Independent Living
RESOURCE CENTER

3033 WEST 2ND STREET NORTH
WICHITA • KANSAS • 67203
TELEPHONE/TTY 316 • 942 • 6300

Direct Support Worker Payroll Registration Packet: TA WAIVER

****

READ THIS PAPERWORK BEFORE FILLING IT OUT. MAKE SURE YOU UNDERSTAND IT ALL BEFORE SIGNING IT. YOUR SIGNATURE(S) WILL INDICATE THAT YOU DID IN ITS ENTIRITEY, THESE ARE LEGAL DOCUMENTS.

THIS PAPERWORK MUST BE FILLED OUT CORRECTLY IN ORDER TO BE PROCESSED. ANY ERRORS OR OMISSIONS THE PAPERWORK WILL EITHER BE GIVEN BACK TO YOU OR MAILED TO THE CUSTOMER WITH INSTRUCTIONS ON WHAT TO DO.

1. _____ DIRECT SUPPORT WORKER. IF YOUR NAME IS LISTED HERE, THESE ARE THE HIGHLIGHTED AREAS THAT YOU WILL FILL OUT WITH YOUR INFORMATION!

2. _____ CUSTOMER. IF YOUR NAME IS LISTED HERE, THESE ARE THE HIGHLIGHTED AREAS THAT YOU WILL FILL OUT WITH YOUR INFORMATION!

3. **RETURN THESE NUMBERED/UNDERLINED ITEMS: 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, 29, 30 (*regardless, if a signature is required*).**

4. **YOU WILL NEED TO MAKE A COPY OF THIS PAPERWORK FOR YOUR RECORDS!**

5. **USE BLUE OR BLACK INK ONLY WHEN FILLING THIS PAPERWORK OUT.**

6. ***DO NOT** SUBMIT THIS PAPERWORK UNTIL YOU HAVE ALL OF THE REQUIRED DOCUMENTATION, AS STATED ON THE "DSW EMPLOYMENT REQUIREMENTS TA WAIVER PAGE" (PAGE "2").*

7. **PAPERWORK IS ACCEPTED MONDAY TO THURSDAY 8AM TO 3PM. SEE BELOW ON HOW TO SUBMIT PAPERWORK TO OUR OFFICE.**

   IN PERSON. REMINDER IT IS THE RESPONSIBILITY OF THE DIRECT SUPPORT WORKER TO BRING THE PAPERWORK TO OUR OFFICE, DO NOT ALLOW ANYONE ELSE TO BRING IN YOUR PAPERWORK. IT WILL NOT BE ACCEPTED.

   SCAN AND EMAIL THE PAPERWORK IN PDF FORM ONLY TO swickery@ilrcks.org.

   FAX IT TO 316-337-5085 OR 316-670-1424.

   PLACE IT IN THE GREEN TIME SHEET BOX UNDER THE CANOPY.

   MAIL PAPERWORK TO ILRC 3033 W 2ND ST N STE 1, WICHITA, KS 67203.

If you have any questions about anything contained in this packet, please call our office at 316-942-6300 between the hours of 8am to 4:00pm Monday through Friday.

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TELEPHONE/TTY 316•942•6300

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

Adult Care Homes & Home Health Agencies KSA 39-970, 65-5117	HCBS X = existing prohibition KSA 39-2009	OFFENSE Note: Green shading denotes a new prohibition for this type of facility.	PROHIBITED Does Not Expire ⇩	Expires 6 Yrs. * ⇩
21-5301 21-3301	X	Attempt to commit a prohibited offense [1]	See Key	
21-5302 21-3302	X	Conspiracy to commit a prohibited offense [2]	See Key	
21-5303 21-3303	New	Criminal solicitation to commit a prohibited offense[3]	See Key	
21-5401 21-3439	X	Capitol Murder (Felony)	Yes	
21-5402 21-3401	X	First degree murder (Felony)	Yes	
21-5403 21-3402a 21-3302	X	Second degree murder (Felony)	Yes	
21-5404 21-3403	X	Voluntary manslaughter (Felony)	Yes	
21-5405 21-3404	X	Involuntary manslaughter (Felony)		6 Years*
21-5407 21-3406	X	Assisting suicide (Felony)	Yes	
21-5412(b) 21-3410	X	Aggravated assault (Felony)		6 Years*
21-5412(d) 21-3411	X	Aggravated assault on a law enforcement officer (Felony)		6 Years*
21-5414 21-3412a	X	Domestic Battery (Felony)		6 Years*
21-5413(c) 21-3413	X	Battery against a law enforcement officer (Felony)		6 Years*
21-5413(b) 21-3416	X	Aggravated battery (Felony)		6 Years*
21-5413(d) 21-3415	X	Aggravated battery against a law enforcement officer (Felony)		6 Years*
21-5415(a) 21-3419	X	Criminal threat (Felony)		6 Years*
21-5415(b) 21-3419(a)	X	Aggravated criminal threat (Felony)		6 Years*
21-5408(a) 21-3420	X	Kidnapping (Felony)		6 Years*
21-5408(b) 21-3421	X	Aggravated kidnapping (Felony)		6 Years*

