

## WORKER ENROLLMENT

The Worker Enrollment form is the first step in the enrollment and onboarding process with Public Partnerships. The information you provide on this form will be used for both employment and payment preferences. Please provide the following information.

### Worker Name

First Name:

Middle Name:

Last Name:

Maiden or Previous Last Name(s):

### Worker Address

Physical Address (no PO Box):

Physical Address 2 (APT., STE., etc.)

Physical City:

Physical State:

Physical Zip Code

Physical County:

Physical Municipality:

Select if physical address is the same as mailing address.

If mailing address is different, complete the section below.

Mailing Address:

Mailing Address 2 (APT., STE., etc.)

Mailing City:

Mailing State:

Mailing Zip Code

### Worker Personal Information

Date of Birth:

Social Security Number:

Gender:

Male  Female  Prefer not to disclose

### Worker Contact Information

There will be times we have important information we need to share with you. **We need to have at least two (2) reliable means of communicating with you. Email is the preferred method of communication.**

Email Address:

Mobile Phone:

Home or Alternate Phone:

Public Partnerships (PPL) has my permission to text me using the mobile phone number above.  
I understand that carrier charges may apply.  Yes  No

Please select how you want to be paid: Direct Deposit to your Bank Account or by Debit Card. You will be paid by paper check until direct deposit is set up. This is because it takes one to two pay periods for direct deposit to become active. If you need to update your bank account information, you must submit a new form.

Select this option if you would like all payments to be deposited in the same account for all participants for which you provide services.

**Payment Information**

**Direct Deposit to Bank Account**

Account Type (select one):  Checking Account  Savings Account

Banking Institution Name:

Routing Number: 

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Account Number: 

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**Deposit to Debit Card**

If you select Debit Card as your payment method, you must provide PPL with a physical address. If you work for more than one Participant and select Debit Card, all payments will be on one pay card.

**Pay Stub**

Your pay stub is available through the BetterOnline™ web portal or the mobile app. If you do not have access to the internet through a computer, tablet, or smart phone, then select the checkbox below.

Please send my pay stub in the mail.

**Worker Directory Opt-In**

If available, would you like to be added to a directory to help Participants locate Workers in their area?

- Yes, please list my name and basic contact information in a Worker directory.
- No, I would prefer not to be listed in the Worker directory.

**PPL Terms and Conditions**

1. I understand and accept that Public Partnerships LLC (PPL) is not my employer.
2. I understand that PPL will help my employer collect my personal data needed to complete the employment forms. PPL, as an FEA (Fiscal Employer Agent), will support my employer in processing their taxes and payroll tasks.
3. I understand that information provided to PPL, on behalf of my employer, can/will be used to fill required forms for employment that are required under Federal/State and Consumer-Directed Services programs.
4. I understand that PPL will collect my account numbers only to process my payroll on behalf of my employer only after my employer signs my timesheet.
5. I understand that through PPL I can select my preferred method of contact. PPL can contact me through phone calls, email, and physical mail with information provided by me.
6. I know that if I want to find out other ways PPL might use my information, I can find it in PPL's Privacy Policy on their website.

**Authorization and Signature**

By signing below, I, the Worker, confirm that I have read this Worker Enrollment form in its entirety and the information and responses I have provided on this form are accurate and complete. I understand that if employed, any false statement on this application may result in my dismissal and other consequences. I also understand that this document is not meant to be a contract of employment or designation, nor does this document obligate the Participant/Employer in any way, should they employ me. I understand that my employment or designation is contingent on giving enough documentation to verify my right to work in the US.

I authorize Public Partnerships LLC (PPL) to deposit my payment directly into my account using an Automated Clearing House (ACH) transaction. I recognize that if I fail to provide complete and accurate information on this form, processing may be delayed or made impossible, or my electronic payments may be erroneously made. I authorize PPL to withdraw from the designated account all amounts deposited electronically in error. If the designated account is closed or has an insufficient balance to allow withdrawal, then I authorize PPL to withhold any payment owed to me until the erroneous deposited amounts are repaid. If I decide to cancel direct deposit, I will contact PPL customer service and provide both the account and routing numbers of my account.

**Worker Signature:**

**Date:**

# PARTICIPANT AND WORKER AGREEMENT

## Worker Information

First Name:  Last Name:  PPL ID:

## Participant Information

First Name:  Last Name:  PPL ID:

## Employer Information (complete this section even if the employer is the same as the participant)

First Name:  Last Name:

This Agreement defines the terms and conditions that apply to the Participant/Employer, any official representative they may have, and their paid Worker.

## Terms and Conditions

This is an agreement between the Participant/Employer and the Worker. This agreement describes the responsibilities that the Participant/Employer and the Worker agree to perform. It sets out rules that the Participant/Employer and Worker agree to follow. It also describes certain rights that each party has. Public Partnerships LLC (PPL) is not a party to this agreement. However, both the Participant/Employer and the Worker agree to use PPL's services in carrying out this agreement.

- Workers can be a friend or family member of the person they're paid to support; however, they cannot be paid to provide support they would have given anyway, without being paid.
- Workers cannot be paid to provide support to someone in Consumer Direction if they are the member's spouse, Representative for Consumer Direction, legal guardian, Power of Attorney (POA) or conservator (unless a court order that indicates such support is allowed is provided).
- Workers cannot be paid to provide Transportation, Personal Assistance, Supportive Home Care, or Respite to someone if they live in the same house with the member.
- Workers should only be paid to provide support the person needs. Workers should never try to talk anyone into letting them provide more hours of service.
- Workers should not be paid to provide support if there are family members, friends, or other people who are willing and able to provide the help the person needs without pay. This is true whether the person is at home or out in the community.
- Workers cannot be paid for services provided while the member is in the hospital, Nursing Facility or other inpatient care setting.
- Workers cannot provide services to other family members, friends, or pets (except for service animals).

