(b)</td>
<td>Aggravated criminal sodomy (Felony)</td>
<td>Yes</td>
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<tr>
<td>21-5513</td>
<td>Lewd and lascivious behavior (Felony)</td>
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<tr>
<td>21-5508(a)</td>
<td>Indecent solicitation of a child (Felony)</td>
<td>Yes</td>
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<td>21-5508(b)</td>
<td>Aggravated indecent solicitation of a child (Felony)</td>
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<tr>
<td>21-6420</td>
<td>Promoting prostitution (Felony)</td>
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<tr>
<td>21-5510</td>
<td>Sexual exploitation of a child (Felony)</td>
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<table>
<thead>
<tr>
<th>Case Number</th>
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<tr>
<td>21-5505(a)</td>
<td>Sexual battery (Felony)</td>
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<td>21-5505(b)</td>
<td>Aggravated sexual battery (Felony)</td>
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<td>21-5512</td>
<td>Unlawful sexual relation (Felony)</td>
<td>6 Years*</td>
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<td>21-5507</td>
<td>Unlawful voluntary sexual relations (Felony)</td>
<td>6 Years*</td>
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<td>21-5509</td>
<td>Electronic solicitation (Felony)</td>
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<tr>
<td>21-5604(a)</td>
<td>Incest (Felony)</td>
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<td>21-5604(b)</td>
<td>Aggravated incest (Felony)</td>
<td>6 Years*</td>
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<td>21-5605(a)</td>
<td>Abandonment of a child (Felony)</td>
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<td>21-3604</td>
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<td>21-5605(b)</td>
<td>Aggravated abandonment of a child (Felony)</td>
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<td>21-3604(a)</td>
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<td>21-5601(b)</td>
<td>Aggravated endangering a child (Felony)</td>
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<td>21-3608(a)</td>
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<td>21-5602</td>
<td>Abuse of a child (Felony)</td>
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<td>21-5607(b)</td>
<td>Furnishing alcoholic beverages to a minor for illicit purpose (Felony)</td>
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<td>21-3610(b)</td>
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<td>21-5603</td>
<td>Contributing to a child’s misconduct or deprivation (Felony)</td>
<td>6 Years*</td>
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<tr>
<td>21-5801</td>
<td>New Theft (Felony)***</td>
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<td>21-5430</td>
<td>Distribution of a controlled substance causing great bodily harm (Felony)</td>
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<td>21-5606</td>
<td>Criminal nonsupport (Felony)</td>
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<td>21-5410</td>
<td>Interference with custody of a committed person (Misdemeanor and Felony)</td>
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<td>21-5416</td>
<td>Mistreatment of a confined person (Misdemeanor and Felony)</td>
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<td>Unlawful administration of a substance (Misdemeanor and Felony)</td>
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<td>21-5708</td>
<td>Unlawful obtainment or sale of a prescription-only drug (Felony)</td>
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<td>21-5823</td>
<td>New Forgery (Felony)</td>
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<td>21-5828</td>
<td>New Criminal Use of a Financial Card (Felony)</td>
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<td>21-5825</td>
<td>New Any violation of Kansas Medicaid Fraud Control Act (Felony)</td>
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<td>21-5927</td>
<td>New Making false claim, statement or representation to the Medicaid program (Felony)</td>
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<td>21-5828</td>
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<td>Unlawful acts relating to the Medicaid program ** (Felony)</td>
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<td>Obstruction of a Medicaid fraud investigation** (Felony)</td>
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<td>21-6224</td>
<td>New</td>
<td>Violation of a protective order; extended protective orders, penalties ** (Felony)</td>
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<td>21-8107</td>
<td>New</td>
<td>Identity theft; identity fraud **(Felony)</td>
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<td>21-8412</td>
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<td>Cruelty to animals ** (Misdemeanor or Felony)</td>
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<td>21-6422</td>
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<td>29-0720</td>
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<td>Social welfare fraud ** (Misdemeanor or Felony)</td>
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<td>21-5703</td>
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<td>Unlawful manufacture, distribution, cultivation or possession of controlled substances using a communication facility** (Felony)</td>
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<td>21-5710</td>
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<td>Unlawful distribution or possession of a simulated controlled substance ** (Felony)</td>
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<td>21-5406</td>
<td>New</td>
<td>Vehicular Homicide (Felony)</td>
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<td>NOTE:</td>
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<tr>
<td></td>
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<td>Similar Statutes of Other States &amp; Federal Government.</td>
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</table>

**KEY**

6 Years* For this type of conviction the individual is prohibited until six or more years have elapsed since completion of the sentence imposed or the applicant was discharged from probation, a community correctional services program, parole, post release supervision, conditional release or a suspended sentence; or if the applicant has been granted a waiver of such six-year disqualification.
*Waivers* An individual who has been disqualified for employment due to conviction or adjudication of the offenses marked by a single asterisk * may apply to the secretary for aging and disability services for a waiver of such disqualifications if five years have elapsed since completion of the sentence for such conviction.

**Yes** The individual is prohibited. The prohibition does not expire and waivers are not available.

** Note: A prohibition for these offenses became effective on July 1, 2018. An individual shall not be prohibited due to a conviction of these offenses who is employed by a center, facility, hospital or provider of services on or before July 1, 2018, and is continuously employed by the same center, facility, hospital or provider of services or to any person during or upon successful completion of a diversion agreement.

*** Note: A prohibition for this offense became effective on July 1, 2010. Further, an individual shall not be prohibited due to a conviction of Felony Theft if the individual is employed by an adult care home or home health agency on July 1, 2010, and continuously employed by the same adult care home or home health agency.

1,2,3. Convictions for attempt to commit, conspiracy to commit, or criminal solicitation to commit any offense listed above which carries a prohibition that does not expire will result in a prohibition that does not expire. Convictions for attempt to commit, conspiracy to commit, or criminal solicitation to commit any offense listed above which carries a six-year prohibition will result in a six-year prohibition.
PD / FE / IDD / TA / TBI WAIVERS
Customer Verification of Signature

The State of Kansas requires us to verify that your signature on correction sheets and paperwork matches the signature we have on file. If we ever have a question about your signature we can refer back to this page for verification. If we have any further questions we will contact you.

**Customer Name** (The person receiving HCBS services name goes on this line do not list the parent/guardian or DPOA name. Please print)

**Customer Signature (*)**

**Date**

*NOTE: If customer is unable to sign for themselves see Signature of Limitations below:

**Signature Of Limitations**

In all situations, the expectation is that the beneficiary (customer) provides oversight and accountability for those providing services. Signature options are provided in recognition that a beneficiary’s (customer) limitations may make assistance necessary in carrying out this function.

A designated signatory can be anyone who is aware of HCBS services that were provided. The direct support worker cannot make corrections to their hours on behalf of the beneficiary (customer) or sign any paperwork on behalf of the beneficiary (customer).

How to sign this paperwork see sample below.

**SUSAN SAMPLE**

Customer Name

**Jane Doe** (Parent or Guardian) for Susan Sample

Customer Signature

Customer Representative (print name)

Customer Representative Signature

Representative’s relationship to customer (i.e. POA, DPOA, Guardian etc)

Revision 05 2013
BACKGROUND CHECK REGISTRATION NOTICE

EFFECTIVE 11/18/2016, IN COORDINATION AND COMPLIANCE WITH ALL STATE REGULATIONS REGARDING HOME AND COMMUNITY BASED SERVICES AND FINANCIAL MANAGEMENT (FMS) SERVICES, ILRC FISCAL AGENT HAS IMPLEMENTED THE FOLLOWING POLICY.

ALL REQUIRED PAPERWORK MUST BE COMPLETED AND ALL REQUIRED BACKGROUND CHECKS MUST BE PASSED BEFORE ANYONE CAN START TO WORK FOR THE CUSTOMER/EMPLOYER UNDER THIS PROGRAM.

THE BACKGROUND CHECK PROCESS CAN TAKE UP TO 4 WEEKS BEFORE ALL OF THE RESULTS ARE RECEIVED FROM THE STATE.