21-5409(a) 21-3422	X	Interference with parental custody (Felony)	6 Years*
21-5409(b) 21-3422(a)	X	Aggravated interference with parental custody (Felony)	6 Years*
21-5420(a) 21-3426	X	Robbery (Felony)	6 Years*
21-5420(b) 21-3427	x	Aggravated robbery (Felony)	6 Years*
21-5428 21-3428	X	Blackmail (Felony)	6 Years*
21-5424 21-3435	X	Exposing another to a life threatening communicable disease (Felony)	6 Years*
21-5417 21-3437	X	Mistreatment of a dependent adult or Mistreatment of an elder person. (Misdemeanor or Felony)	Yes
21-5427 21-3438	X	Stalking (Felony)	6 Years*
21-5405(a)(3) 21-3442	X	Involuntary manslaughter while driving under the influence (Felony)	6 Years*
21-5426(a) 21-3446	X	Human Trafficking (Felony)	Yes
21-5426(b) 21-3447	X	Aggravated Human Trafficking (Felony)	Yes
21-5413(f) 21-3448	X	Battery against a mental health employee (Felony)	6 Years*
21-5421 21-3449	X	Terrorism (Felony)	6 Years*
21-5422 21-3450	X	Illegal use of weapons of mass destruction (Felony)	6 Years*
21-5423 21-3451	x	Furtherance of Terrorism or Illegal Use of Weapons of Mass Destruction (Felony)	6 Years*
21-5503 21-3502	X	Rape (Felony)	Yes
21-5506(a) 21-3503	X	Indecent liberties with a child (Felony)	Yes
21-5506(b) 21-3504	X	Aggravated indecent liberties with a child (Felony)	Yes
21-5504(a) 21-3505	X	Criminal sodomy (felony)	6 Years*
21-5504(b) 21-3506	X	Aggravated criminal sodomy (Felony)	Yes
21-5513 21-3508	X	Lewd and lascivious behavior (Felony)	6 Years*
21-5508(a) 21-3510	X	Indecent solicitation of a child (Felony)	Yes
21-5508(b) 21-3511	x	Aggravated indecent solicitation of a child (Felony)	Yes
21-6420 21-3513	X	Promoting prostitution (Felony)	6 Years*
21-5510 21-3516	X	Sexual exploitation of a child (Felony)	Yes

21-5505(a) 21-3517	X	Sexual battery (Felony)	Yes
21-5505(b) 21-3518	X	Aggravated sexual battery (Felony)	Yes
21-5512 21-3520	X	Unlawful sexual relation (Felony)	6 Years*
21-5507 21-3522	X	Unlawful voluntary sexual relations (Felony)	6 Years*
21-5509 21-3523	x	Electronic solicitation (Felony)	6 Years*
21-5604(a) 21-3602	X	Incest (Felony)	6 Years*
21-5604(b) 21-3603	X	Aggravated incest (Felony)	6 Years*
21-5605(a) 21-3604	X	Abandonment of a child (Felony)	6 Years*
21-5605(b) 21-3604(a)	X	Aggravated abandonment of a child (Felony)	6 Years*
21-5601(b) 21-3608(a)	X	Aggravated endangering a child (Felony)	6 Years*
21-5602 21-3609	X	Abuse of a child (Felony)	6 Years*
21-5607(b) 21-3610(b)	X	Furnishing alcoholic beverages to a minor for illicit purpose (Felony)	6 Years*
21-5603 21-3612	x	Contributing to a child's misconduct or deprivation (Felony)	6 Years*
21-5801 21-3701	New	Theft (Felony)***	6 Years*
21-5430	X	Distribution of a controlled substance causing great bodily harm (Felony)	6 Years*
21-5606 21-3605	X	Criminal nonsupport (Felony)	6 Years*
21-5410 21-3423	X	Interference with custody of a committed person ** (Misdemeanor and Felony)	6 Years*
21-5416 21-3425	X	Mistreatment of a confined person ** (Misdemeanor and Felony)	6 Years*
21-5425 21-3445	X	Unlawful administration of a substance ** (Misdemeanor and Felony)	6 Years*
21-5708 21-36a08 21-4214	X	Unlawful obtainment or sale of a prescription–only drug ** (Felony)	6 Years*
21-5823 21-3710	New	Forgery** (Felony)	6 Years*
21-5828 21-3729	New	Criminal Use of a Financial Card** (Felony)	6 Years*
21-5925 21-3844	New	Any violation of Kansas Medicaid Fraud Control Act** (Felony)	6 Years*
21-5927 21-3846	New	Making false claim, statement or representation to the Medicaid program ** (Felony)	6 Years*

21-5928 21-3847	New	Unlawful acts relating to the Medicaid program ** (Felony)	6 Years*
21-5929 21-3856	New	Obstruction of a Medicaid fraud investigation** (Felony)	6 Years*
21-5924 21-3843	New	Violation of a protective order; extended protective orders, penalties ** (Felony)	6 Years*
21-6107 21-4018	New	Identity theft: identity fraud **(Felony)	6 Years*
21-6412 21-3727 21-4310 21-4311	New	Cruelty to animals ** (Misdemeanor or Felony)	6 Years*
21-6422	New	Commercial sexual exploitation of a child (Felony)	Yes
39-0720	New	Social welfare fraud ** (Misdemeanor or Felony)	6 Years*
21-4301 21-4301a 21-6401	New	Promoting obscenity or promoting obscenity to minors ** (Misdemeanor or Felony)	6 Years*
21-5703 65-4159 21-36a03	X	Unlawful manufacturing of controlled substances ** (Felony)	6 Years*
21-5705 65-4161 21-36a05 65-4163	X	Unlawful cultivation or distribution of controlled substances ** (Felony)	6 Years*
21-5707 21-36a07	X	Unlawful manufacture, distribution, cultivation or possession of controlled substances using a communication facility** (Felony)	6 Years*
21-5710 21-36a10	X	Unlawful distribution of drug precursors and drug paraphernalia ** (Felony)	6 Years*
21-5713 21-36a13 65-4152	X	Unlawful distribution or possession of a simulated controlled substance ** (Felony)	6 Years*
21-5406	New	Vehicular Homicide (Felony)	6 Years*
NOTE:		Similar Statutes of Other States & Federal Government.	

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.

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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

1. **Can the customer sign this paperwork for themselves? YES or NO**

   IF "YES" go on to fill out the packet (orange areas only).

   IF "NO" see "Signature of Limitations" below for further instructions:

Signature of Limitations

In all situations, the expectation is that the beneficiary (customer) provides oversight and accountability for those providing their HCBS services. Signature options are provided in recognition that a beneficiary's (customer) limitations may make assistance necessary in carrying out this function. If a consumer is not able to sign for themselves Durable Power of Attorney paperwork must be provided.

The Direct Support Worker (caregiver) CANNOT sign any paperwork or make corrections to their hours on behalf of the beneficiary (customer).