### The services listed in this Agreement must be provided to the member only.

- Workers providing Transportation, Personal Assistance, Supportive Home Care, or Respite services can't live in the home with the person receiving services.
- Consumer Direction services can't be provided to anyone but the person who is enrolled in TN Katie Beckett. This includes the person's spouse, children, or others who live in the home, including family pets.
- The person's spouse, Representative for Consumer Direction, legal guardian, Power of Attorney (POA) cannot be paid to provide services.
- The person's conservator cannot be paid to provide services unless the court order says it's ok.
- Workers cannot report that they have worked hours that they did not work for the member.
- Workers cannot use someone else's identity to work for a member in Consumer Direction.
- Workers cannot help someone else commit fraud by making false statements (written or verbal) for them, or falsifying documents.

Should the Worker's employment lapse or be inactive for 6 months or longer, they may be required to complete new enrollment paperwork.

## Transportation

- If the Worker will accompany the member into the community, check this box.
- If the Worker will transport the member into the community, check this box.
- If this box is checked, whose car will the Worker drive?
  - If the Worker will drive their own car, will the Worker be reimbursed for gas or mileage?  Yes  No
    - If Yes, explain how (fixed amount per mile, reimburse cost of gas, etc.)
- 
- If Yes, will the Worker be reimbursed using the Consumer Directed Community Transportation benefit?  Yes  No

The Participant/Employer and the Worker understand that TN Katie Beckett will only reimburse the cost of Community Transportation services provided through Consumer Direction that are needed to access employment, activities and resources in the community that are in the member's Person-Centered Support Plan ("Support Plan"). If the member can get rides from family, friends, co-workers, or others who are willing to help without being paid, Community Transportation services should not be used.

Accompanying or transporting the member must be listed as one of the "Tasks to be performed" for that service. If it is, the time spent doing those things can be paid through TN Katie Beckett Consumer Direction as part of the hourly wage for that service.

The Participant/Employer and the Worker understand that the cost of transportation is not covered for services provided through Consumer Direction.

## Approval of Services Delivered through Consumer Direction

To pay for services in Consumer Direction, they must be in the Member's approved Support Plan. The Member will have a budget for each service they choose to receive through Consumer Direction. The budget will be based on how much of that service their Support Plan says they need.

Personal Assistance or Supportive Home Care will have a monthly budget. TN Katie Beckett can only pay Workers up to the amount of the Member's monthly budget for that service. The Participant/Employer cannot ask Workers (or let Workers) provide more. If the Member uses all of their monthly budget for a service in the first part of the month, they will not get more services approved for the rest of the month. If the Participant/Employer can't manage services within the Member's monthly budget, the Member may not be able to stay in Consumer Direction.

The Participant/Employer will schedule, and the Worker will provide ONLY those services the member is approved to receive. The Participant/Employer will not ask the Worker to perform, and the Worker will not provide support that's not covered under the TN Katie Beckett program. This includes, but is not limited to:

- Any service the member is not approved to receive in their Support Plan;
- More of any service than the member is approved to receive based on their monthly budget for that service (or annual budget for hourly respite);
- Any service provided after the member's TennCare ends, or after the member is no longer in Consumer Direction or the TN Katie Beckett program.
- Care or household tasks (including washing dishes or laundry, fixing meals, shopping, or yard work) for anyone other than the member, even if they live in the same household.
- Care of non-service-related pets and animals. This includes feeding, walking, bathing, or cleaning up after pets.

The Participant/Employer agrees to tell the Worker right away if the member is no longer in Consumer Direction or the TN Katie Beckett program.

The Participant/Employer agrees to pay the Worker for any care he asks the Worker to give that's not covered under the TN Katie Beckett program.

TN Katie Beckett will not pay for any service that is not in the member's approved Support Plan or for any hours of service provided in excess of the member's approved budget amount for that service.

## Schedule of Services

Services should be given at the time it's needed by the member.

The Participant/Employer will decide when each Worker will deliver services, based on the needs of the member as described in the Support Plan. A Worker should sign this agreement ONLY if they will be able to provide services at the time it's needed by the member.

If the member's needs change—the member needs a different kind of service or needs more or less of the service—the Participant/Employer must tell the member's Nurse Care Manager so the Support Plan can be updated.

If services will be needed at a different time, the Participant/Employer should give the Worker as much advance notice as possible. The Participant/Employer must make sure the Worker will be able to work at the new time the service is needed. If not, the Participant/Employer will have to find another Worker who can provide the service at the time it's needed by the member.

The Worker must notify the Participant/Employer as soon as possible if he will not be able to provide services as scheduled. (This includes when the Worker can't provide services at all, will be late arriving, or must leave early). This will allow the Participant/Employer to arrange back-up support so the member's needs are met.

Repeated problems providing services as scheduled may affect the Worker's employment in Consumer Direction.

### **Recording time worked**

The Worker agrees to record all time worked including the beginning and end times of each service provided. The Worker will record time using the method preferred by the Participant/Employer (online via the Public Partnerships' BetterOnline™ web portal, Public Partnerships' Time4Care™ mobile app, or paper time sheets). All-time records must be signed by the Worker, then verified and signed and the Participant/Employer before being submitted to Public Partnerships.