WE ASK THAT YOU DO NOT CALL ILRC FOR STATUS UPDATES ON WHERE YOU ARE AT IN THE PROCESS.

ONCE ALL OF THE BACKGROUND CHECKS ARE RECEIVED YOUR PAPERWORK WILL THEN BE PROCESSED AND AN ID# WILL BE ISSUED BY SABRINA FROM ILRC AND EMAILED TO THE WORKER, THEY WILL ALSO RECEIVE A FOLLOW UP PHONE CALL LETTING THEM KNOW THEY ARE ELIGIBLE TO BEGIN WORKING UNDER THE HCBS PROGRAM FOR THE CUSTOMER.

IF NO EMAIL IS AVAILABLE YOU WILL GET A PHONE CALL FROM SABRINA AND BE GIVEN THE OPTION TO PICK UP THE INFORMATION OR HAVE IT MAILED TO YOU.

By signing below I have read and understand the above agreement regarding the background checks and process.

__________________________
Customer/Employer Signature

__________________________
Direct Support Workers Signature

__________________________
Date

__________________________
Date
BACKGROUND CHECK FEES AGREEMENT

WE ARE REQUIRED TO PERFORM INITIAL BACKGROUND CHECKS ON EACH NEW DIRECT SUPPORT WORKER AND THEN EVERY 2 YEARS AFTER THAT IF THEY ARE STILL EMPLOYED.

ILRC STAFF WILL CHECK WHICH BOX THAT APPLIES BELOW:

A $30.00 REFUNDABLE DEPOSIT ($60.00 IF DSW HAS AN OUT OF STATE DRIVERS LICENSE) MUST BE SUBMITTED WITH THE BACKGROUND CHECK AUTHORIZATION PAPERWORK. YOU MUST PASS ALL OF THE REQUIRED BACKGROUND CHECKS IN ORDER TO BE ELIGIBLE FOR THE REFUND. THIS FEE MUST BE PAID UPON RECEIPT OF THE NEW DSW PAPERWORK IN CASH OR CHECK FORM PAYABLE TO ILRC BEFORE THE BACKGROUND CHECKS WILL BE RUN, YOU CAN SEND DEBIT/CREDIT CARD INFORMATION TO US AS WELL. NO MONEY ORDERS.

"YOU" THE CUSTOMER HAVE EXCEEDED "5" DIRECT SUPPORT WORKERS "YOU" THE CUSTOMER/EMPLOYER MUST PAY THE $30.00 BACKGROUND CHECK FEES ($60.00 IF DSW HAS AN OUT OF STATE DRIVERS LICENSE). DEPOSIT NO LONGER APPLIES.

☐ $30.00 BACKGROUND CHECK FEES IF DSW HAS KANSAS DRIVERS LICENSE

☐ $60.00 BACKGROUND CHECK FEES AND IF DSW HAS OUT OF STATE DRIVERS LICENSE

NOTE: IF EXCESSIVE HIRING OF WORKERS CONTINUES AFTER THE FEE HAS BEEN IMPLEMENTED YOU MAY BE ASKED TO FIND A NEW PAYROLL PROVIDER THIS DOCUMENT SERVES AS YOUR NOTICE.

******************************************************

HAVE YOU EVER BEEN CONVICTED OF A FELONY? ☐ YES ☐ NO

IF YES, EXPLAIN: __________________________________________

 __________________________________________

NOTE: IF YOU HAVE ANY PROHIBITED OFFENSES LISTED IN THE PREVIOUS PAGES PER K.S.A. 39-970, K.S.A. 65-5117. YOU ARE NOT ELIGIBLE TO WORK IN THIS PROGRAM DO NOT FILL OUT THIS PAPERWORK. 

________________________________________
Customer Signature

Date

________________________________________
Direct Support Worker Signature

Date
CRIMINAL RECORD CHECK REQUEST FORM

FACILITY NAME: INDEPENDENT LIVING RESOURCE CENTER, INC.  FACILITY ID #: G087218

ADDRESS: 3033 W 2ND ST N  CITY: WICHITA  STATE: KANSAS

ZIP CODE: 67203

Applicant information: ALL REQUESTED INFORMATION MUST BE PROVIDED or the form will not be processed.

Last Name:   First Name:   Middle Name:   Suffix (Jr., Sr., etc):

Other Names Ever Used:

Last Name:

Last Name: **

** List additional names on back. Check here if more on back. [ ]

Social Security Number:   Date of Birth:   Sex:   Race:

A - Asian or Pacific Islander  B - Black  I - Native American/Alaskan Native  W - White

Address:

City:   State:   County:   Zip Code:   Post Office Box # (if applicable):

Home Phone:   Work Phone:

Certificate # (if applicable):

Job Classification: Determine the correct job classification for the applicant and insert the three letter abbreviation in the box. [HHA]

Activities Staff: ACS  Food Service Worker: FSW  Medical Records Staff: MRS
Administrator: ADM  Home Health Aide: HHA  Operator: OPR
Business and Administrative: BAS  Home Health Aide Trainer: HHT  Paid Driver: DRV
Certified Medication Aide: CMA  Housekeeping: HSK  Paid Nutrition Assistant: PNA
Certified Nurse Aide: CNA  Human Resources Staff: HRS  Personnel Staff: PER
Nurse Aide Trainee: NAT  Laundry Workers: LDW  Restorative Aide: RSA
Chaplain: CHN  Maintenance Worker: MTW  Social Service Designee: SSD
Cherical Staff: CLS  Marketing Staff: MKT  Volunteer Coordinator: VLC

Completed by:  Date:

FORMC - REV - 7/42
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:** Sabrina Wickery  
**Phone #:** (316) 942-6300  
**Email:** swickery@ilrcks.org

**Agency/Org.:** ILRC as Fiscal Agent  
**Address:** 3033 W 2nd St. N, Suite 1  
**City/State/Zip:** Wichita, KS 67203

**Return Results by:** ☑ Encrypted email (list if different than above):  
**Payment/Account Information (check box which applies):**

- [ ] Fee included
- [ ] Pre-Pay Account* Agency/Org. has Pre-Pay Account. FEIN: 32-0504847
- [ ] Mentoring Account* As listed in the Kansas Mentors’ Partner Directory: http://mentor.kansas.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

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**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:**

**Gender:** ☐ Male ☐ Female

**Social Security #:**

**Current Address:**

**City, State, Zip:**

**Phone:**

**Email:**

**Signature:**

**Date:**

---

**DCF ONLY:**

This applicant is listed in the Child Abuse/Neglect Central Registry. A Kansas child abuse investigation may result in a reportable child abuse

**MATCH**

**Cleared**
I, ___________________________, give permission for the release of information concerning myself in the Adult Abuse, Neglect, Exploitation Central Registry to:

Contact Person(s)*
Agency name
Agency mailing address
Agency email address

☐ Check box if agency is a CDDO, CMHC, or ILRC
Maiden Name and/or Other Names Known By:

Address:
Street
City
State
Zip Code

DOB: __________ / __________ / __________
SS#: __________
□ Male  □ Female

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 the 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 and Neglect Central Registry each year while I am employed or associated with the above agency: ☐ Yes  ☐ No

Signature: ____________________________ Date: __________ / __________ / __________

Per statute 65-6205 Community Service Providers, Mental Health Centers and Independent Living Centers may request information for the purpose of obtaining background information on applicants for employment without signed consent. Signature is not required from the individual for which the inquiry is made.