How to sign this paperwork see sample below:

SUSAN SAMPLE	*Mary Sample for Susan Sample*
Customer Name	Customer Signature

_____

Customer Representative Name (print name)

_____

Customer Representative Signature

_____

Representative's relationship to customer (POA, DPOA, Guardian, etc.)

2

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DSW EMPLOYMENT REQUIREMENTS TA WAIVER

1. "You" the **Direct Support Worker must be at least 18 years of age** and must pass ALL, of the required background checks.

2. **"You" the Direct Support Worker and the Customer have completed ALL, of the paperwork correctly without any errors or omissions**, *ILRC staff will review the paperwork, if there are items that need corrected or are missing it will be mailed to the Customer with instructions on what to do.*

3. "You" the Direct Support Worker have provided your **2 forms of ID's** as stated on the List Of Acceptable Documents page in this packet ***these must be current and unexpired***

4. **Background check deposit as stated on Item "4"** has been provided *(ILRC staff will check which box applies).*

5. ***High School Diploma or Equivalent**, must be provided, this is a requirement from the State.*

6. "You" the Direct Support Worker **MUST** provide **proof of address**, this must be something **CURRENT** such as an electric bill, gas bill, water bill, lease agreement, bank statement or correspondence from City, State or County.

7. Paperwork is accepted **Monday to Thursday 8am to 3pm**. Paperwork received after 3pm on Thursday will not be processed until the following week.

8. **"You" the Direct Support Worker are not an employee of the Customer until you have received your AuthentiCare ID number and the clock in and out instructions from ILRC.** Upon receiving this information will be the day you can start working for the Customer.

9. IF "You" are hired as a **BACKUP** worker you **MUST work at least every 3 months** to remain active, IF you sit idle you will be **removed from payroll** and possibly have to do new paperwork!

Any hours worked prior to receiving your AuthentiCare ID number and clock in and clock out instructions are invalid and not payable by ILRC. All hours worked MUST be done using the mandatory Kansas AuthentiCare call in system. If the Customer, had you work it will be their responsibility to pay you out of pocket.

By signing below, you are indicating that you have read and understand the requirements for employment.

_____ _____

Customer Signature Date

_____ _____

Direct Support Worker Signature Date

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3

BACKGROUND CHECK REGISTRATION NOTICE

EFFECTIVE 11/18/2016, IN COORDINATION AND COMPLIANCE WITH ALL STATE REGULATIONS REGARDING HOME AND COMMNITY BASED SERVICES AND FINACIAL 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.

DO NOT CALL ILRC FOR STATUS UPDATES ON WHERE YOU ARE AT IN THE PROCESS. WE CANNOT RUSH THIS PROCESS.

ONCE ALL OF THE BACKGROUND CHECKS ARE RECEIVED YOUR PAPERWORK WILL BE PROCESSED AND AN ID# WILL BE ISSUED 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 THE INFORMATION WILL BE MAILED TO YOU.

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

_____ _____

Customer/Employer Signature Date

_____ _____

Direct Support Workers Signature Date

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RESOURCE CENTER

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TELEPHONE/TTY 316 • 942 • 6300

4

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 AS REQUIRED BY THE STATE AS LONG AS YOU ARE STILL EMPLOYED.

ILRC STAFF WILL CHECK THE BOX THAT APPLIES:

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. WE ACCEPT PAYMENT IN THE FORM OF: ☐

- *CASH OR CHECK PAYABLE TO ILRC – **NO MONEY ORDERS***
- *DEBIT OR CREDIT CARD INFORMATION:*

  CARD #: _____ *EXP DATE:* _____ *CODE:* _____

Note: If paying by card your card will not be charged UNLESS you fail the background check.

YOU HAVE EXCEEDED IN HIRING "5" DIRECT SUPPORT WORKERS. THE CUSTOMER MUST PAY THE BACKGROUND CHECK FEES ($30.00 IF DSW HAS A KANSAS DRIVERS LICENSE OR $60.00 IF DSW HAS AN OUT OF STATE DRIVERS LICENSE). THE REFUNDABLE DEPOSIT NO LONGER APPLIES. ☐

- *CASH OR CHECK PAYABLE TO ILRC – NO MONEY ORDERS*
- *DEBIT OR CREDIT CARD INFORMATION:*

  CARD #: _____ *EXP DATE:* _____ *CODE:* _____

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.

****

1. **ARE YOU LISTED ON THE CHILD ABUSE, ADULT ABUSE, SEX OFFENDER, KANSAS NURSE AIDE REGISTRIES?**

   ☐ **YES or** ☐ **NO**

   IF "**YES**", *YOU ARE NOT ELIGIBLE TO WORK IN THIS PROGRAM DO NOT FILL THIS PAPERWORK OUT.*

2. **HAVE YOU EVER BEEN CONVICTED OF A FELONY?**

   ☐ **YES or** ☐ **NO**

   *IF "**YES**", EXPLAIN*: _____

***NOTE:** IF "YES", MAKE SURE THE OFFENSE IS NOT LISTED IN THE PROHIBITED OFFENSES PAGES, 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 THIS PAPERWORK OUT.*

_____ _____

Customer Signature Date

_____ _____

Direct Support Worker Signature Date

HEALTH OCCUPATIONS CREDENTIALING
612 SOUTH KANSAS AVE, TOPEKA, KS 66603-3404

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. ☐

One of the following **must** be selected

Social Security Number Date of Birth Sex Race

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

Address Post Office Box # (if applicable)

City State County Zip Code

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 Trainee	**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 Ade	**RSA**
Chaplain	**CHN**	Maintenance Worker	**MTW**	Social Service Designee	**SSD**
Clerical Staff	**CLS**	Marketing Staff	**MKT**	Volunteer Coordinator	**VLC**
				Wellness Staff	**WEL**

FORM C - REV - 7/12

Completed by Date

Kansas Department for Children and Families
Strong Families Make a Strong Kansas

KANSAS DEPARTMENT FOR CHILDREN AND FAMILIES

Child Abuse and Neglect Central Registry
P.O. Box 2637 • Topeka, KS 66601 • DCF.CentralRegistry@ks.gov