If the Worker forgets to record time or makes a mistake recording time, the Worker agrees to tell the Participant/Employer and contact Public Partnerships right away. The Worker agrees to work with the Participant/Employer and Public Partnerships to resolve any problems with recorded time.

The Worker understands that he may not be paid for services if he fails to record time for each visit, unless or until the problem can be resolved.

### **Payment for Approved Services**

This Agreement does not guarantee the Worker a minimum number of hours or a minimum amount of income each pay period. The Worker will be paid for services approved in the member's Support Plan that are actually provided to the member.

The Worker's pay will be based on the total hours of approved service provided, minus deductions for the employee's share of federal taxes.

The Worker agrees to be paid according to the published payroll schedule (every other week) by direct deposit to a checking, savings, or debit card account, or by paper check.

The Worker understands that he will not be paid by Public Partnerships:

- For services not approved in the member's Support Plan;
- For hours of service provided in excess of the member's approved monthly budget for Personal Assistance or Supportive Home Care or yearly budget for Respite;
- For services not provided or time not worked;
- While a member is hospitalized, in an inpatient respite or short-term stay setting (nursing facility, intermediate care facility for individuals with intellectual disabilities to other type of inpatient care facility); or
- To provide care at the same time a member is receiving any other service in TN Katie Beckett. (The Worker can be reimbursed for transportation expenses if it's part of this Service Agreement.)

The Worker cannot log or bill and will not be paid for time to travel to and from work at the member's home

### **Benefits**

The Worker will not receive insurance or other benefits under this agreement or participate in any pension or retirement plan. The Worker understands that the Participant/Employer is not required to have Worker's compensation insurance.

### **Worker Qualifications**

By signing this Agreement, the Worker attests that they meet minimum qualifications to be a Worker in the TN Katie Beckett Consumer Direction program.

The Worker:

- Is 18 years of age or older.
- Is not the member's Representative for Consumer Direction.
- Is not the member's spouse, legal guardian or Power of Attorney.
- Is able to perform all of the services (including tasks) needed by the member.

- Is able to provide care at the schedule needed by the member.
- Has basic reading and writing skills.
- Has a valid Social Security number and is authorized to work in the United States.
- Has passed a criminal record check or been granted an exception by the Participant/Employer and doesn't appear on the abuse and sexual offender registries.
- Has completed all required training.
- Has completed all required paperwork to provide services through Consumer Direction.
- Has signed a Medicaid Agreement for a Medicaid Worker ID number.
- Has provided a valid driver's license and proof of insurance (if transporting the member).
- Does not live with the member.

### **Additional Worker Responsibilities**

The Worker understands that they work for the Participant/Employer, and not for Public Partnerships, the member's MCO, or the State of Tennessee.

1. The Worker agrees to comply the EVV requirements including checking in and out of visits.
2. The Worker agrees to provide all of the services listed in this agreement.
3. The Worker agrees to perform all of the tasks needed by the member that are part of that service.
4. The Worker agrees to provide services when it's needed by the member, at the schedule set by the Participant/Employer.
5. The Worker will not provide services that are not approved by the member's MCO or not covered by TennCare.
6. The Worker may refuse to provide services or perform a task that:
  - a. Might be adverse to the member's health.
  - b. The Worker believes poses a danger to their own health.
  - c. The Worker believes they have not been adequately trained to perform.
  - d. Is not part of this Agreement.
7. The Worker agrees to be on time and neatly and appropriately dressed.
8. If the Worker is sick or has an emergency and cannot provide services as scheduled, they agree to tell the Participant/Employer right away so that back-up support can be arranged.
9. The Worker agrees to participate in any and all training that's required and all training requested by the Participant/Employer.
10. The Worker agrees to provide safe care as directed by the Participant/Employer.
11. The Worker agrees to use Universal Precautions.
12. The Worker agrees to call 911 if there's an emergency.
13. The Worker agrees to report any suspected abuse, neglect or exploitation to Adult Protective Services or Child Protective Services as appropriate.
14. The Worker agrees to notify the member's Nurse Care Manager of any significant changes in the member's condition or needs. This includes (but is not limited to) any time the member is admitted to a hospital or other type of inpatient care facility or stops receiving services (even temporarily) for any reason.
15. The Worker agrees to report all critical incidents to the member's Nurse Care Manager immediately and to cooperate with all investigations.
16. The Worker agrees to inform Public Partnerships of any changes in mailing address or phone number.
17. The Worker agrees to treat the member with dignity and respect. This includes respecting the member's beliefs, choices, culture, religion, privacy, and personal property, and behaving respectfully toward the member's family, friends, and guests.
18. The Worker agrees to communicate effectively with the member. If the member has a preferred communication method or device, it should be respected and used.
19. The Worker agrees to keep good notes about the services delivered and the tasks performed for each service.
20. The Worker agrees to keep all information about the member and the member's family private. This includes information about the member's needs and the services provided by the Worker for the member.
21. The Worker agrees to have the employee's share of required federal taxes withheld from their wages. This includes Social Security, Medicare, and Federal income taxes.
22. The Worker agrees to cooperate with the Participant/Employer and with Public Partnerships in providing information needed to comply with all labor and tax laws and regulations.
23. The Worker understands that they cannot use member's property unless the member and their Representative say it's OK. This should only be when it's part of giving the member's care. This includes the member's telephone.
24. The Worker agrees to not make or accept personal phone calls, or send or receive personal text messages or emails while providing services through Consumer Direction

### Conditions of Agreement

The Participant/Employer and the Worker agree to use the help provided by Public Partnerships for TN Katie Beckett members in Consumer Direction. This includes (but is not limited to) paying Workers and filing Participant/Employer payroll taxes and forms. It also includes using the assigned Supports Broker to help with enrollment into Consumer Direction and with resolving payroll issues.