RETURN TO:
DTE.APSRegistry@KS.GOV
or
Adult Abuse Registry
555 S. Kansas Ave
Topeka, Kansas 66603-3444

(Please allow 3-5 days for processing email requests and an additional 3-5 days if returning by US Postal Service)

FOR PPS ADMINISTRATION USE ONLY:
Record Found? ☐ No  ☐ Yes  ❑ "Yes" indicates the individual is listed on the adult abuse, neglect, exploitation registry. If yes, check all that apply: ☐ Abuse  ☐ Neglect  ☐ Exploitation  ☐ Fiduciary Abuse
Perpetrator’s Name: ____________________________ Date Substantiated: ____________________________
Initial: ____________________________ Date: ____________________________
DRIVING RECORDS RELEASE AND AUTHORIZATION
(This is not good for any other purpose than Driving Records)

I hereby authorize, without reservation, the appropriate governmental agencies or departments to release records of my driving history to INDEPENDENT LIVING RESOURCE CENTER, INC., OR OTHER AGENT OF INDEPENDENT LIVING RESOURCE CENTER, INC.

I further acknowledge that a telephonic facsimile (FAX) or photographic copy shall be as valid as the original. According to the Fair Credit Reporting ACT, I am entitled to know if any adverse action is taken because of the information obtained by my present or prospective employer from a consumer reporting agency. If so, I will be so advised and be given the name of the agency or source of information. My signature acknowledges that I have been given a copy of this release.

Please fill out the information below.

1. First Name: ____________________  Middle Initial: _____  Last Name: ____________________

2. Home Address: ____________________________________________________________

3. City: __________________________  State: ______________  Zip: __________

4. Social Security Number: __________________________  Date of birth: ____________

Will you be driving the customer in a motor vehicle?  □ YES (see item 1)  □ NO (see item 3)

1. Do you have a valid current Driver’s License?  □ YES (see item 2)  □ NO (see item 3)

2. Driver’s License Number: __________________________  State that issued DL: __________

3. Do you only have a Photo ID?  □ YES (see item 4)

4. You will not be allowed to drive the customer in a motor vehicle. A valid driver’s license is required.

Please sign this form below:

SIGNATURE: __________________________  DATE: ____________

Revised 02/06/2017
Enhanced Care Services a.k.a Sleep Cycle Policy

ECS (SLEEP CYCLE) SERVICES MUST BE APPROVED BY THE CONSUMER’S MANAGED CARE ORGANIZATION (MCO) AND LISTED ON THE CUSTOMER’S PLAN OF CARE (POC).

IF THE CUSTOMER HAS APPROVAL FOR ECS AND THE POC CONFIRMS THIS INFORMATION, THE DIRECT SUPPORT WORKER (DSW) IS REQUIRED TO PROVIDE DOCUMENTATION THAT VERIFIES THEIR HOME ADDRESS. THIS INFORMATION IS TO BE SUBMITTED ALONG WITH THIS APPLICATION. IF THE DSW FAILS TO PROVIDE PROOF OF ADDRESS, ILRC WILL NOT PROCESS THE APPLICATION AND SERVICES PROVIDED TO THE CUSTOMER BY THE DSW WILL NOT BE ELIGIBLE FOR PAY UNTIL ILRC GIVES AUTHORIZATION.

DSW(S) ARE NOT ALLOWED TO LIVE IN THE CUSTOMERS HOME TO PROVIDE THIS SERVICE.

EXAMPLES OF PROOF OF ADDRESS ARE LISTED BELOW AND MUST HAVE THE DSW NAME LISTED AND BE CURRENT TO DATE: DO NOT SUBMIT ANYTHING ELSE IN PLACE OF WHAT IS LISTED.

- UTILITY BILL, PHONE BILL, GAS BILL
- LEASE AGREEMENT
- CHANGE OF ADDRESS CONFIRMATION FROM POST OFFICE

THE CUSTOMER MUST CONTACT ILRC TO CREATE OR EDIT AN ECS CONTRACT BEFORE A DSW MAY BEGIN WORKING FOR THEM. THIS INCLUDES CHANGES OR ADDITIONS TO STAFF, OR ANY CHANGES MADE TO SCHEDULING THAT ARE NOT CONCURRENT WITH AN ECS CONTRACT THAT IS ALREADY IN PLACE WITH ILRC.

ECS SERVICES ARE LIMITED TO HOURS AGREED UPON BY THE CUSTOMER AND ILRC IN THE SIGNED ECS CONTRACT. WORKERS MUST CLOCK IN FOR A MINIMUM OF 6 HOURS AND FOR NO MORE THAN 9 HOURS FOR THESE SERVICES. ADDITIONALLY, WORKERS MUST CLOCK IN FOR ECS EITHER BEFORE OR AFTER MIDNIGHT CONSISTANTLY. FAILURE TO DO SO WILL RESULT IN INACCURATE TIMEKEEPING AND WILL AFFECT THE WORKER’S PAY, WHICH MAY OR MAY NOT BE ABLE TO BE RECONCILED.

CUSTOMER NAME (print) ___________________________ DATE __________

CUSTOMER NAME (signature) ________________________

DIRECT SUPPORT WORKER NAME (print) ___________________________ DATE __________

DIRECT SUPPORT WORKER NAME (signature) ________________________

ILRC STAFF USE ONLY: DOES CUSTOMER HAVE ECS:

If “yes” is checked the worker will need their proof of address it is required: YES □

If “no” is checked proof of address is not required at this time: NO □
Notice of Employment – TA

I ___________________________ have been hired to provide Direct Support Worker Services by ___________________________. Direct Support Worker Services will be participating in the Self-Directed Home and Community Based Services (HCBS) Program. My employer has chosen Independent Living Resource Center, d.b.a ILRC as Fiscal Agent to provide payroll services.

I understand if the assignment with the Customer ends for any reason, I am required to contact Sabrina in the Independent Living Resource Center Inc., d.b.a. ILRC as Fiscal Agent Payroll Department at 316-670-1224, 316-942-6300 Ext. 224 or at swickery@ilrcs.org. This contact must be made by the next business day to complete a termination form and an application to be placed on the worker registry to be selected by another Employer. I acknowledge that failure to comply with the above requirements indicates that I have voluntarily quit the assignment which could result in unemployment benefits being denied.

By signing below I have read and understand the above agreement.

_________________________________________ ________________________
Customer/Employer Signature        Date

_________________________________________ ________________________
Direct Support Workers Signature      Date

Revised 09/03/2015
DIRECT SUPPORT WORKER PERSONAL INFORMATION – TA

Enter your start date here: ________________________________

Your Name ___________________________________________

First                      Middle                     Last

Address _____________________________________________

City/State __________________________ Zip Code __________

Home Phone (____) ___________________ Cell Phone (____) ___________________

Social Security # ______________________________ Date of Birth __________/______/______

Email address (for ILRC purposes only): ______________________________

Authenticare Mandatory Information. This information is mandatory per the State of Kansas and Authenticare. You’re information will be entered into the Kansas Authenticare system prior to you receiving a 5 digit ID number in order to begin calling in your hours. PLEASE MAKE SURE YOU HAVE ANSWERED THE QUESTIONS BELOW.

Bilingual? □ YES □ NO

Related to the client? □ YES □ NO If YES, what is your relationship: ______________________________

Sign language? □ YES □ NO

Customer’s Signature __________________ Date ____________

Direct Support Signature __________________ Date ___________

ILRC PAYROLL REPRESENTATIVE USE ONLY:

W4_________K4___________ENT TABS_________ENT CYMA_________MAX HOURS TABLE IN CATS ________

PAY RATE ___________________.AUTH ID # ___________________ CSR LAST 7 MED. # ___________________
EMPLOYMENT AGREEMENT

THIS EMPLOYMENT AGREEMENT (the "Agreement") is effective on this \[\text{day of } \text{ , } 20\], between \[\text{Employer}\], an individual, and \[\text{Caregiver}\], 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 INDEPENDENT LIVING RESOURCE CENTER, 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 Sedgwick 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.

```
CUSTOMER / EMPLOYER

Signature

Print name

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

DIRECT SUPPORT WORKER / EMPLOYEE

Signature

Print name
```
TA WAIVER DSW WAGE AGREEMENT

Effective immediately, in passing on reimbursement increases announced by Kansas Department of Aging and Disability Services (KDADS), Independent Living Resource Center dba ILRC as Fiscal Agent will be raising the ceiling on the range in which you may pay your employees. The payment of overtime is still required by ILRC as Fiscal Agent to remain compliant with waiver changes, Department of Labor (DOL) rules, and the Fair Labor Standards Act (FLSA).