Release of Information

OBI 1011
9/2018
Page 1 OF 1

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
Agency/Org.: ILRC as Fiscal Agent
Phone #: (316) 942-6300
Address: 3033 W 2nd St. N, Suite 1
Email: swickery@ilrcks.org
City/State/Zip: Wichita, KS 67203

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

Payment/Account Information (check box which applies)

☐ *Fee included*	$10 per request. Check, Money Order (payable to DCF) or cash. ***Postal mail only.***	
☐ *Online Payment**	www.dcf.ks.gov – 'Online DCF Payments' bottom of page. Payment Portal. Submit receipt with ROI form(s).	
☒ *Pre-Pay Account**	Agency/Org. has Pre-Pay Account.	FEIN: 32-0504847
☐ *Mentoring Account**	As listed in the Kansas Mentors' Partner Directory. http://mentorkansas.org/Find-a-Program	
☐ *Exempt**	No fee for State government agencies (Sub-contracting agencies not included).	

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

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

FIRST, MIDDLE, LAST NAME: _____

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

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

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

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

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

CURRENT ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE: _____ **EMAIL:** _____

SIGNATURE: _____ **DATE:** _____

DCF ONLY:

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

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

ADULT ABUSE, NEGLECT, EXPLOITATION CENTRAL REGISTRY RELEASE OF INFORMATION

OBI 10400
REV 4/21

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

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

Contact Person(s)* SABRINA WICKERY **Phone** 316-942-6300 EXT. 224

Agency name ILRC AS FISCAL AGENT

Agency mailing address 3033 W 2ND ST N, STE 1, WICHITA, KS 67203

Email address: Will return via Encrypted email unless marked otherwise swickery@ilrcks.org

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

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

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

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

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

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

RETURN TO:

Email: DCF.APSRegistry@ks.gov

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

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

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DRIVING RECORDS RELEASE AND AUTHORIZATION

YOU MUST HAVE A VALID DRIVERS LICENSE TO DRIVE THE CUSTOMER IN ANY MOTOR VEHICLE!

THIS FORM MUST BE FILLED OUT WHETHER YOU DRIVE OR DON'T DRIVE.

1. Will you be driving the customer in any motor vehicle? _____

2. Do you have a Valid Driver's License? _____
   (If you only have a Photo ID you are not eligible to drive).

3. First Name: _____

4. Middle Initial: _____

5. Last Name: _____

6. Address: _____

7. City: _____ State: _____ Zip: _____

8. Social Security Number: _____ Date of birth: _____

9. Driver's License Number: _____ State: _____

   OR

   Photo ID Number: _____ State: _____

Please sign this form below:

SIGNATURE: _____ **DATE:** _____

Revised 09/2020

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.

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Enhanced Care Services (Sleep Cycle Policy)

IF THE CUSTOMER IS APPROVED FOR THIS SERVICE ILRC STAFF WILL DESIGNATE THIS BY CHECKING THE "YES" BOX BELOW:

DIRECT SUPPORT WORKER MUST provide proof of current address: YES ☐

Note: Failure to provide proof of address means you cannot provide this service to the customer until we have this on file.

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

EXAMPLES OF PROOF OF ADDRESS ARE LISTED BELOW. THESE ARE THE ONLY ITEMS WE WILL ACCEPT AS PROOF OF ADDRESS.

DO NOT SUBMIT ANYTHING ELSE IN PLACE OF WHAT IS LISTED BELOW WE ONLY NEED ONE ITEM FROM THE LIST AND IT MUST BE CURRENT:

- ELECTRIC BILL, GAS BILL, WATER BILL
- LEASE AGREEMENT, BANK STATEMENT
- CORRESPONDENCE FROM CITY, STATE OR COUNTY

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 consistently. 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)

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Notice of Employment – TA

I _____ have been hired to provide
Direct Support Worker Name (Print Above) Name

Direct Support Worker Services by_____ participating
Customer/Employer Name (Print Above)

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. 1224 or at swickery@ilrcks.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

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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

Are you related to the client? ☐ YES ☐ NO If YES, what is your relationship: _____

Sign language? ☐ YES ☐ NO

Are you a DPOA for client? ☐ 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. #_____

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EMPLOYMENT AGREEMENT

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

W I T N E S S E T H:

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 Guardian/Designated Representative, the Caregiver must report the accident to the Guardian/Designated Representative, Care Coordinator, Targeted Case Manager and to the FMS Payroll provider 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.

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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

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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.

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 will list both workers, their maximum hours of 55 and 15, and pay rates at any amount in the range between $7.25 - $11.77 on the first worker and any wage between $7.25 and $13.38 for the second worker. If your plan of care has less than 40 hours per week you can ignore the chart on the back and enter any pay rate between $7.25 - $13.38 per hour below.

Please list your workers, indicate the maximum number of hours you would like to allot for each worker, and list the pay rate you would like to pay each worker. The available range of pay rates runs from the minimum wage of $7.25 to the maximum indicated on the chart on the back of this page.

***BELOW ARE THE HOURS YOU ARE ALLOWED,* REGARDLESS OF HOW MANY WORKERS YOU HIRE.**

☐ ***YOU ARE ON A MONTHLY PLAN; YOU WILL NEED TO DECIDE HOW MANY HOURS PER WEEK THE DSW WILL WORK FOR YOU.***

☐ ***YOU ARE ALLOWED A TOTAL OF _____ HOURS PER _____.***

☐ **YOU NEED TO CALL _____ AT 316-942-6300 EXT. 1203 ABOUT PAY RATES.**

DIRECT SUPPORT WORKER(S) NAME	WEEKLY MAXIMUM HOURS	PAY RATE

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 only within the agreed upon limits above.