### Complying with State and Federal Laws

The Participant/Employer and the Worker agree to follow all of TennCare's rules for Consumer Direction in the TN Katie Beckett program.

The Participant/Employer and the Worker agree to comply with all State and Federal laws, including labor and tax laws. The Participant/Employer and the Worker understand that:

- State and Federal Medicaid funds will be used to pay for services delivered by the Worker through Consumer Direction.
- Billing for service that weren't given (or billing for more hours of service than were provided) is against the law.
- A person who knows a service wasn't provided and allows the service to be paid for is also responsible.
- Any intentional act or failure to act that results in payment of State or Federal funds that should not have been paid is an act of fraud under the State's TennCare program and title XIX of the federal Social Security Act.
- Fraudulent acts including, but are not limited to, misrepresenting the time that's worked, the services performed, or the person providing the service.
- Under the Tennessee Medicaid False Claims Act, any person that causes a claim for payment to be submitted under the TennCare program that's false or fraudulent is subject to Federal and State civil and criminal penalties.
- A member, representative or Worker who fails to follow all State and Federal rules cannot be part of Consumer Direction in the TN Katie Beckett program.

### Duration of Agreement

This agreement is effective when it's signed by both parties. The agreement will be in effect until either party informs the other party that they want to end the agreement. Notice may be provided verbally or in writing. Whenever possible, notice should be given at least two (2) weeks before the agreement will end. The Participant/Employer may not give two (2) weeks' notice if there are serious problems with the services provided by the Worker.

This agreement will also end immediately if the member loses TennCare or is no longer in Consumer Direction or the TN Katie Beckett program.

### Changing the Agreement

This agreement can be changed only by agreement of both parties. Any changes to this Agreement must be made in writing. Both parties must sign the revised Agreement to show that they agree to any changes that are made. A copy of the revised agreement must be given to Public Partnerships after it is signed by both parties.

### Change of Employer

The Employer would be considered a successor employer in the event the Employer is assuming the employment relationship that was entered into by the Worker's previous employer, so long as the services being provided by the Worker are uninterrupted and continues to be provided to the same Participant. As a successor employer, the Employer would assume certain responsibilities the previous employer had completed, including certain forms, such as the Form I-9.

### Holding Others Harmless (Indemnification)

The parties agree to hold harmless, release, and forever discharge the State of Tennessee, the Division of TennCare, the member's MCO, Public Partnerships, and any and all of their employees and agents from any claims and/or damages that may arise out of any decision, act or omission by the member, Participant/Employer or Worker.

By signing below, both parties affirm that they understand and agree with this information, and promise to abide by this agreement, carry out all of their responsibilities, and follow the rules for Consumer Direction in TN Katie Beckett.

### Medicaid Fraud Information

Violating any of the rules outlined in this agreement is considered fraud. It could lead to an investigation by the Office of Inspector General (OIG) or the Tennessee Bureau of Investigation Medicaid Fraud Control Unit (MFCU). It could also lead to criminal charges.

Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person.

Some examples of fraud include:

- A Worker putting time on their timesheet that they did not work
- A Worker putting more time on their timesheet without actually providing support

- Putting trips on a transportation log that were not performed
- Putting payments to friends or co-workers on a transportation log for gas money that the Worker did not pay or use for gas
- Hiring someone who TennCare says is not allowed to work for the Person Supported (for example, someone who lives with them)

If a case of fraud and abuse in the TennCare program is discovered or suspected, it must be reported immediately. To report fraud:

Contact Public Partnerships at 1-888-866-1153.

Other agencies that you can call or write to report fraud and abuse:

**Office of Inspector General (OIG)**

1-800-433-3982

Office of Inspector General

P.O. Box 282368

Nashville, TN 37228

**Tennessee Bureau of Investigation (TBI)**

1-800-433-5454

TBI Medicaid Fraud Control Unit

901 R.S. Glass Blvd.

Nashville, TN 37216

Fraud and abuse can also be reported online at: <http://tn.gov/tnoig>. Then click on "Report Fraud" on the left-hand side of the page.

### Electronic Signatures

PPL will support both Participants and Workers with the use of electronic signatures, to authenticate and authorize their enrollment forms electronically. PPL will apply electronic signature practices, unless officially stated as not applicable or unlawful. In cases, where forms cannot be processed, PPL may facilitate obtaining a physical signature, when required.

### Electronic Visit Verification (EVV)

EVV means a "GPS location enabled" mobile device or landline is used to submit work hours and verify the location of the Worker at the start and at the end of their shift. Workers must use the EVV procedure to submit their work hours.

### Authorization and Signature

By signing below, I and my Member/EOR attest that we have read and understand all program rules and responsibilities. I understand I must sign and return this form as a condition of employment in this program. I further attest by signing below, that I understand what is being requested of me, and I agree to abide by these terms and conditions. I further understand and agree that violation of any of the terms and/or conditions may result in termination of this agreement.

I authorize the Member and TennCare Katie Beckett to proceed with all registry and criminal record checks required by state and federal law. This information cannot be released for any other purpose without my written permission.