Any time worked over 40 hours in a week must still be paid at 1.5 times the regular wage. This can be accomplished by hiring additional workers or adjusting pay rates downward to allow overtime to be paid within your Medicaid budget.

- **YOUR PLAN OF CARE IS OVER 40 HOURS PER WEEK, USE THE CHART(S) ON THE NEXT PAGES TO DETERMINE THE WAGES.** For example if you have two workers and the first works 55 hours per week while the second worker works 15 hours per week, you would list both workers, their maximum hours of 55 and 15, and pay rates at any amount in the range between $7.25 - $11.35 on the first worker and any wage between $7.25 and $13.08 for the second worker.

- **YOUR PLAN OF CARE IS UNDER 40 HOURS PER WEEK.** Enter your workers name and a pay rate between $7.25 - $13.08 per hour below.

Please list your workers, indicate the weekly maximum number of hours you would like to allot for each worker, and list the pay rate you would like to pay each worker.

☐ **YOU HAVE SLEEP CYCLE SUPPORT DO NOT FILL THIS FORM OUT.**

☐ **YOU ARE ON A MONTHLY HOURS PLAN YOU WILL NEED TO DECIDE HOW MANY WEEKLY MAXIMUM HOURS YOUR WORKER WILL WORK FOR YOU EACH WEEK.**

<table>
<thead>
<tr>
<th>WORKER</th>
<th>WEEKLY MAXIMUM HOURS</th>
<th>PAY RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

By signing below I am acknowledging I am the sole employer of the workers I self-direct and that any hours worked above the plan of care or beyond the direction given above are my sole responsibility. I hereby direct ILRC to pay my workers only within the existing Plan of Care and also only within the agreed upon limits above.

_________________________  ________________________  __________
Customer Signature        Customer Print Name         Date

YOU ARE ALLOWED A TOTAL OF __________________________ HOURS PER __________________________
<table>
<thead>
<tr>
<th>Hours</th>
<th>Gross Pay Allowable Under Medicaid Budget</th>
<th>Maximum Rate Including Overtime</th>
</tr>
</thead>
<tbody>
<tr>
<td>40 and below</td>
<td>526.47</td>
<td>13.08</td>
</tr>
<tr>
<td>40.25</td>
<td>529.74</td>
<td>13.04</td>
</tr>
<tr>
<td>40.5</td>
<td>533.01</td>
<td>13.00</td>
</tr>
<tr>
<td>40.75</td>
<td>536.28</td>
<td>12.96</td>
</tr>
<tr>
<td>41</td>
<td>539.55</td>
<td>12.92</td>
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<tr>
<td>41.25</td>
<td>542.82</td>
<td>12.88</td>
</tr>
<tr>
<td>41.5</td>
<td>546.09</td>
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<td>41.75</td>
<td>549.36</td>
<td>12.81</td>
</tr>
<tr>
<td>42</td>
<td>552.63</td>
<td>12.78</td>
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<tr>
<td>42.25</td>
<td>555.90</td>
<td>12.74</td>
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<tr>
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<td>559.17</td>
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<td>42.75</td>
<td>562.44</td>
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<td>43</td>
<td>565.71</td>
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<td>43.25</td>
<td>568.98</td>
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<td>43.5</td>
<td>572.25</td>
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<tr>
<td>43.75</td>
<td>575.52</td>
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<td>44</td>
<td>578.79</td>
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<td>582.06</td>
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<td>12.39</td>
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<td>598.41</td>
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<td>608.22</td>
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<td>47</td>
<td>618.03</td>
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<td>47.25</td>
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<tr>
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<td>11.85</td>
</tr>
<tr>
<td>50.75</td>
<td>663.81</td>
<td>11.83</td>
</tr>
</tbody>
</table>
KANSAS AUTHENTICARE CALL IN SYSTEM AGREEMENT

The Kansas AuthentiCare call in system is a mandatory system put in place by the State of Kansas. Using the system is a condition of HCBS FMS service, failure to use it will result in disqualified hours. The system mandates that your Direct Support Worker use it to record the hours they are working for you. The system is simple to use, your Direct Support Worker will be given instructions along with their ID number. Direct Support Workers are not to overlap hours with another worker who is already clocked in.

"You" the Customer MUST have a phone available for your Direct Support Worker to clock in and out with. If you do not have a phone your Direct Support Worker will not be allowed to work until you obtain one, unless your worker has been approved for the mobile app. This system is mandatory and it’s your responsibility as the Customer to make sure a phone is available for your Direct Support Worker to use at all times.

- The HCBS services are to be provided to the CUSTOMER ONLY do not perform tasks for anyone else that resides in the household while you are clocked IN.

- Direct Support Workers CANNOT be clocked in at the same time.

- "You" the Customer, are responsible for adding or removing any registered numbers to your record in Kansas Authenticare. Workers numbers are not allowed to be registered.

- If your Direct Support Worker misses a clock in OR clock out a claim correction form can be submitted to the Payroll Department. HOWEVER if the worker fails to clock in and clock out for their entire shift on any given day no correction forms will be accepted, the Kansas Authenticare call in system is mandatory. Also workers time will not be reversed if they have clocked in and out using a registered phone listed on your record.

- If the customer goes into the hospital, rehab or nursing facility, jail, out of State without you, etc., please let us know immediately. You are NOT allowed to clock in and out during this time this is Medicaid Fraud and will be reported to Medicaid, the Kansas Attorney General’s Office, and the insurance company.

- This HCBS waiver has a limit of 12 hours per day: however, you must limit your hours to only the hours authorized on the customer's Plan of Care/ISP. Hours worked in excess of what are authorized on the Plan of Care/ISP shall not be paid by ILRC as fiscal agent.

Corrections are limited to 6 per month. Any corrections in excess of this limit will result in corrective action procedures. Any customer who has worker(s) who have exceeded the monthly limit 2 or more times will not be eligible for any corrections of errors or omissions for any of their worker without possible additional fees.

By signing below you the Direct Support Worker and the Customer agree to the above agreement.

__________________________
Customer Signature

__________________________
Date

__________________________
Direct Support Workers Signature

Revision 03/11/2020
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND COMPLIANCE POLICY

I acknowledge that I have received a copy of the Independent Living Resource Center's Notice of Privacy Practices, Compliance Policy, Abuse & Exploitation, Drug & Alcohol Policy, Harassment Policy, ADA Compliance, EECC, Productive Work Environment, Workplace Violence/Weapons Policy, Attendance & Punctuality.

________________________
Print Direct Support Worker Name

________________________
Signature of Direct Support Worker

________________________
Date
INDEPENDENT LIVING RESOURCE CENTER
d.b.a ILRC AS FISCAL AGENT
APPLICANT CONSENT FORM

Independent Living Resource Center d.b.a. ILRC as Fiscal Agent has informed me that it will conduct a criminal background check. In so doing, Independent Living Resource Center d.b.a. ILRC as Fiscal Agent may utilize the services of a consumer-reporting agency as a resource in making employment-related decisions or recommendations about hiring or retention of Direct Support Workers. Any information obtained may be shared with my HCBS recipient employer.

I understand a reporting agency’s investigation may include information regarding my credit background, references, character, past employment, work habits, education, general reputation, personal characteristics, mode of living, judgement, liens and criminal background.

I also understand that before an adverse decision or recommendation about my eligibility to serve, as a Direct Support Worker is made based in whole or part on information obtained in the report. I will be provided a copy of the report and a description in writing of my rights under the Fair Credit Reporting Act.

I understand if I disagree with the accuracy of any information in the report, I must notify Independent Living Resource Center d.b.a. ILRC as Fiscal Agent within four days of my receipt of the report. If I notify Independent Living Resource Center d.b.a. ILRC as Fiscal Agent within four days of the receipt of the report that I am challenging information in the report, Independent Living Resource Center d.b.a. ILRC as Fiscal Agent will not make a final decision on my employment eligibility until after I address the information contained in the file report.