Customer Signature	Customer or Representative Printed Name	Date

TA

STRAIGHT TIME 13.38

Hours		Gross Pay Allowable Under Medicaid Budget	Maximum Rate Including Overtime
40	and below		13.38
40.25		538.55	13.34
40.5		541.89	13.30
40.75		545.24	13.26
41		548.58	13.22
41.25		551.93	13.18
41.5		555.27	13.14
41.75		558.62	13.11
42		561.96	13.07
42.25		565.31	13.03
42.5		568.65	13.00
42.75		572.00	12.96
43		575.34	12.93
43.25		578.69	12.90
43.5		582.03	12.86
43.75		585.38	12.83
44		588.72	12.80
44.25		592.07	12.77
44.5		595.41	12.74
44.75		598.76	12.71
45		602.10	12.68
45.25		605.45	12.65
45.5		608.79	12.62
45.75		612.14	12.59
46		615.48	12.56
46.5		622.17	12.51
46.25		618.83	12.53
46.75		625.52	12.48
47		628.86	12.45
47.25		632.21	12.43
47.5		635.55	12.40
47.75		638.90	12.38
48		642.24	12.35
48.25		645.59	12.33
48.5		648.93	12.30
48.75		652.28	12.28
49		655.62	12.25
49.25		658.97	12.23
49.5		662.31	12.21
49.75		665.66	12.19
49.25		658.97	12.23
49.5		662.31	12.21
49.75		665.66	12.19
50		669.00	12.16
50.25		672.35	12.14
50.5		675.69	12.12

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KANSAS AUTHENTICARE CALL IN SYSTEM AGREEMENT

The Kansas AuthentiCare calls 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.

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 allow the Direct Support Worker to perform tasks for anyone else that resides in the household while they are clocked IN.

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

Direct Support Workers ARE NOT allowed to be clocked in at the same time if they work for multiple Customers.

ONLY 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. **You will have 2 weeks to turn in a correction sheet to us for processing, we do not process any corrections sheets that are over 2 weeks old, this is mandatory based on our billing process that we follow.** 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 in your record, you as the Customer are responsible for all phone numbers in 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 **Date**

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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, EEOC, Productive Work Environment, Workplace Violence/Weapons Policy, Attendance & Punctuality.

_____

Print Direct Support Worker Name

_____

Signature of Direct Support Worker

_____

Date

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

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

Acceptable Receipts

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

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

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

Employment Eligibility Verification

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)			**Additional Information**		
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)			☐ Check here if you used an alternative procedure authorized by DHS to examine documents.		

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

* only fill out if this applies to you.

Supplement B,
Reverification and Rehire (formerly Section 3)

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

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

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

Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the Handbook for Employers: Guidance for Completing Form I-9 (M-274)

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	Last Name (Family Name)	First Name (Given Name)	Middle Initial

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

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

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	Last Name (Family Name)	First Name (Given Name)	Middle Initial

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

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

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	Last Name (Family Name)	First Name (Given Name)	Middle Initial

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

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

* only fill out if this applies to you.

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2023

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Step 1: Enter Personal Information

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

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

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, other details, 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) Reserved for future use.

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

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

TIP: If you have self-employment income, see page 2.

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

Step 3: Claim Dependent and Other Credits

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

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

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

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

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2023 if you meet both of the following conditions: you had no federal income tax liability in 2022 **and** you expect to have no federal income tax liability in 2023. You had no federal income tax liability in 2022 if (1) your total tax on line 24 on your 2022 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2023 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2024.

Your privacy. 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).

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 income and self-employment taxes through withholding from your wages, you should enter the self-employment income on Step 4(a). Then compute your self-employment tax, divide that tax by the number of pay periods remaining in the year, and include that resulting amount per pay period on Step 4(c). You can also add half of the annual amount of self-employment tax to Step 4(b) as a deduction. To calculate self-employment tax, you generally multiply the self-employment income by 14.13% (this rate is a quick way to figure your self-employment tax and equals the sum of the 12.4% social security tax and the 2.9% Medicare tax multiplied by 0.9235). See Pub. 505 for more information, especially if the sum of self-employment income multiplied by 0.9235 and wages exceeds $160,200 for a given individual.

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.

If you (and your spouse) have a total of only two jobs, you may check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is 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. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2023 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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

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

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables.

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 2023 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $

2 Enter:
- $27,700 if you're married filing jointly or a qualifying surviving spouse
- $20,800 if you're head of household
- $13,850 if you're single or married filing separately

. . . . . **2** $

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

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

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

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$850	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,870
$10,000 - 19,999	0	930	1,850	2,000	2,200	2,220	2,220	2,220	2,220	2,220	3,200	4,070
$20,000 - 29,999	850	1,850	2,920	3,120	3,320	3,340	3,340	3,340	3,340	4,320	5,320	6,190
$30,000 - 39,999	850	2,000	3,120	3,320	3,520	3,540	3,540	3,540	4,520	5,520	6,520	7,390
$40,000 - 49,999	1,000	2,200	3,320	3,520	3,720	3,740	3,740	4,720	5,720	6,720	7,720	8,590
$50,000 - 59,999	1,020	2,220	3,340	3,540	3,740	3,760	4,750	5,750	6,750	7,750	8,750	9,610
$60,000 - 69,999	1,020	2,220	3,340	3,540	3,740	4,750	5,750	6,750	7,750	8,750	9,750	10,610
$70,000 - 79,999	1,020	2,220	3,340	3,540	4,720	5,750	6,750	7,750	8,750	9,750	10,750	11,610
$80,000 - 99,999	1,020	2,220	4,170	5,370	6,570	7,600	8,600	9,600	10,600	11,600	12,600	13,460
$100,000 - 149,999	1,870	4,070	6,190	7,390	8,590	9,610	10,610	11,660	12,860	14,060	15,260	16,330
$150,000 - 239,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
$240,000 - 259,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
$260,000 - 279,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	18,140
$280,000 - 299,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,870	17,870	19,740
$300,000 - 319,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,470	15,470	17,470	19,470	21,340
$320,000 - 364,999	2,040	4,440	6,760	8,550	10,750	12,770	14,770	16,770	18,770	20,770	22,770	24,640
$365,000 - 524,999	2,970	6,470	9,890	12,390	14,890	17,220	19,520	21,820	24,120	26,420	28,720	30,880
$525,000 and over	3,140	6,840	10,460	13,160	15,860	18,390	20,890	23,390	25,890	28,390	30,890	33,250