If I request the Direct Deposit payment selection, I authorize Public Partnerships to process payments owed to me for services authorized by TennCare Katie Beckett. Public Partnerships will deposit my payment directly into my bank account using Automated Clearing House (ACH) transaction. I recognize that if I fail to provide complete and accurate information on this form, processing may be delayed or made impossible, or my electronic payments may be erroneously made. I certify that I have read and agree to comply with Public Partnerships' rules governing payments and electronic transfers. I authorize Public Partnerships to withdraw from the designated account all amounts deposited electronically in error. If the designated account is closed or has an insufficient balance to allow withdrawal, then I authorize Public Partnerships to withhold any payment owed to me by Public Partnerships until the erroneous deposited amounts are repaid. If I decide to change or revoke this authorization, I recognize that I must forward such notice to Public Partnerships.

**Worker Signature:**

**Date:**

**Participant/Employer Signature:**

**Date:**





# WORKER SERVICES AND RATE(S)

Worker Information		
First Name: <input style="width: 95%;" type="text"/>	Last Name: <input style="width: 95%;" type="text"/>	PPL ID: <input style="width: 95%;" type="text"/>
Participant Information		
First Name: <input style="width: 95%;" type="text"/>	Last Name: <input style="width: 95%;" type="text"/>	PPL ID: <input style="width: 95%;" type="text"/>
Employer Information (complete this section even if employer is the same as participant)		
First Name: <input style="width: 95%;" type="text"/>	Last Name: <input style="width: 95%;" type="text"/>	

The Participant/Employer and/or their Representative will determine the hourly rate of pay for their Worker based on their Consumer-Directed Services budget. You will complete and sign this form with your Participant/Employer and/or their Representative.

**! IMPORTANT:** We need to know the hourly rate of pay, not the hourly rate plus Employer taxes or other costs. For example: If a person works in a job, they can tell you how much money they make per hour. That's the information you write in the "Hourly Rate".

"Change Hourly Rate" should be marked ONLY if the Worker is already working and you want to change their hourly rate of pay. Upon receipt and processing of a complete and accurate pay rate change form, PPL will change the hourly rate of pay at the beginning of the next available pay period. Please include Service Name and Service code for the hourly rate being changed.

**Request Type:**     New Service                       Change Hourly Rate

Worker Pay Rate		
Service Name	Service Code	Hourly Rate

- The Worker wants to serve as back-up if other Workers are sick or unable to provide services.
- The Worker does not want to serve as back-up if other Workers are sick or unable to provide services.

Authorization and Signature	
<p>By signing below, we, the Worker and my Participant/Employer/Representative, confirm that we have read this Worker Service Rate(s) form in its entirety and the information and responses we have provided on this form are accurate and complete. We understand that if employed, any false statement on this application may result in dismissal and other consequences. We also understand that this document is not meant to be a contract of employment or designation, nor does this document obligate the Participant/Employer/Representative in any way, should they employ me. We understand that employment or designation is contingent on giving enough documentation to verify my right to work in the US.</p>	
<b>Worker Signature:</b>	<b>Date:</b>
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
<b>Participant/Employer/Representative Signature:</b>	<b>Date:</b>
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>



**Employment Eligibility Verification**  
**Department of Homeland Security**  
 U.S. Citizenship and Immigration Services

**USCIS**  
**Form I-9**  
 OMB No. 1615-0047  
 Expires 10/31/2022

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

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

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

Last Name <i>(Family Name)</i>		First Name <i>(Given Name)</i>		Middle Initial	Other Last Names Used <i>(if any)</i>	
Address <i>(Street Number and Name)</i>			Apt. Number	City or Town		State ZIP Code
Date of Birth <i>(mm/dd/yyyy)</i>	U.S. Social Security Number □□□□ - □□ - □□□□		Employee's E-mail Address		Employee's Telephone Number	

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

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

<input type="checkbox"/> 1. A citizen of the United States	
<input type="checkbox"/> 2. A noncitizen national of the United States <i>(See instructions)</i>	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ Some aliens may write "N/A" in the expiration date field. <i>(See instructions)</i>	
<p><i>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</i></p> <p>1. Alien Registration Number/USCIS Number: _____  <b>OR</b>          2. Form I-94 Admission Number: _____  <b>OR</b>          3. Foreign Passport Number: _____          Country of Issuance: _____</p>	
QR Code - Section 1 Do Not Write In This Space	

Signature of Employee	Today's Date <i>(mm/dd/yyyy)</i>
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**Preparer and/or Translator Certification (check one):**  
 I did not use a preparer or translator.     A preparer(s) and/or translator(s) assisted the employee in completing Section 1.  
*(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)*

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

Signature of Preparer or Translator		Today's Date <i>(mm/dd/yyyy)</i>	
Last Name <i>(Family Name)</i>		First Name <i>(Given Name)</i>	
Address <i>(Street Number and Name)</i>		City or Town	State ZIP Code

STOP *Employer Completes Next Page* STOP



**Employment Eligibility Verification**  
**Department of Homeland Security**  
 U.S. Citizenship and Immigration Services

**USCIS**  
**Form I-9**  
 OMB No. 1615-0047  
 Expires 10/31/2022

**Section 2. Employer or Authorized Representative Review and Verification**

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

<b>Employee Info from Section 1</b>	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
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List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date (if any) (mm/dd/yyyy)		Expiration Date (if any) (mm/dd/yyyy)		Expiration Date (if any) (mm/dd/yyyy)
Document Title		Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				