I hereby consent to the investigation and authorize Independent Living Resource Center d.b.a. ILRC as Fiscal Agent to procure a report on my background as stated above from a consumer-reporting agency.

Direct Support Workers Signature

Date
LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

**LIST A**
Documents that Establish Both Identity and Employment Authorization

1. U.S. Passport or U.S. Passport Card
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa
4. Employment Authorization Document that contains a photograph (Form I-766)
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status:
   a. Foreign passport; and
   b. Form I-94 or Form I-94A that has the following:
      (1) The same name as the passport; and
      (2) An endorsement of the alien’s nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.
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

**LIST B**
Documents that Establish Identity

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

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

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

**LIST C**
Documents that Establish Employment Authorization

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. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
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. Native American tribal document
5. U.S. Citizen ID Card (Form I-197)
6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
7. Employment authorization document issued by the Department of Homeland Security

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

Refer to the instructions for more information about acceptable receipts.
Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation (Employees must complete and sign before accepting a job offer.)

<table>
<thead>
<tr>
<th>Last Name (Family Name)</th>
<th>First Name (Given Name)</th>
<th>Middle Initial</th>
<th>Other Last Names Used (If any)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address (Street Number and Name)</th>
<th>Apt. Number</th>
<th>City or Town</th>
<th>State</th>
<th>ZIP Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth (mm/dd/yyyy)</th>
<th>U.S. Social Security Number</th>
<th>Employee's E-mail Address</th>
<th>Employee's Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

- 1. A citizen of the United States
- 2. A noncitizen national of the United States (See instructions)
- 3. A lawful permanent resident (Alien Registration Number/USCIS Number):
- 4. An alien authorized to work until expiration date if applicable, mm/dd/yyyy:
  
  Some aliens may write "N/A" in the expiration date field. (See instructions)

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:

1. Alien Registration Number/USCIS Number: ________________________________
2. Form I-94 Admission Number: ________________________________
3. Foreign Passport Number: ________________________________
   Country of Issuance: ________________________________

Preparer and/or Translator Certification (check one):

- I did not use a preparer or translator.
- A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

Signature of Preparer or Translator

Today's Date (mm/dd/yyyy)

<table>
<thead>
<tr>
<th>Last Name (Family Name)</th>
<th>First Name (Given Name)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address (Street Number and Name)</th>
<th>City or Town</th>
<th>State</th>
<th>ZIP Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

STOP Employer Completes Next Page

Form I-9 10/21/2019
Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

Section 2. Employer or Authorized Representative Review and Verification
(Employee or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "List of Acceptable Documents.")

<table>
<thead>
<tr>
<th>Employee Info from Section 1</th>
<th>List A</th>
<th>OR</th>
<th>List B</th>
<th>AND</th>
<th>List C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name (Family Name)</td>
<td>Document Title</td>
<td>Document Title</td>
<td>Document Title</td>
<td>Document Title</td>
<td></td>
</tr>
<tr>
<td>First Name (Given Name)</td>
<td>Issuing Authority</td>
<td>Issuing Authority</td>
<td>Issuing Authority</td>
<td>Issuing Authority</td>
<td></td>
</tr>
<tr>
<td>M.I.</td>
<td>Document Number</td>
<td>Document Number</td>
<td>Document Number</td>
<td>Document Number</td>
<td></td>
</tr>
<tr>
<td>Citizenship/Immigration Status</td>
<td>Expiration Date (if any) (mm/dd/yyyy)</td>
<td>Expiration Date (if any) (mm/dd/yyyy)</td>
<td>Expiration Date (if any) (mm/dd/yyyy)</td>
<td>Expiration Date (if any) (mm/dd/yyyy)</td>
<td></td>
</tr>
<tr>
<td>Identity and Employment Authorization</td>
<td>Document Title</td>
<td>Document Title</td>
<td>Document Title</td>
<td>Document Title</td>
<td></td>
</tr>
<tr>
<td></td>
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<td>Expiration Date (if any) (mm/dd/yyyy)</td>
<td>Expiration Date (if any) (mm/dd/yyyy)</td>
<td></td>
</tr>
</tbody>
</table>

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

The employee's first day of employment (mm/dd/yyyy): (See Instructions for exemptions)

Signature of Employer or Authorized Representative

Today's Date (mm/dd/yyyy)

Title of Employer or Authorized Representative

HCSR

Last Name of Employer or Authorized Representative

First Name of Employer or Authorized Representative

Employer's Business or Organization Name

HCBS SERVICES RECIPIENT

Employer's Business or Organization Address (Street, Number and Name)

City or Town

State

ZIP Code

Section 3. Reverification and Rehires (To be completed and signed by employer or authorized representative.)

A. New Name (if applicable)

Last Name (Family Name) | First Name (Given Name) | Middle Initial | Date (mm/dd/yyyy)

| Document Title | Document Number | Expiration Date (if any) (mm/dd/yyyy) |

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative | Today's Date (mm/dd/yyyy) | Name of Employer or Authorized Representative

Form I-9 10/21/2019
Page 2 of 3
**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.

### Step 1: Enter Personal Information

- **(a) First name and middle initial**
- **(b) Social security number**
- **(c) Address**
- **City or town, state, and ZIP code**

> Does your name match the name on your social security card? If not, we may be unable to process your return. If you need to change your social security number, contact the Social Security Administration at 1-800-772-1213 or go to www.ssa.gov.

- Single or Married filing separately
- Married filing jointly (or Qualifying widow(er))
- Head of household (Check only if you’re unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual)

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

### Step 2: Multiple Jobs or Spouse Works

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

Do only one of the following.

- **(a) Use the estimator at [www.irs.gov/IVW4App](http://www.irs.gov/IVW4App) for most accurate withholding for this step (and Steps 3–4); or**
- **(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(d) below for roughly accurate withholding; 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 accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld.**

**TIP:** To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

**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

If your 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 and enter the total here: $

**4(a) $**

### Step 4: Other Income (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)**

For Privacy Act and Paperwork Reduction Act Notice, see page 3.
General Instructions

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.

Exemption from withholding. You may claim exemption from withholding for 2020 if you meet both of the following conditions: you had no federal income tax liability in 2019 and you expect to have no federal income tax liability in 2020. You had no federal income tax liability in 2019 if (1) your total tax on line 16 on your 2019 Form 1040 or 1040-SR is zero or (less than the sum of lines 18a, 18b, and 18c), 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 2020 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(a). 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, 2021.

Your privacy. If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

When to use the estimator. Consider using the estimator at www.irs.gov/W4App if you:
1. Expect to work only part of the year;
2. Have dividend or capital gain income, or are subject to additional taxes, such as the additional Medicare tax;
3. Have self-employment income (see below); or
4. Prefer the most accurate withholding for multiple job situations.

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.

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

If you (and your spouse) have a total of only two jobs, you may instead 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 roughly 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. Step 3 of Form W-4 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. 972, Child Tax Credit and Credit for Other Dependents. You can also include other tax credits in this step, such as education tax credits and the foreign tax credit. 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 2020 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.

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 2020 itemized deductions (from Schedule A (Form 1040 or 1040-SR)). Such deductions may include qualifying charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income.

   $1

2 Enter:
   • $24,800 if you're married filing jointly or qualifying widow(er)
   • $18,650 if you're head of household
   • $12,400 if you're single or married filing separately

   $2

3 If line 1 is greater than line 2, subtract line 2 from line 1. 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 or 1040-SR)). 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(l)(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 possessions 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 Widow(er)

<table>
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<th>Higher Paying Job Annual Taxable Wage &amp; Salary</th>
<th>Lower Paying Job Annual Taxable Wage &amp; Salary</th>
<th>Single or Married Filing Separately</th>
<th>Head of Household</th>
</tr>
</thead>
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<td>$110,000 - 119,999</td>
<td>$110,000 - 119,999</td>
<td>$110,000 - 119,999</td>
</tr>
</tbody>
</table>

*Note: The table provides details for different income brackets, with calculations for single or married filing separately, and for the head of household. Each bracket specifies the taxable wage and salary range and the corresponding tax amounts for the lower paying job.*
KANSAS EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

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 785-368-9222.