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$310	$890	$1,020	$1,020	$1,020	$1,860	$1,870	$1,870	$1,870	$1,870	$2,030	$2,040
$10,000 - 19,999	890	1,630	1,750	1,750	2,600	3,600	3,600	3,600	3,600	3,760	3,960	3,970
$20,000 - 29,999	1,020	1,750	1,880	2,720	3,720	4,720	4,730	4,730	4,890	5,090	5,290	5,300
$30,000 - 39,999	1,020	1,750	2,720	3,720	4,720	5,720	5,730	5,890	6,090	6,290	6,490	6,500
$40,000 - 59,999	1,710	3,450	4,570	5,570	6,570	7,700	7,910	8,110	8,310	8,510	8,710	8,720
$60,000 - 79,999	1,870	3,600	4,730	5,860	7,060	8,260	8,460	8,660	8,860	9,060	9,260	9,280
$80,000 - 99,999	1,870	3,730	5,060	6,260	7,460	8,660	8,860	9,060	9,260	9,460	10,430	11,240
$100,000 - 124,999	2,040	3,970	5,300	6,500	7,700	8,900	9,110	9,610	10,610	11,610	12,610	13,430
$125,000 - 149,999	2,040	3,970	5,300	6,500	7,700	9,610	10,610	11,610	12,610	13,610	14,900	16,020
$150,000 - 174,999	2,040	3,970	5,610	7,610	9,610	11,610	12,610	13,750	15,050	16,350	17,650	18,770
$175,000 - 199,999	2,720	5,450	7,580	9,580	11,580	13,870	15,180	16,480	17,780	19,080	20,380	21,490
$200,000 - 249,999	2,900	5,930	8,360	10,660	12,960	15,260	16,570	17,870	19,170	20,470	21,770	22,880
$250,000 - 399,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
$400,000 - 449,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
$450,000 and over	3,140	6,380	9,010	11,510	14,010	16,510	18,010	19,510	21,010	22,510	24,010	25,330

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$620	$860	$1,020	$1,020	$1,020	$1,020	$1,650	$1,870	$1,870	$1,890	$2,040
$10,000 - 19,999	620	1,630	2,060	2,220	2,220	2,220	2,850	3,850	4,070	4,090	4,290	4,440
$20,000 - 29,999	860	2,060	2,490	2,650	2,650	3,280	4,280	5,280	5,520	5,720	5,920	6,070
$30,000 - 39,999	1,020	2,220	2,650	2,810	3,440	4,440	5,440	6,460	6,880	7,080	7,280	7,430
$40,000 - 59,999	1,020	2,220	3,130	4,290	5,290	6,290	7,480	8,680	9,100	9,300	9,500	9,650
$60,000 - 79,999	1,500	3,700	5,130	6,290	7,480	8,680	9,880	11,080	11,500	11,700	11,900	12,050
$80,000 - 99,999	1,870	4,070	5,690	7,050	8,250	9,450	10,650	11,850	12,260	12,460	12,870	13,820
$100,000 - 124,999	2,040	4,440	6,070	7,430	8,630	9,830	11,030	12,230	13,190	14,190	15,190	16,150
$125,000 - 149,999	2,040	4,440	6,070	7,430	8,630	9,980	11,980	13,980	15,190	16,190	17,270	18,530
$150,000 - 174,999	2,040	4,440	6,070	7,980	9,980	11,980	13,980	15,980	17,420	18,720	20,020	21,280
$175,000 - 199,999	2,190	5,390	7,820	9,980	11,980	14,060	16,360	18,660	20,170	21,470	22,770	24,030
$200,000 - 249,999	2,720	6,190	8,920	11,380	13,680	15,980	18,280	20,580	22,090	23,390	24,690	25,950
$250,000 - 449,999	2,970	6,470	9,200	11,660	13,960	16,260	18,560	20,860	22,380	23,680	24,980	26,230
$450,000 and over	3,140	6,840	9,770	12,430	14,930	17,430	19,930	22,430	24,150	25,650	27,150	28,600

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K-4
(Rev. 8-15)

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 785-368-8222.

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

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

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

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

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

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

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

Personal Allowance Worksheet (Keep for your records)

A Allowance Rate: If you are a single filer mark "Single"
If you are married and your spouse has income mark "Single"
If you are married and your spouse does not work mark "Joint"
A ☐ Single ☐ 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) ..... **B** _____

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

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

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

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

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

K-4
(Rev. 9-12)

Kansas Employee's Withholding Allowance Certificate

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

1 Print your First Name and Middle Initial	Last Name	2 Social Security Number

Mailing Address

City or Town, State and Zip Code

3 Allowance Rate
Mark the allowance rate selected in line A above.
☐ Single ☐ Joint

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

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

SIGN HERE ▶ DATE

7 Employer's name and address	8 EIN (Employer ID Number)
	32-0504847

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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. Pick one of the following options below.

I _____

DIRECT SUPPORT WORKERS NAME PRINT HERE

PICK ONE OF THE FOLLOWING OPTIONS BELOW.

☐ **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. You will receive your paystub each week in the paystub portal. **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 and we "ILRC" will have to wait until the money is returned before we can do anything.**

☐ **WISLEY BANK - VISA CASH CARD**

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 Wisely Bank will send you a card with your name printed on it, you should have your payroll card in about 7 to 10 business days. If your card is lost or stolen, please contact our office (ILRC) immediately to come pick up another temporary card and then you will need to call Wisely Bank 1-866-313-6901 to get it activated. You will receive your paystub each week in the paystub portal.

NOTE – The card that you will receive is only for YOU and is not to be shared with anyone else. Sharing your pay card with anyone for them to use will be determined as fraud and action will be taken.

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

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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 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.**

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

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WISELY PAY VISA CARD ENROLLMENT FORM

Account Owner Information (Please Print Legibly)

FIRST NAME:	MIDDLE:	LAST:

ADDRESS:

CITY:	STATE:	ZIP:

PHONE:	CELL:

DATE OF BIRTH:	SSN:

1. **You will receive a temporary card from Independent Living Resource Center. Wisely will mail a card to you with your name printed on it in 7 to 10 business days.**
   NOTE – The card that you will receive is only for YOU and is not to be shared with anyone else. Sharing your pay card with anyone for them to use will be determined as fraud and action will be taken.

2. **EMPLOYEE PAYSTUB PORTAL:**

   Pay Stubs are available in the Employee Portal, **this is the only way to receive and view your paystub each week**. Please provide your **current** email address below, information for use of the Employee Portal will be emailed to you. If you change your email address, please let our office know so we can update your record.

   EMAIL ADDRESS FOR PAY STUB PORTAL: _____

3. **By signing below I am authorizing ILRC dba ILRC as Fiscal Agent, to deposit my weekly pay to the Wisley Pay Visa Card.**

EMPLOYEE SIGNATURE: _____ **DATE**: _____

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HCBS Technology Assisted Waiver
Personal Service Attendant (PSA) Training Checklist

Name of TA waiver recipient:	Medicaid ID #:

☐ YES	☐ NO	Lifting and Body Mechanics	☐ YES	☐ NO	Diapering Technique and Protocol
☐ YES	☐ NO	Transfers and Positioning	☐ YES	☐ NO	Enema/Suppository Insertion
☐ YES	☐ NO	Ambulation Techniques	☐ YES	☐ NO	Seizure Control Protocol
☐ YES	☐ NO	Bathing and Hair Care	☐ YES	☐ NO	Range of Motion exercises
☐ YES	☐ NO	Oral Care	☐ YES	☐ NO	Communication Techniques
☐ YES	☐ NO	Skin and Nail Care	☐ YES	☐ NO	Behavior Modification Techniques
☐ YES	☐ NO	Dressing Assistance	☐ YES	☐ NO	Infection Control Procedures
☐ YES	☐ NO	Hearing Impaired Assistance	☐ YES	☐ NO	CPR/First Aid
☐ YES	☐ NO	Visually Impaired Assistance	☐ YES	☐ NO	Emergency Procedures
☐ YES	☐ NO	Specialized Diet / Nutrition Preparation	☐ YES	☐ NO	Laundry Assistance
☐ YES	☐ NO	NG/GT/NJ Feeding and Care	☐ YES	☐ NO	Room/Housekeeping Assistance
☐ YES	☐ NO	Medication Administration	☐ YES	☐ NO	Documentation/Record Keeping
☐ YES	☐ NO	Temperature Monitoring	☐ YES	☐ NO	Other (specify below)
☐ YES	☐ NO	Blood Pressure Monitoring	☐ YES	☐ NO	
☐ YES	☐ NO	Pulse Assessment	☐ YES	☐ NO	
☐ YES	☐ NO	Pulse Ox Monitoring	☐ YES	☐ NO	
☐ YES	☐ NO	Respiration Monitoring	☐ YES	☐ NO	
☐ YES	☐ NO	Oxygen Administration	☐ YES	☐ NO	
☐ YES	☐ NO	Use of Suction Machine	☐ YES	☐ NO	
☐ YES	☐ NO	Use of Glucometer	☐ YES	☐ NO	
☐ YES	☐ NO	Tracheotomy Care			
☐ YES	☐ NO	Catheter Care / Recording Input & Output			

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.

_____ Date _____

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 _____ under my authority.

_____ Date _____

Parent/Legal Guardian Signature

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.

YOU WILL NEED TO SHOW PROOF OF ID WHEN PICKING UP PAYROLL ITEMS. PAYSTUBS CAN BE VIEWED AND PRINTED ON THE PORTAL. IF WE PRINT THEM FOR YOU THERE WILL BE A $5.00 CHARGE.

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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.

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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.

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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.

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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.

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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.

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 IMEDIATELY to Adult Protective Services at 1-800-922-5330.

Independent Living
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Empowering people with disabilities
www.ilrcks.org TEL 316 • 942 • 5300 V/TTY
TFN 800 • 479 • 6861 V/TTY
3033 West 2nd Street North • Wichita • Kansas • 67203

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.

Independent Living
RESOURCE CENTER

Empowering people with disabilities

Independent living Resource Center
Administrative Policy
DEFICIT REDUCTION ACT INFORMATION FOR EMPLOYEES, CONTRACTORS AND VENDORS

Independent living Resource Center is required by federal law to provide information to its employees (including management), contractors and agents regarding the federal False Claims Act, administrative remedies for false claims and statements, any state laws pertaining to civil or criminal penalties for false claims and statements, whistleblower protections under these laws, and The Independent living Resource Center policies and procedures for preventing and detecting fraud, waste and abuse. This policy serves to inform employees, contracted staff and vendors as to the details, remedies and whistleblower protections associated with such federal and state laws as well as reminding employees and contracted staff and informing agents of The Independent living Resource Center compliance program and related policies.

Federal False Claims Act
What it does:
Allows a civil action to be brought against a health care provider who:

- Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval to any federal employee;
- Knowingly makes, uses or causes to be made or used a false record or statement to get a false or fraudulent claim paid; or
- Conspires to defraud the government by getting a false or fraudulent claim allowed or paid.

Examples of a false claim:

- Billing for procedures not performed;
- Violation of another law, for example a claim was submitted appropriately but the service was the result of an illegal relationship such as a kickback for referrals;
- Falsifying information in the medical record; or
- Double billing.

Remedies:

- A federal false claims action may be brought by the U.S. Department of Justice Civil Division of the office of the United States Attorney.

- An individual may bring what is called a qui tam action. This means the individual files an action on behalf of the government directly against the health care provider. An individual who files such an action has the burden of establishing a violation and the action may take several months, or even years, to be resolved.

- Violation of the federal False Claims Act is punishable by a civil penalty of between $5,500 and $11,000 per false claim, plus three times the amount of damages incurred by the government.
- If a qui tam action is successful, and certain legal requirements are met, the whistleblower may receive between 15% and 30% of any recovery and may also be entitled to reasonable expenses including attorney's fees and costs for bringing the lawsuit.
- If a health care provider is held liable under the False Claims Act, the Office of Inspector General may seek to exclude the provider from participation in federal health care programs such as Medicare and Medicaid.

Federal Program Fraud Civil Remedies Act
The federal Program Fraud Civil Remedies Act of 1986 provides administrative remedies for knowingly submitting false claims and false statements to federal agencies.

- A violation may result in a maximum civil penalty of $5,000 per each wrongfully filed claim plus an assessment of up to twice the amount of each false or fraudulent claim that has been paid.
- Remedies are separate from, and in addition to, any liability that may be imposed under the federal False Claims Act.

Federal Whistleblower Protections
Federal law prohibits an employer from discriminating against an employee in the terms or conditions of his or her employment because the employee initiated or otherwise assisted in a false claims action.

State False Claims Provisions
Kansas does not currently have provisions that parallel the federal False Claims Act, but it has adopted provisions that appear in the Kansas Criminal Code, known generally as the Kansas Medicaid Fraud Control Act.

- Unlawful acts include any false or fraudulent claim, statement or report, and any wholly or partially false or fraudulent record, document or data;
- Any knowing or intentional solicitation or receipt of any kickback, bribe or rebate in return for any referral or arrangement involving goods or services for which payment may be made under the Medicaid program is prohibited;
- Unlike the federal False Claims Act, current Kansas false claims statutes do not contain a whistleblower provision or anti-retaliation protections. Kansas case law generally provides a cause of action if an employee is discharged in retaliation for whistleblowing out of a good faith concern as to an employer's wrongful activity pertaining to public health, safety and welfare but these rules have yet to be applied in this context.

Independent Living
RESOURCE CENTER

Empowering people with disabilities since 1984

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.

PROVIDING ACCURATE AND COMPLETE DOCUMENTATION

It is the responsibility of all directors and employees to accurately document services provided to ensure that they are medically necessary and properly coded (up coding, fragmentation, use of inappropriate or outdated codes is unacceptable)

NEGOTIATING AGREEMENTS AND MANAGING RELATIONSHIPS WITH CONTRACTORS AND SUPPLIERS

Statements, communications and representations to prospective partners and suppliers must be accurate and truthful. Contractual obligations must be performed in compliance with the contract. All suppliers should be treated uniformly and fairly. When deciding among competing suppliers, the selections should be based upon objective criteria (including among other factors: quality, technical capabilities, prices, delivery, adherence to schedules, service) and not favoritism. Relationships with contractors and suppliers should be managed in a fair and reasonable manner; consistent with applicable laws and good business practices. Directors and employees may not communicate confidential third party business information given to ILRC by a contractor or supplier without its permission. This ILRC compliance policy will be provided to applicable contractors.

GIFTS

ILRC directors and employees are not permitted to accept personal gifts. Occasionally, business related gifts or benefits may be accepted if they are of nominal value. Prior to accepting any gift or benefit, the Compliance Officer should be contacted for guidance. Directors and employees should not give business related gifts without consulting the Compliance Officer.

ACCURATE BILLING PRACTICES

Billings and claims must reflect that services are supported by relevant documentation and are submitted in accordance with applicable laws, rules regulations and program requirements. Honesty and accuracy in billing and the making of claims to public and private payers is vital. Employees must be alert for and report improper billing to the Compliance Officer. Improper or fraudulent billing activity may include; cost report falsifications, duplicate billing, multiple coverage and secondary payer fraud, false claims and statements, over billing, billing for services that were not provided, billing for unnecessary services, billing for non- approved treatment or equipment usage, improper coding, (using a billing code that provides a higher payment rate than the billing code which accurately reflects the service provided, up coding, unbundling, etc.) submitting more than one claim for the same service, non ordered/non performed testing submissions, improper physician or provider referrals (Stark and Anti-Kickback Rules) or certifying or making inaccurate or false statements.

REFERALS

Any business arrangement with a physician or provider must be structured appropriately to ensure compliance with the applicable laws and regulations. ILRC does not pay for referrals and does not accept payment for any referrals that it makes. If a director or employee becomes aware of or is involved with any situation involving bribery, kickbacks, or inappropriate referrals, the director or employee must immediately contact the Compliance Officer.

CONFLICT OF INTEREST

A conflict of interest may occur if a director's or employee's outside activities or personal interests influence or appear to influence their ability to make decisions for the ILRC. A conflict of interest may also exist if the demands of outside activities or personal interests interfere with the performance of a director or employee's duties for the ILRC. If a director or employee has a question regarding conflict of interest, s/he should consult the Compliance Officer.

CONMPLIANCE WITH LAWS, REGULATIONS AND GUIDANCE

ILRC, through its directors and employees, will comply with all applicable state and federal laws, regulations and guidance documents. In particular, laws regulations and guidance related to participation in and reimbursements from state and federal public benefit programs will be followed. ILRC will also comply with laws related to anti trust and trade regulations, tax responsibilities, and discrimination in employment or in the provision of services, workplace safety, business practices.

REPORTING RESPONSIBILITY

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

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 Executive Director 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 Executive Director, employees are encouraged to report violations to the ILRC Board President.

COMPLAINCE OFFICER
The ILRC's Executive Director 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.

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 Executive Director 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.

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

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/ COMPLAINCE OFFICER
Cindi Unruh
Independent Living Resource Center
316-942-6300 ext. 222, cunruh@ilrcks.org
3033 W. 2nd Street N.
Wichita, KS 67203

ILRC MANAGEMENT STAFF
Executive Director: Cindi Unruh 316-942-6300 ext. 1222
Finance Manager: Michael Streit 316-942-6300 ext. 1229
ILS Manager: Harley Anderson 316-942-6300 ext. 1210

DISCIPLINARY MEASURES FOR COMPLIANCE POLCIY AND STANDARDS OF CONDUCT VIOLATIONS
ILRC will through its Executive Director and in accordance with its human resource policies and procedures will enforce this policy through appropriate disciplinary action up to and including termination of employees. For directors found to be in violation of this policy, appropriate sanctions will be implemented by the Board of Directors, including termination from participation as a director. For contractors and agents found to be in violation of this policy, appropriate contractual remedies will be pursued by the Executive Director.