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

**The employee's first day of employment (mm/dd/yyyy):** \_\_\_\_\_ **(See instructions for exemptions)**

Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)	Title of Employer or Authorized Representative	
Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative		Employer's Business or Organization Name	
Employer's Business or Organization Address (Street Number and Name)		City or Town	State	ZIP Code

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

<b>A. New Name (if applicable)</b>			<b>B. Date of Rehire (if applicable)</b>	
Last Name (Family Name)	First Name (Given Name)	Middle Initial	Date (mm/dd/yyyy)	

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

Document Title	Document Number	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 document(s), the document(s) I have examined appear to be genuine and to relate to the individual.**

Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Name of Employer or Authorized Representative
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## LISTS OF ACCEPTABLE DOCUMENTS

### All documents must be UNEXPIRED

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

<b>LIST A</b> <b>Documents that Establish Both Identity and Employment Authorization</b>	OR	<b>LIST B</b> <b>Documents that Establish Identity</b>	AND	<b>LIST C</b> <b>Documents that Establish Employment Authorization</b>
<ol style="list-style-type: none"> <li>1. U.S. Passport or U.S. Passport Card</li> <li>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</li> <li>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</li> <li>4. Employment Authorization Document that contains a photograph (Form I-766)</li> <li>5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status:               <ol style="list-style-type: none"> <li>a. Foreign passport; and</li> <li>b. Form I-94 or Form I-94A that has the following:                   <ol style="list-style-type: none"> <li>(1) The same name as the passport; and</li> <li>(2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.</li> </ol> </li> </ol> </li> <li>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</li> </ol>		<ol style="list-style-type: none"> <li>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</li> <li>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</li> <li>3. School ID card with a photograph</li> <li>4. Voter's registration card</li> <li>5. U.S. Military card or draft record</li> <li>6. Military dependent's ID card</li> <li>7. U.S. Coast Guard Merchant Mariner Card</li> <li>8. Native American tribal document</li> <li>9. Driver's license issued by a Canadian government authority</li> <li style="text-align: center;"><b>For persons under age 18 who are unable to present a document listed above:</b></li> <li>10. School record or report card</li> <li>11. Clinic, doctor, or hospital record</li> <li>12. Day-care or nursery school record</li> </ol>		<ol style="list-style-type: none"> <li>1. A Social Security Account Number card, unless the card includes one of the following restrictions:               <ol style="list-style-type: none"> <li>(1) NOT VALID FOR EMPLOYMENT</li> <li>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</li> <li>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</li> </ol> </li> <li>2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)</li> <li>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</li> <li>4. Native American tribal document</li> <li>5. U.S. Citizen ID Card (Form I-197)</li> <li>6. Identification Card for Use of Resident Citizen in the United States (Form I-179)</li> <li>7. Employment authorization document issued by the Department of Homeland Security</li> </ol>

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

**Refer to the instructions for more information about acceptable receipts.**

# 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.**

**2020**

<b>Step 1:</b> <b>Enter Personal Information</b>	(a) First name and middle initial	Last name	(b) Social security number
	Address		▶ <b>Does your name match the name on your social security card?</b> If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to <a href="http://www.ssa.gov">www.ssa.gov</a> .
	City or town, state, and ZIP code		
	(c) <input type="checkbox"/> <b>Single or Married filing separately</b> <input type="checkbox"/> <b>Married filing jointly</b> (or Qualifying widow(er)) <input type="checkbox"/> <b>Head of household</b> (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

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

**Step 2: Multiple Jobs or Spouse Works**

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

Do **only one** of the following.

(a) Use the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App) for most accurate withholding for this step (and Steps 3–4); **or**

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

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ▶

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

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

<b>Step 3:</b> <b>Claim Dependents</b>	If your income will be \$200,000 or less (\$400,000 or less if married filing jointly):		
	Multiply the number of qualifying children under age 17 by \$2,000 ▶ \$ _____		
	Multiply the number of other dependents by \$500 . . . . . ▶ \$ _____		
	Add the amounts above and enter the total here . . . . .	<b>3</b>	\$ _____
<b>Step 4 (optional): Other Adjustments</b>	(a) <b>Other income (not from jobs).</b> 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 . . . . .	<b>4(a)</b>	\$ _____
	(b) <b>Deductions.</b> 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 . . . . .	<b>4(b)</b>	\$ _____
	(c) <b>Extra withholding.</b> Enter any additional tax you want withheld each pay period . . . . .	<b>4(c)</b>	\$ _____

**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**

<b>Employers Only</b>	Employer's name and address	First date of employment	Employer identification number (EIN)



## General Instructions

### Future Developments

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

### Purpose of Form

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

**Exemption from withholding.** You may claim exemption from withholding for 2020 if you meet both of the following conditions: you had no federal income tax liability in 2019 **and** you expect to have no federal income tax liability in 2020. You had no federal income tax liability in 2019 if (1) your total tax on line 16 on your 2019 Form 1040 or 1040-SR is zero (or less than the sum of lines 18a, 18b, and 18c), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2020 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(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 16, 2021.

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

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

**When to use the estimator.** Consider using the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App) if you:

1. Expect to work only part of the year;
2. Have dividend or capital gain income, or are subject to additional taxes, such as the additional Medicare tax;
3. Have self-employment income (see below); or
4. Prefer the most accurate withholding for multiple job situations.