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 dependents.

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 work mark "Joint"
| B | Enter "0" or "1" if you are married or single and no one else can claim you as a dependent (entering "0" may help you avoid having too little tax withheld).........................................................
| 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)
| D | Enter "2" if you will file head of household on your tax return (see conditions under Head of household above)........
| 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.
| F | Add lines B through E and enter the total here........................................................................................................

---

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

---

K-4 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

2 Print Last Name

3 Print Social Security Number

---

Mark the allowance rate selected in line A above.

| 4 | Total number of allowances you are claiming (from line F above).............................................................
| 5 | Enter any additional amount you want withheld from each paycheck (this is optional)....................................
| 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.

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)

32-0504847
PAY DELIVERY AGREEMENT

Independent Living Resource Center (ILRC) will make your pay available in one of the following methods as directed by you. **ILRC direct deposit is mandatory.**

**DIRECT SUPPORT WORKERS NAME PRINT HERE**

**CHOOSE ONE OF THE OPTIONS BELOW AND FILL OUT THE APPROPRIATE FORM FOR YOUR CHOICE:**

☐ DIRECT DEPOSIT TO A CHECKING OR SAVINGS ACCOUNT
This is the most convenient way to ensure you will have your money each Friday. We will directly deposit your money into your personal checking or savings account. It will be available to you first thing Friday morning. We will mail you a direct deposit stub to inform you of your pay information. For this option, your money will be deposited into your account by the next payday.

You must notify us immediately if you change/ close your bank account for any reason. If you fail to do so, your money will still go to that account that is on file.

☐ GLOBAL CASH CARD - VISA
Each payroll period your money will be automatically loaded with your wages for the week. The cards will work like a debit card and can be used for purchases anywhere Visa is accepted. The cards can also provide immediate access to cash without the need for a checking account because the cards can be cashed out at any ATM or Bank Teller. You will receive a temporary payroll card from ILRC and META Bank will send you a card with your name printed on it, you should have your payroll card in about two (2) weeks.

➔ Treat your payroll card as if it were cash keep track of it at all times. If your card is lost or stolen, please contact Sabrina 316-942-6300 Ext. 224 at ILRC immediately and come in for a temporary card and then you will need to call Meta Bank at 1-888-220-4477.

Your signature below indicates that you have read and understand the above pay and paystub delivery methods. Furthermore, you agree to abide with the above regardless of the method you chose to receive your pay.

Direct Support Worker Signature ___________________________ Date ________________

Revised 07 2015 04 2017 SN
DIRECT DEPOSIT TO CHECKING OR SAVINGS ACCOUNT ONLY

I (we) hereby authorize Independent Living Resource Center to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my (our) account indicated below and the depository named below to credit and/or debit the same to such account.

Money will be sent to your bank account each week based upon when you started working for the Customer, our payroll weeks run Sunday to Saturday and payday is each Friday.

**BANK NAME:**

**LOCATION:**  CITY: ___________________  STATE: _________  ZIP: _______

**ACCOUNT NUMBER:**

**ROUTING NUMBER:**

**ACCOUNT TYPE**  CHECKING: [ ]  SAVINGS: [ ]

**EMPLOYEE PAYSTUB PORTAL:**

Pay Stubs are available along with other employment information at our Employee Portal. Please provide your current email address below, information for portal user setup will be emailed to you.

If you change your email address please let Sabrina know as soon as possible at swickery@ilrcks.org.

**EMAIL ADDRESS FOR PAYSTUB PORTAL:**

**NOTE**: The Employee Paystub Portal is the only way you will be able to access to your paystubs if you require them for any personal business. This is the only current method for getting your paystubs.

---

This authority is to remain in full force and effective until Independent Living Resource Center has received written notification from me of its termination in such time and in such manner as to afford them and the Depository a reasonable opportunity to act on it.

**Employee name:** ______________________________  **Last 4 SSN:** _______

**Signature** ______________________________  **Date:** __________

---

**ATTACH A VOIDED CHECK HERE**
Global Cash Card

NEW CASH CARD ENROLLMENT FORM

If you are using a P.O. Box the bank will also require a physical address to be listed.

You will receive a temporary card from Independent Living Resource Center. A card printed with your name on it will be mailed to you from Global Cash Card (Meta Bank).

Global Cash Card - Account Owner Information (Please Print Legibly)

<table>
<thead>
<tr>
<th>FIRST NAME:</th>
<th>MIDDLE:</th>
<th>LAST:</th>
</tr>
</thead>
</table>

 ADDRESS: ____________________________

<table>
<thead>
<tr>
<th>PO BOX (NEED PHYSICAL ADDRESS LISTED HERE)</th>
</tr>
</thead>
</table>

 CITY: ____________________________

<table>
<thead>
<tr>
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<th>ZIP:</th>
</tr>
</thead>
</table>

 PHONE: ____________________________

<table>
<thead>
<tr>
<th>CELL:</th>
</tr>
</thead>
</table>

 DATE OF BIRTH: ____________________________

<table>
<thead>
<tr>
<th>SSN:</th>
</tr>
</thead>
</table>

EMPLOYEE PAYSTUB PORTAL:

Pay Stubs are available along with other employment information at our Employee Portal. Please provide your current email address below, information for portal user setup will be emailed to you. If you change your email address please let Sabrina know as soon as possible at swickery@ilrcks.org.

EMAIL ADDRESS FOR PAY STUB PORTAL: ____________________________

**NOTE**: The Employee Paystub Portal is the only way you will be able to access to your paystubs if you require them for any personal business. This is the only current method for getting your paystubs.

EMPLOYEE SIGNATURE: ____________________________

DATE: ____________________________
Name of TA waiver recipient: | Medicaid ID #:  

<table>
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<tr>
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<th>Diapering Technique and Protocol</th>
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</thead>
<tbody>
<tr>
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<td>Transfers and Positioning</td>
<td>YES</td>
<td>NO</td>
<td>Enema/Suppository Insertion</td>
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<tr>
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<td>NO</td>
<td>Ambulation Techniques</td>
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<td>Seizure Control Protocol</td>
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<tr>
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<td>NO</td>
<td>Bathing and Hair Care</td>
<td>YES</td>
<td>NO</td>
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<tr>
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<td>NO</td>
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<td>Communication Techniques</td>
</tr>
<tr>
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<td>NO</td>
<td>Skin and Nail Care</td>
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<td>NO</td>
<td>Behavior Modification Techniques</td>
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<tr>
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<td>NO</td>
<td>Dressing Assistance</td>
<td>YES</td>
<td>NO</td>
<td>Infection Control Procedures</td>
</tr>
<tr>
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<td>Hearing Impaired Assistance</td>
<td>YES</td>
<td>NO</td>
<td>CPR/First Aid</td>
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<tr>
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<td>NO</td>
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<td>YES</td>
<td>NO</td>
<td>Emergency Procedures</td>
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<tr>
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<td>Specialized Diet / Nutrition Preparation</td>
<td>YES</td>
<td>NO</td>
<td>Laundry Assistance</td>
</tr>
<tr>
<td>YES</td>
<td>NO</td>
<td>NG/GT/NJ Feeding and Care</td>
<td>YES</td>
<td>NO</td>
<td>Room/Housekeeping Assistance</td>
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<tr>
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<td>NO</td>
<td>Medication Administration</td>
<td>YES</td>
<td>NO</td>
<td>Documentation/Record Keeping</td>
</tr>
<tr>
<td>YES</td>
<td>NO</td>
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<td>Other (specify below)</td>
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<td>Catheter Care / Recording Input &amp; Output</td>
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<td>NO</td>
<td></td>
</tr>
</tbody>
</table>

My signature confirms that I, ________________________________ (print name) have been trained by the parent or legal guardian to perform the delegated tasks identified in the PSA Training Checklist and that I am able to perform these tasks.

Personal Service Attendant (PSA) Signature

My signature confirms that I, ________________________________ (print name) as parent/legal guardian of ________________________________ (print name) have the authority to delegate and train PSA in the tasks identified in the above training checklist. The PSA may perform the specified tasks while providing care for ________________________________ (print name) under my authority.

Parent/Legal Guardian Signature

Date

The parent or legal guardian’s delegation of tasks to be provided by the PSA is limited to the term services are provided for the specific consumer in which he/she is trained to provide. Parents or legal guardian understand by delegating tasks to the PSA that he/she assumes all responsibility for the action or inaction of the PSA to which authorization of tasks are given.
NOTICE OF PRIVACY PRACTICES
FOR INDEPENDENT LIVING RESOURCE CENTER

Dear Customer and/or Direct Support Worker,

Attached to this letter you will find a Notice of Privacy Practices describing the health information practices of Independent Living Resource Center (ILRC) and its affiliates. We are required by federal law to provide this notice to persons who use our services.

The following is a brief summary of the contents of the Notice. We encourage you to read the entire Notice and ask any questions you may have concerning its contents.

Your Rights Regarding Your Health Information. This section describes the following rights you have with respect to your health information and tells you how you may exercise these rights:
- Right to inspect and copy
- Right to request amendment
- Right to an accounting of disclosures
- Right to request restrictions on certain uses and disclosures
- Right to request alternative means of communication
- Right to receive a paper copy of the Notice

How To File Complaints Concerning ILRC’s Privacy Practices. This section tells you what you can do if you believe any of your rights have been violated. You will not be penalized for filing any complaint.

How ILRC May Use and Disclose Health Information About You. This section describes the different ways ILRC may use or disclose your health information. This section identifies those uses and disclosures permitted by federal law without first obtaining from you a specific authorization.

Maintaining the privacy of your health information is very important to us. Again, if you have any questions concerning the attached Notice, please do not hesitate to ask.

Notice of Privacy Practices – Independent Living Resource Center
INDEPENDENT LIVING RESOURCE CENTER

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have questions concerning this notice, please contact:

Cindi Unruh
Executive Director
3033 W. 2nd
316-942-6300 phone
316-942-2078 fax
1-800-479-6861 voice & TTY
cunruh@ilrcks.org

ILRC is required by law to maintain the privacy of your health information. This Notice describes your rights and certain obligations ILRC and its affiliates have regarding the use and disclosure of health information. It also tells you about the ways in which ILRC may use and disclose health information about you. ILRC is obligated to follow the terms of the notice that is currently in effect.

ILRC is committed to protecting the confidentiality of your health information. This Notice applies to all health information maintained by ILRC.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION.

Right To Inspect and Copy. You have the right to inspect and copy health information collected and maintained by ILRC. To inspect and copy your health information, you must complete a specific form providing information needed to process your request. To obtain this form or to obtain more information concerning this process, please contact the person identified on the first page of this Notice. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies and services associated with your request. We may require that you pay such fee prior to receiving the requested copies. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
**Right To Request Amendment.** If you believe that ILRC's records contain information about you that is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for ILRC. To request an amendment, you must complete a specific form providing information we need to process your request, including the reason that supports your request. To obtain this form or to obtain more information concerning this process, please contact the person identified on the first page of this Notice.

We may deny your request for an amendment if you fail to complete the required form in its entirety. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information kept by or for ILRC;
- Is not part of the information that you would be permitted to inspect and copy; or
- Is accurate and complete.

If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records.

**Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of health information about you, with certain exceptions specifically defined by law. To request this list or accounting of disclosures, you must complete a specific form providing information we need to process your request. To obtain this form or to obtain more information concerning this process, please contact the person identified on the first page of this Notice.

Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

**We are not required to agree to your request.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must complete a specific form providing information we need to process your request. To obtain this form or to obtain more information concerning this process, please contact the person identified on the first page of this Notice.
Right to Request Alternative Methods of Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request an alternative method of communications, you must complete a specific form providing information we need to process your request. To obtain this form or to obtain more information concerning this process, please contact the person identified on the first page of this Notice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact the person identified on the first page of this Notice.

COMPLAINTS:

If you believe your rights with respect to health information about you have been violated by ILRC, you may file a complaint with ILRC or with the Secretary of the Department of Health and Human Services. To file a complaint with ILRC, contact the person identified on the first page of this Notice. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

HOW ILRC MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.

Uses and Disclosures of Protected Health Information Without Your Specific Authorization

ILRC may use and disclose your health information about you for payment or health care operations without any consent or authorization beyond your use of ILRC’s services.

- Payment means activities associated with collecting fees for services provided to you by ILRC. Activities associated with payment include, but are not limited to:
  - Collection of fees from agencies
  - Review of payment decisions upon appeal

- Health Care Operations means
  - Case management and care coordination
  - Contacting you about services
  - Training of non-health care professionals
  - Business planning and development
  - Analysis related to managing and operating ILRC
  - Development or change of payment methods
  - Educational activities

Pursuant to applicable federal law, there are several other uses and disclosures ILRC may make without your specific authorization.
1. **Creation of de-identified health information.** ILRC may use your protected health information to create de-identified health information. This means that all data items that would help identify you, such as name, address, birth date, and hire date are removed or modified. This would allow analysis of information without the analyst knowing who the data refers to. Once information is de-identified it is no longer protected.

2. **Furnishing data to Business Associates.** ILRC’s Business Associates (e.g., other agencies, legal counsel, and consultants) receive and maintain your protected health information to carry out payment and health care operations.

3. **Uses and disclosures required by law.** ILRC will use and/or disclose your protected health information when required by law to do so. The disclosure will be the minimum necessary to fulfill the legal requirement.

4. **Disclosures for public health activities.** We may disclose your protected health information for the following public health activities:
   - To a public health authority that is authorized by law to collect data for the purpose of preventing or controlling disease, injury, or disability.
   - To a public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect.
   - To a person or business subject to the jurisdiction of the Food and Drug Administration (“FDA”) for activities related to the quality, safety, or effectiveness of an FDA-regulated product or activity.
   - To a person who may have been exposed to a communicable disease if such disclosure is permitted by law.

5. **Disclosures about victims of abuse, neglect or domestic violence.** ILRC may disclose your protected health information to a government authority if we reasonably believe you are a victim of abuse, neglect, or domestic violence. Such disclosure will be made only (i) to extent required by law, (ii) with your agreement, or (iii) as expressly authorized by statute or regulation.

6. **Disclosures for health oversight activities.** ILRC may disclose your protected health information to a health oversight agency for oversight activities. The disclosure must be authorized by law and could include audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions. It could also include other activities necessary for appropriate oversight of the system or entities subject to civil rights laws for which health information is necessary for determining compliance.

7. **Disclosures for judicial and administrative proceedings.** Your protected health information may be disclosed during any judicial or administrative proceeding if it is:
   - In response to an order of a court or administrative tribunal and includes no more information than that required to satisfy the order;
   - In response to a subpoena, discovery request, or other lawful process not accompanied by an order and the party seeking information has made reasonable efforts to inform you of its actions.

Notice of Privacy Practices – Independent Living Resource Center
8. **Disclosures for law enforcement purposes.** We may disclose your protected health information to a law enforcement official as required by law or in compliance with:
   - A court order, court-ordered warrant, subpoena, or summons issued by a judicial officer;
   - A grand jury subpoena; or
   - An administrative request related to a legitimate law enforcement inquiry.

9. **Disclosures regarding victims of a crime.** In response to a law enforcement official’s request, ILRC may disclose information about you without your approval. We may also disclose information in an emergency situation or if you are incapacitated, if it appears you were the victim of a crime.

10. **Disclosures to avert a serious threat to health or safety.** We may disclose your protected health information to prevent or lessen a serious and imminent threat to the health and safety of a person or the public or as necessary for law enforcement authorities to identify or apprehend an individual.

11. **Disclosures for specialized government functions.** ILRC may disclose your protected health information as required to comply with governmental requirements for national security reasons or for protection of certain government personnel or foreign dignitaries.

12. **Disclosures for research purposes.** ILRC may use or disclose your protected health information for research provided that we obtain documentation that authorization has been waived by either an Institutional Review Board or a privacy board.

**Uses and Disclosures Requiring Your Authorization**

All other uses and disclosures of your health information will be made by ILRC only with your express written authorization. If you provide authorization for any use or disclosure of your protected health information, you may revoke that authorization, in writing, at any time. The revocation will not apply to any previous use or disclosure. Disclosures requiring an authorization include, but are not limited to the following:

1. You want ILRC to disclose information to a family member, close friend, or any other individual (other than a Business Associate of ILRC for the purposes of payment or health care operations).

2. ILRC or a Business Associate of ILRC cannot provide you with marketing materials or disclose your protected health information to any other marketing organization without your authorization.

ILRC reserves the right to change the terms of this notice and to make the revised notice effective with respect to all protected health information regardless of when the information was created. If the notice is revised, the new notice will be provided to you, if you are still using ILRC’s services, either through e-mail or U.S. postal service, within sixty days of such revision. Otherwise, once every three years we will provide you a reminder of the availability of this Notice and how to obtain the Notice.
ILRC POLICY FOR CUSTOMERS & DIRECT SUPPORT WORKER

ADA compliance statement:
The Independent Living Resource Center, Inc. is committed to providing equal access to employment and in all Agency programs, services, and activities to persons with disabilities and fully complies with the American with Disabilities Act and Kansas law.

EQUAL EMPLOYMENT OPPORTUNITY
ILRC believes equal opportunity for all employees is important for the continuing success of our organization. In accordance with state and federal law, ILRC will not discriminate against an employee or applicant for employment because of race, disability, color, creed, religion, sex, age, national origin, ancestry, citizenship, or military status in hiring, promoting, demoting, training, benefits, transfers, layoffs, terminations, recommendations, rates of pay, and all other terms, conditions, and privileges of employment. Opportunity is provided to employees based on qualifications and job requirements. Reasonable accommodations will be made for individuals with disabilities.

PRODUCTIVE WORK ENVIRONMENT
It is the policy of ILRC to promote a productive work environment and not to tolerate verbal or physical conduct by any employee that harasses, disrupts, or interferes with another's work performance or that creates an intimidating, offensive, or hostile environment.

Employees are expected to maintain a productive work environment that is free from harassing or disruptive activity. No form of harassment will be tolerated, including harassment for the following reasons: race, disability, color, creed, religion, sex, age, national origin, ancestry, citizenship, pregnancy, and military status. Special attention should be paid to the prohibition of sexual harassment.

WORKPLACE VIOLENCE/WEAPONS
The possession of firearms, explosives, or other dangerous weapons (including knives with blade lengths above four (4) inches), concealed or unconcealed, on ILRC and consumer property, or while conducting agency business is expressly forbidden.

ATTENDANCE AND PUNCTUALITY
Employees are expected to report to work on time and on a regular basis. Unexcused absenteeism and lateness are expensive and disruptive and place an unfair burden on other employees. Unsatisfactory attendance and punctuality may result in disciplinary action, up to and including termination.

DRUG AND ALCOHOL POLICY
Section 1: Policy
ILRC recognizes that the abuse of alcohol and controlled substances are serious social problems, which can negatively impact the performance and image of employees and ILRC. Therefore, to help ensure a safe, healthy and productive work environment for our employees and others, to protect ILRC property, and to ensure efficient operations, ILRC has adopted a policy of maintaining a workplace free of the use of alcohol and illegal use of controlled substances.

Section 2: General Prohibitions and Restrictions
Individuals under the influence of alcohol and/or the illegal use of controlled substances on the job pose serious safety and health risks not only to themselves, but also to all those who surround or come in contact with the user. Therefore, possessing, using, consuming, purchasing, distributing, manufacturing, dispensing, or selling alcohol or controlled substances, or being under the influence of alcohol or controlled substances without medical authorization during your work hours, on ILRC premises, on an ILRC work site, and/or while on duty, is cause for disciplinary action up to and including immediate termination. Being "under the influence" with regard to alcohol is defined as a blood alcohol content of .04% or greater. Being "under the influence" with regard to a controlled substance is defined as testing positive in a urine or blood test.

ABUSE NEGLECT & EXPLOITATION:
Any suspicion of abuse, neglect or exploitation of any Customer must be reported IMMEDIATELY to Adult Protective Services at 1-800-922-5330.
ILRC COMPLIANCE POLICY

GENERAL
The Independent Living Resource Center requires directors, and employees to observe high standards of business and personal ethics in the conduct of their duties and responsibilities. As employees and representatives of the Independent Living Resource Center, we must practice honesty and integrity in fulfilling our responsibilities and comply with all applicable laws and regulations.

REPORTING RESPONSIBILITY
It is the responsibility of all directors, and employees to report ethics violations or suspected violations in accordance with the Compliance Policy.

NO RETALIATION
No director, manager or employee who in good faith reports an ethics violation shall suffer harassment, retaliation or adverse employment consequence. An employee who retaliates against someone who has reported a violation in good faith is subject to disciplinary action up to and including termination of employment. This Compliance Policy is intended to encourage and enable employees and others to raise serious concerns within the Independent Living Resource Center prior to seeking resolution outside of the Independent Living Resource Center

REPORTING VIOLATIONS
The Independent Living Resource Center has an open door policy and suggests that employees share their questions, concerns, suggestions or complaints with someone who can address them properly. In most cases, an employee’s manager is in the best position to address an area of concern. However, if you are not comfortable speaking with your manager or you are not satisfied with your manager’s response, you are encouraged to speak to the Human Resources Manager or anyone in management whom you are comfortable approaching. Managers are required to report suspected ethics violations to the ILRC Human Resource Manager who will act as the Compliance Officer and who has specific and exclusive responsibility to investigate all reported violations. If there is a direct conflict of interest with the situation reported and the Human Resource Manager, employees are encouraged to report violations to the Executive Director or ILRC Board President.

COMPLAINECE OFFICER
The ILRC’s Finance Manager will act as the ILRC Compliance Officer and is responsible for investigating and resolving all reported complaints and allegations concerning violations and at his/her discretion, shall advise the Executive
Director and/or the audit/finance committee. The Compliance Officer has direct access to the audit/finance committee of the board of directors and is required to report to the audit committee at least annually on compliance activity.

ILRC COMPLIANCE POLICY (cont.)

ACCOUNTING AND AUDITING MATTERS
The audit/finance committee of the board of directors shall address all reported concerns or complaints regarding corporate accounting practices, internal controls or auditing. The ILRC Human Resource Manager acting as the Compliance Officer shall immediately notify the audit committee of any such complaint and work with the committee until the matter is resolved.

ACTING IN GOOD FAITH
Anyone filing a complaint concerning a violation or suspected violation must be acting in good faith and have reasonable grounds for believing the information disclosed indicates a violation. Any allegations that prove not to be substantiated and which prove to have been made maliciously or knowingly to be false will be viewed as a serious disciplinary offense.

CONFIDENTIALITY
Violations or suspected violations may be submitted on a confidential basis by the complainant or may be submitted anonymously. Reports of violations or suspected violations will be kept confidential to the extent possible, consistent with the need to conduct an adequate investigation.

HUMAN RESOURCE MANAGER/ COMPLAINECE OFFICER
Michael Streit
Independent Living Resource Center
316-942-6300 ext. 229 mstreit@ilrck.org
3033 W. 2nd Street N.
Wichita, KS 67203

ILRC MANAGEMENT STAFF
Executive Director: Cindi Unruh 316-942-6300 ext. 222
Finance Manager: Michael Streit 316-942-6300 ext. 229