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

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

## Specific Instructions

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

**Step 2.** Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

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

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



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

**Step 3.** Step 3 of Form W-4 provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

### Step 4 (optional).

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

**Step 4(b).** Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2020 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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



If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on only ONE Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

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

- 1 Two jobs. If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, skip to line 3
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
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
c Add the amounts from lines 2a and 2b and enter the result on line 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.
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)

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



- 1 Enter an estimate of your 2020 itemized deductions (from Schedule A (Form 1040 or 1040-SR)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 7.5% of your income
2 Enter: { \$24,800 if you're married filing jointly or qualifying widow(er); \$18,650 if you're head of household; \$12,400 if you're single or married filing separately }
3 If line 1 is greater than line 2, subtract line 2 from line 1. If line 2 is greater than line 1, enter "-0-"
4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040 or 1040-SR)). See Pub. 505 for more information
5 Add lines 3 and 4. Enter the result here and in Step 4(b) of Form W-4

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 possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

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

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

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

**Married Filing Jointly or Qualifying Widow(er)**

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	\$220	\$850	\$900	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,210	\$1,870	\$1,870
\$10,000 - 19,999	220	1,220	1,900	2,100	2,220	2,220	2,220	2,220	2,410	3,410	4,070	4,070
\$20,000 - 29,999	850	1,900	2,730	2,930	3,050	3,050	3,050	3,240	4,240	5,240	5,900	5,900
\$30,000 - 39,999	900	2,100	2,930	3,130	3,250	3,250	3,440	4,440	5,440	6,440	7,100	7,100
\$40,000 - 49,999	1,020	2,220	3,050	3,250	3,370	3,570	4,570	5,570	6,570	7,570	8,220	8,220
\$50,000 - 59,999	1,020	2,220	3,050	3,250	3,570	4,570	5,570	6,570	7,570	8,570	9,220	9,220
\$60,000 - 69,999	1,020	2,220	3,050	3,440	4,570	5,570	6,570	7,570	8,570	9,570	10,220	10,220
\$70,000 - 79,999	1,020	2,220	3,240	4,440	5,570	6,570	7,570	8,570	9,570	10,570	11,220	11,240
\$80,000 - 99,999	1,060	3,260	5,090	6,290	7,420	8,420	9,420	10,420	11,420	12,420	13,260	13,460
\$100,000 - 149,999	1,870	4,070	5,900	7,100	8,220	9,320	10,520	11,720	12,920	14,120	14,980	15,180
\$150,000 - 239,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,190	16,050	16,250
\$240,000 - 259,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,520	17,170	18,170
\$260,000 - 279,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	13,120	15,120	17,120	18,770	19,770
\$280,000 - 299,999	2,040	4,440	6,470	7,870	9,190	10,720	12,720	14,720	16,720	18,720	20,370	21,370
\$300,000 - 319,999	2,040	4,440	6,470	8,200	10,320	12,320	14,320	16,320	18,320	20,320	21,970	22,970
\$320,000 - 364,999	2,720	5,920	8,750	10,950	13,070	15,070	17,070	19,070	21,290	23,590	25,540	26,840
\$365,000 - 524,999	2,970	6,470	9,600	12,100	14,530	16,830	19,130	21,430	23,730	26,030	27,980	29,280
\$525,000 and over	3,140	6,840	10,170	12,870	15,500	18,000	20,500	23,000	25,500	28,000	30,150	31,650

**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	\$460	\$940	\$1,020	\$1,020	\$1,470	\$1,870	\$1,870	\$1,870	\$1,870	\$2,040	\$2,040	\$2,040
\$10,000 - 19,999	940	1,530	1,610	2,060	3,060	3,460	3,460	3,460	3,640	3,830	3,830	3,830
\$20,000 - 29,999	1,020	1,610	2,130	3,130	4,130	4,540	4,540	4,720	4,920	5,110	5,110	5,110
\$30,000 - 39,999	1,020	2,060	3,130	4,130	5,130	5,540	5,720	5,920	6,120	6,310	6,310	6,310
\$40,000 - 59,999	1,870	3,460	4,540	5,540	6,690	7,290	7,490	7,690	7,890	8,080	8,080	8,080
\$60,000 - 79,999	1,870	3,460	4,690	5,890	7,090	7,690	7,890	8,090	8,290	8,480	9,260	10,060
\$80,000 - 99,999	2,020	3,810	5,090	6,290	7,490	8,090	8,290	8,490	9,470	10,460	11,260	12,060
\$100,000 - 124,999	2,040	3,830	5,110	6,310	7,510	8,430	9,430	10,430	11,430	12,420	13,520	14,620
\$125,000 - 149,999	2,040	3,830	5,110	7,030	9,030	10,430	11,430	12,580	13,880	15,170	16,270	17,370
\$150,000 - 174,999	2,360	4,950	7,030	9,030	11,030	12,730	14,030	15,330	16,630	17,920	19,020	20,120
\$175,000 - 199,999	2,720	5,310	7,540	9,840	12,140	13,840	15,140	16,440	17,740	19,030	20,130	21,230
\$200,000 - 249,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
\$250,000 - 399,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
\$400,000 - 449,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,450	19,940	21,240	22,540
\$450,000 and over	3,140	6,230	8,810	11,310	13,810	15,710	17,210	18,710	20,210	21,700	23,000	24,300

**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	\$830	\$930	\$1,020	\$1,020	\$1,020	\$1,480	\$1,870	\$1,870	\$1,930	\$2,040	\$2,040
\$10,000 - 19,999	830	1,920	2,130	2,220	2,220	2,680	3,680	4,070	4,130	4,330	4,440	4,440
\$20,000 - 29,999	930	2,130	2,350	2,430	2,900	3,900	4,900	5,340	5,540	5,740	5,850	5,850
\$30,000 - 39,999	1,020	2,220	2,430	2,980	3,980	4,980	6,040	6,630	6,830	7,030	7,140	7,140
\$40,000 - 59,999	1,020	2,530	3,750	4,830	5,860	7,060	8,260	8,850	9,050	9,250	9,360	9,360
\$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,780	10,980	11,180	11,580	12,380
\$80,000 - 99,999	1,900	4,300	5,710	7,000	8,200	9,400	10,600	11,180	11,670	12,670	13,580	14,380
\$100,000 - 124,999	2,040	4,440	5,850	7,140	8,340	9,540	11,360	12,750	13,750	14,750	15,770	16,870
\$125,000 - 149,999	2,040	4,440	5,850	7,360	9,360	11,360	13,360	14,750	16,010	17,310	18,520	19,620
\$150,000 - 174,999	2,040	5,060	7,280	9,360	11,360	13,480	15,780	17,460	18,760	20,060	21,270	22,370
\$175,000 - 199,999	2,720	5,920	8,130	10,480	12,780	15,080	17,380	19,070	20,370	21,670	22,880	23,980
\$200,000 - 249,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
\$250,000 - 349,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
\$350,000 - 449,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,900	25,200
\$450,000 and over	3,140	6,840	9,560	12,140	14,640	17,140	19,640	21,530	23,030	24,530	25,940	27,240



## DIFFICULTY OF CARE FEDERAL INCOME EXCLUSION

### Worker Information

First Name:  Last Name:  PPL ID:

### Participant Information

First Name:  Last Name:  PPL ID:

### Employer Information (complete this section even if the employer is the same as the participant)

First Name:  Last Name:

Some Employees may owe no taxes on their Self-Directed Services earnings. This is because they qualify for the Difficulty of Care Federal Income Exclusion. In that case, Public Partnerships will not report the payments as income and will not withhold applicable taxes. As a reminder, Public Partnerships LLC is not your Employer.

To determine if you qualify, read the following items below

For more information regarding the Difficulty of Care Federal Income Exclusion visit: <http://www.publicpartnerships.com>

### Part 1: Applying for Difficulty of Care Federal Income Exclusion

Select all that apply:

- I provide services to the Participant in my home.
- I do not have a separate home where I reside.
- This is the home where I reside and regularly perform the routines of private life, including shared meals and holidays with family.

#### ! IMPORTANT:

- If all the above apply, you are eligible for the Difficulty of Care Federal Income Exclusion.
- If both the state taxing authority and program rules follow federal guidelines for the difficulty of care exclusion, the exclusion would also be applicable at the state level.
- You understand that if you no longer reside with the participant, you will no longer qualify and must terminate the Difficulty of Care Federal Income Exclusion by completing Part 2 below.

If none of the above apply, select the option below.

- None of the above.

### Part 2: Terminating Difficulty of Care Federal Income Exclusion

Select if applies:

- I no longer reside with the participant that I provide services to.

### Authorization and Signature

Under penalty of perjury, I declare that I am the Worker, of the Participant/Employer, receiving payments under a state Medicaid, Home and Community-Based Services program, and that the information and responses provided on this form are accurate and complete.

Worker Signature:

Date:

## TAX EXEMPTIONS

### Worker Information

First Name:  Last Name:  PPL ID:

### Participant Information

First Name:  Last Name:  PPL ID:

### Employer Information (complete this section even if the employer is the same as the participant)

First Name:  Last Name:

The information below is used to determine the tax exemptions that may apply to you and the Employer, based on IRS regulations and applicable Federal/State tax laws. As a reminder, Public Partnerships LLC is not your Employer.

For more information regarding Tax Exemptions visit: <http://www.publicpartnerships.com>

Please complete Part 1 and Part 2.

### Part 1 (you must select one of the following statements based on your relationship to the Employer)

- I am the spouse of the employer.
- I am the parent of the employer (including legally adopted children).
- Select all that apply:**
- I also provide care for my grandchild or step-grandchild in my child's home.
- My grandchild or step-grandchild is under 18 or has a physical or mental condition that requires personal care of an adult for at least four weeks in a row during the calendar quarter in which services are performed.
- My child (son or daughter) is widowed, divorced, not remarried or living with a spouse who has a mental or physical condition so the spouse cannot care for my grandchild for at least four weeks in a row during the calendar quarter in which services are performed.
- I am the child of the employer (including legally adopted children).
- I am not the spouse, parent, or child of the employer.

### Part 2 (select all that apply)

- I am a full-time student.
- This job of performing household services (respite) is my primary occupation.
- I am a non-resident alien temporarily in the United States on an F-1, J-1, M-1 or Q-1 visa admitted to the US for providing domestic services.

**! IMPORTANT:** If your information changes you must report it.

### Authorization and Signature

By signing below, I, the Worker, confirm that I have read this Tax Exemptions form in its entirety and the information and responses I have provided on this form are accurate and complete. I understand that if employed, any false statement on this application may result in dismissal and other consequences. I further understand that this document is not meant to be a contract of employment or designation, nor does this document obligate the Participant/Employer in any way if the employer decides to employ me. I understand that employment is contingent on furnishing enough documentation to verify my right to work in the US.

Worker Signature:

Date: