

Please review and complete this application and other forms required for your employment – don't forget to include copies of any required trainings.

TYPE OF APPLICATION (*select one*):

☐ PERSONAL ASSISTANT ☐ COMMUNITY SPECIALIST

PROGRAM QUALIFICATIONS (*Responses to these three questions are REQUIRED.*)

1. Are you a spouse of, legal guardian for, or designated representative to the Individual?
☐ Yes ☐ No
2. Are you under 18 years old?
☐ Yes ☐ No
3. Is the Individual you are applying to provide service for a minor (under age 18) **AND** is he or she your child or step-child?
☐ Yes ☐ No

If you responded YES to any of the questions above, you do **NOT** qualify for employment.

| INDIVIDUAL INFORMATION | |
|-------------------------------|------------------------------|
| Individual First Name: | Individual Last Name: |

| EMPLOYEE INFORMATION | | |
|--|--------------------------------|---|
| Employee First Name: | Employee M.I.: | Employee Last Name: |
| Employees Maiden/Alias Name(s): | | |
| Date of Birth: | Social Security Number: | Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male |
| Relationship to Individual: <input type="checkbox"/> Parent / Step Parent <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandparent <i>(check one box only)</i> <input type="checkbox"/> Grandchild <input type="checkbox"/> Other Relative <input type="checkbox"/> Non-Relative | | |

| PHYSICAL ADDRESS | | |
|---|---------------|------------------|
| Physical Address (<i><u>no</u> P.O. Box</i>): | | |
| Physical Address 2 (<i>apt, number, etc.</i>): | | |
| City: | State: | Zip Code: |
| County: | | |

| | |
|-------------------------|-----------------------|
| INDIVIDUAL NAME: | EMPLOYEE NAME: |
| | |

| | | |
|---|--|-------------|
| MAILING ADDRESS (if different from Physical Address) | | |
| Mailing Address: | | |
| Mailing Address 2 (apt, number, etc.): | | |
| City: | State: | Zip: |
| CONTACT INFORMATION | | |
| Primary Phone Number: | Alternative Phone Number: | |
| E-mail Address (REQUIRED): | | |
| EMERGENCY CONTACT INFORMATION | | |
| Emergency Contact Name: | Emergency Contact Phone Number: | |

| | |
|---|--|
| AUTHORIZATION TO WITHHOLD CITY PAYROLL TAX | |
| Instructions: Check the box next to the statement that best describes where you live and your status regarding payroll tax liability for Kansas City or the city of St. Louis, Missouri. | |
| <input type="checkbox"/> | Outside Kansas City and the city of St. Louis I do not reside in Kansas City or the city of St. Louis, Missouri. My place of employment under the Self-Directed Supports Program is neither in Kansas City nor the city of St. Louis, Missouri. Therefore I am not subject to City Earnings Tax from these municipalities. |
| <input type="checkbox"/> | Kansas City I reside in, or my place of employment under the Self-Directed Supports Program is Kansas City, Missouri. I acknowledge that I am required to pay City Earnings Tax and authorize Public Partnerships, LLC to deduct the City Earnings Tax from my earnings and to pay the amount due to the city. |
| <input type="checkbox"/> | St. Louis I reside in, or my place of employment under the Self-Directed Supports Program is the city of St. Louis, Missouri. I acknowledge that I am required to pay City Earnings Tax and authorize Public Partnerships, LLC to deduct the City Earnings Tax from my earnings and to pay the amount due to the city. |
| IMPORTANT: It is the responsibility of the Employee to Notify Public Partnerships if their City Earnings Tax liability status changes. This will NOT be done automatically. | |

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|-------------------------|-----------------------|
| INDIVIDUAL NAME: | EMPLOYEE NAME: |
| | |

| PERSONAL ASSISTANT EMPLOYMENT REQUIREMENTS | | |
|---|--|--|
| Type of Personal Assistant (PA): <input type="checkbox"/> Regular PA <input type="checkbox"/> Medical PA | | |
| A Personal Assistant must meet one of the following education requirements: <input type="checkbox"/> High School Diploma* <input type="checkbox"/> GED* <input type="checkbox"/> Regional Office Exemption* | | |
| PRE-EMPLOYMENT TRAINING | | |
| <p>The Individual/Designated Representative may exempt the following requirements if the exemption is due to:</p> <p>[A] Duties of the PA named above will not require skills to be attained from this training requirement.</p> <p>[B] The PA named above has adequate knowledge or experience.</p> <p>To grant an exemption, the appropriate reason code must be marked in the exemption column and justification for the exemption and safeguards in place must be documented in the ISP.</p> | <p>Check if TRAINING IS REQUIRED</p> | <p>Check if TRAINING IS EXEMPT</p> <p>Select an EXEMPTION CODE</p> |
| American Red Cross, American Heart Association, or Division of DD approved competency based CPR Training* (Cannot be exempted for Medical PA) | <input type="checkbox"/> | <input type="checkbox"/> A <input type="checkbox"/> B |
| First Aid Training* (Cannot be exempted for Medical PA) | <input type="checkbox"/> | <input type="checkbox"/> A <input type="checkbox"/> B |
| Medication Administration Training* (Cannot be exempt for Medical PA if providing medication administration) | <input type="checkbox"/> | <input type="checkbox"/> A <input type="checkbox"/> B |
| Behavior Intervention Crisis Management Training: <input type="checkbox"/> Mandt* <input type="checkbox"/> NCI/CPI* <input type="checkbox"/> PCMA/SCM* (Cannot be exempted if physical intervention is needed) | <input type="checkbox"/> | <input type="checkbox"/> A <input type="checkbox"/> B |
| Behavior Intervention-Positive Behavior Supports Training: <input type="checkbox"/> "Tools of Choice"* <input type="checkbox"/> Columbus PBS* <input type="checkbox"/> College of Direct Support PBS* <input type="checkbox"/> Other training approved by RO QE dept. or Div. Chief Behavior Analyst* | <input type="checkbox"/> | <input type="checkbox"/> A <input type="checkbox"/> B |
| Abuse and Neglect Training* (Cannot be exempted) | | |
| *Proof of education and training or supporting documentation must be provided to Public Partnerships. All training and certifications must be kept current for the duration that the employee is employed. | | |

| COMMUNITY SPECIALIST EMPLOYMENT REQUIREMENTS |
|--|
| Are you a family member (parent, step parent, sibling, child by blood, adoption, or marriage, spouse, grandparent, or grandchild to the program Individual you are apply for? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| A Community Specialists must meet one of the following education and experience requirements: <input type="checkbox"/> Bachelor degree from an accredited university plus one year experience*; <input type="checkbox"/> Registered Nurse (with an active license in good standing, issued by the Missouri State Board of Nursing)*; <input type="checkbox"/> Associate degree from an accredited university or college plus three years of experience.*; |
| PRE-EMPLOYMENT TRAINING |
| Abuse and Neglect Training* (Cannot be exempted) |
| *Proof of degree/experience and training or supporting documentation must be provided to Public Partnerships. All training and certifications must be kept current for the duration that the employee is employed. |

| | |
|-------------------------|-----------------------|
| INDIVIDUAL NAME: | EMPLOYEE NAME: |
| | |

**APPLICATION FOR DIFFICULTY OF CARE
FEDERAL INCOME TAX EXCLUSION**

Certain payments received by an employee for providing Medicaid services in the Employer's home are considered Difficulty of Care payments excludable from federal income tax. To determine if you are eligible for the income exclusion, complete the following steps. If you are eligible, Public Partnerships will not report the payments as income and will not withhold federal income taxes.

STEP 1: Review information regarding the Difficulty of Care Federal Income Tax Exclusion. Information is available on Public Partnerships website at: <http://www.publicpartnerships.com>.

STEP 2: Check all that apply:

- ☐ **I provide services to the individual participant in my home.** *(Please note that in order to self-direct supports the individual must live in their own private residence or that of your family member.)*
- ☐ **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.**

STEP 3: If all of the above do not apply, you are not eligible for the Difficulty of Care Federal Income Tax Exclusion.

STEP 4: If all of the above apply, you are eligible for the Difficulty of Care Federal Income Tax Exclusion.

Under penalties of perjury, I declare that I am an individual care provider receiving payments under a state Medicaid Home and Community-Based Services program. I live in the home with, and I provide services to, the individual listed at the top of this form.

IMPORTANT: *If you no longer reside with the individual you provide services to, you must notify Public Partnerships and terminate your Difficulty of Care Federal Income Tax Exclusion.*

| | |
|-------------------------|-----------------------|
| INDIVIDUAL NAME: | EMPLOYEE NAME: |
| | |

| RELATIONSHIP QUESTIONNAIRE | |
|---|--|
| <i>This information is necessary, so that we can determine if you are eligible for tax withholding exemptions.</i> | |
| 1. Are you 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 the purpose of providing domestic services? <input type="checkbox"/> YES , that description fits my status. <input type="checkbox"/> NO , that description does not fit my status. | |
| 2. Are you the child of the employer (includes adopted children)? <input type="checkbox"/> YES , my employer is my parent (mother or father). <input type="checkbox"/> NO , my employer is not my parent. | |
| 3. Are you the spouse of the employer? <input type="checkbox"/> YES , my employer is my spouse (husband or wife). <input type="checkbox"/> NO , my employer is not my spouse. | |
| 4. Are you the parent of the employer (includes adopted children)? <input type="checkbox"/> YES , my employer is my child (son or daughter). <input type="checkbox"/> NO , my employer is not my child. | |
| 5. If you answered, “<u>YES</u>,” to Question 4, check any of the following that apply. If you answered, “<u>NO</u>,” proceed to Question 6. <input type="checkbox"/> YES , I also provide care for my grandchild or step-grandchild in my child’s home. <input type="checkbox"/> YES , 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 continuous weeks during the calendar quarter in which services are performed. <input type="checkbox"/> YES , my child (son or daughter) is widowed and divorced and not remarried, or living with a spouse who has a mental or physical condition which prohibits the spouse from caring for my grandchild for at least four continuous weeks during the calendar quarter in which services are performed. | |
| 6. Are you under the age of 18 or do you turn 18 this calendar year? <input type="checkbox"/> YES , I am under 18 or am turning 18 this calendar year. <input type="checkbox"/> NO , I am over 18. <i>If you answered, “<u>YES</u>,” to Question 6, answer the following question. If you answered, “<u>NO</u>,” skip the question below.</i> Is this job of performing household services (respite or nursing) your principal occupation? Note: Do not answer, “YES,” if you are a student. <input type="checkbox"/> YES , this is my principal occupation. <input type="checkbox"/> NO , this is not my principal occupation. | |

| INDIVIDUAL NAME: | EMPLOYEE NAME: |
|------------------|----------------|
| | |

| SERVICE AND RATE INFORMATION | | |
|---|--------------|-------------------|
| <i>This information is necessary in order to process your payments. Please check off ALL applicable services & enter rates for ALL applicable services.</i> | | |
| Service Name | Service Code | Employee Pay Rate |
| <input type="checkbox"/> Personal Assistant (PA) | T1019 U2 | \$ |
| <input type="checkbox"/> Medical PA | T1019 SCSE | \$ |
| <input type="checkbox"/> Team Collaboration PA | G9007 U2 | \$ |
| <input type="checkbox"/> Special PA | T1019 HW | \$ |
| <input type="checkbox"/> Community Specialist | T1016 U2 | \$ |

| PAYMENT INFORMATION | |
|---|--|
| <i>If a payment selection is not checked or the necessary information is not included or is incorrect, you will be enrolled and issued an ADP ALINE™ pay card.</i> | |
| <u>IMPORTANT REMINDERS:</u> It will take approximately one or two pay periods for direct deposit to become active or for you to receive your ADP debit card. Expect your payment to be sent as a paper check while your direct deposit or ADP debit card is being setup. Direct Deposit can be cancelled by calling customer service. If you are changing your bank account information or would like to establish a Direct Deposit account from a ADP Debit Card, a new form must be submitted. Failure to inform Public Partnerships of changes to your account may cause a delay in payment. | |
| Payment Type: (please check only one box) <input type="checkbox"/> Direct Deposit <input type="checkbox"/> Payroll Card | |
| DIRECT DEPOSIT: | |
| Account Type: (please check one box) <input type="checkbox"/> Checking Account <input type="checkbox"/> Savings Account <input type="checkbox"/> ADP ALINE™ Payroll Card | |
| ACCOUNT INFORMATION | |
| Banking Institution Name | |
| Routing Number | |
| Account Number | |
| Account Nickname (if desired) | |
| REMITTANCE ADVICE | |
| <input type="checkbox"/> I do not have access to the BetterOnline™ Web Portal, please send my paystub in the mail. | |

EMPLOYMENT TERMS AND CONDITIONS

The Employer/Designated Representative has elected to hire me to perform care services for the Individual Receiving Services (Individual) in accordance with the Missouri Department of Mental Health, Division of Developmental Disabilities (DMH-DD), Self-Directed Supports Program. I understand that PCG Public Partnerships, LLC (PPL) is the Fiscal Employer Agent (F/EA) who assists the employer with employer-related tasks and IS NOT my employer. The Federal Employer Identification Number (FEIN) holder is my employer. The employer may select a Designated Representative (DR) to be responsible for managing employees.

Enrollment - I have received an Employee Enrollment Packet that contains mandatory forms and information on trainings. I am responsible for understanding the information, and completing all documents.

Supervision - The Employer/DR is responsible for training, managing and supervising the Employee and controlling the Employee's workplace activities. The Employer/DR is solely responsible for the decisions to hire and retain or not retain Employee.

Training – Employee acknowledges that they must complete the pre and post-employment training requirements detailed in this application to be eligible for initial and on-going employment. Post-employment training must be completed within 30 days of employment. All training certifications must be remain current. Employees who do not to complete or maintain post-employment trainings and certifications will not be eligible for on-going employment.

- ✓ All employees must be trained annually on the Individuals new Support Plan (ISP).
- ✓ All employees must complete abuse and neglect training every two years.

Effective Date - Employment will be effective upon completion and review of the Employee Enrollment Packet and associated training modules. Your Employer/Designated Representative must receive a “Good to Go” notification before you begin work.

Age and Education Eligibility - Employee acknowledges that they meet the age and education eligibility requirements under the Self-Directed Supports Program:

- ✓ I am more than 18 years old and have a high school diploma or GED.
- ✓ If working as a Community Specialist, I have a bachelor's degree plus one year relevant experience, or I am licensed Registered Nurse, or I have an associate degree plus three years relevant experience.

Family as Caregiver Eligibility - Family is defined as a parent, step-parent, sibling, child by blood, adoption, or marriage, spouse, grandparent or grandchild. In order for a family member to be authorized as a paid caregiver, the following terms and conditions must be adhered to:

- ✓ No self-directed service may be provided by an Individual's spouse, Legal Guardian, Designated Representative or the Individual's parent if the Individual is a minor (under the age of 18).
- ✓ The Individual for whom the services are authorized must not be opposed to the family member providing the services.
- ✓ The Individual for whom the services are authorized has the right to make a change in selecting a paid personal assistant.
- ✓ The services to be provided are solely for the Individual and not household tasks expected to be shared with people living in the family unit.
- ✓ The planning team has determined the family member providing the service will best meet the Individual's needs.
- ✓ Only the hours of service determined necessary through the assessment and person-centered planning process may be authorized.

- ✓ A family member cannot be paid for more than 40 hours per week. Any support provided above this amount would be considered a natural or unpaid support that a family member would typically provide.
- ✓ A family member cannot be hired as a Support Broker or Community Specialist.

Other Conditions - The quality, appropriateness and timeliness of services reimbursed through this Agreement shall be subject to evaluation, thorough inspection or other means by the regional office of DMH-DD. The Support Coordinator shall monitor services on at least a quarterly basis. Other employment conditions include:

- ✓ Employees working more than 40 hours per week cannot be billed to the Medicaid Waiver program. Hours worked over 40 hours per week are the responsibility of the employer/Designated representative and must be paid through the FMS in order to ensure employer related taxes are withheld.
- ✓ Per the Medicaid Waiver program, Personal Assistant, services does not allow for payment of employees for sleep time. If an employer schedules an employee to work 24 hours or more, the employer and employee agree to exclude from hours worked up to 8 hours of sleep time if:
 - The employer furnishes sleep facilities
 - The employee can usually sleep uninterrupted

Acknowledgement - I acknowledge the following:

- ✓ I am an Employee of the Individual or their Guardian, and am not the Employee of PPL or the State of Missouri.
- ✓ I declare that I am an Employee receiving payments under a state Medicaid Home and Community-Based Services program.
- ✓ This Agreement does not guarantee the Employee a specific number of hours of work, nor does it limit the Employer from hiring other Employees under the Self-Directed Supports Program.
- ✓ This Agreement does not prohibit the Employee from working for more than one Individual under the Self-Directed Supports Program.
- ✓ Information shared with the Employee by the Employer/Designated Representative or the DMH-DD Regional Office and affiliated agencies regarding the Individual shall be confidential.
- ✓ I agree to carry out assigned duties and responsibilities explained by the Employer/Designated Representative, as outlined in the Individual Service Plan.
- ✓ I agree to fulfill and maintain all training requirements as outlined in this application.
- ✓ I understand I am expected to be dependable and report to work on time.
- ✓ I agree to call the Employer/Designated Representative with as much advance notice as possible if I am ill or unable to report to work on time.
- ✓ I agree to give the employer two weeks written notice if I decide to terminate this employment.
- ✓ The Employer/Designated Representative shall set the conditions of employment, and termination of employment shall be the prerogative of the Employer/Designated Representative.
- ✓ The Employer/Designated Representative will immediately dismiss the Employee if (1) they have been found to have been placed on an Employee Disqualification Registry or List maintained by either the Missouri Dept. of Health and Senior Services or the Missouri Dept. of Mental Health, (2) have committed abuse, neglect, or misuse of funds or property of an Individual receiving services, (3) have committed fraud or violated the terms of this Agreement, or (4) do not maintain annual training requirements.
- ✓ I understand I will be subject to an employee background screening through the Missouri Department of Health and Senior Services Family Care Safety Registry prior to employment and that the results of the background screening may be shared with the Missouri Department of Mental Health, Division of Developmental Disabilities (DMH-DD) and/or the Individual Receiving Services/Designated Representative with whom I work.

- ✓ I understand that I must report possible neglect, abuse or misuse of funds or property of an Individual to Individual's Service Coordinator immediately. Employee may also call the DMH-DD hotline at 1-800-364-9687.
- ✓ I understand that I not authorized to begin employment until the results of the background screening have been received and approved, I have completed all trainings, and my employer has received an "Good to Go" notification from PPL.
- ✓ I understand that I will be covered by workers' compensation insurance and unemployment insurance.
- ✓ I understand that PPL will pay me on behalf of the employer on a biweekly basis, following the submission of accurate and approved timesheets and service documentation.
- ✓ I understand that I must record daily service documentation that describe various covered activities in which the Individual participated and record situations or incidents (good or bad) that arise affecting the Individual.
- ✓ I understand that I may not bill Medicaid if the Individual becomes ineligible for Medicaid Services, (2) the Employee performs unauthorized tasks or works more hours than are approved on the Individual Service Plan, or (3) the Employee begins work prior to receiving notice of "Good-to-Go" from PPL.
- ✓ I understand that payment will be for normal services rendered as assigned by the Employer/DR and as outlined in the Individual Service Plan at the rate(s) described in this document.
- ✓ I understand that must notify PPL if/when my address or personal information changes or if I wish to change my payment and tax withholding preferences.

SIGNATURES

By signing below, I and my Employer attest that we have read and understand all program rules and responsibilities and certify that all the answers and information given herein are true and complete to the best of my knowledge. I understand I must sign and return this form as a condition of employment in this program, and that I cannot begin working until this form is completed and returned to PPL. 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 o may result in termination of this agreement and payment for employment to any Medicaid Recipient of this program.

EMPLOYER/DESIGNATED REPRESENTATIVE NAME:

EMPLOYER/DESIGNATED REPRESENTATIVE SIGNATURE:

DATE:

EMPLOYEE NAME:

EMPLOYEE SIGNATURE:

DATE:



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
FAMILY CARE SAFETY REGISTRY
WORKER REGISTRATION

FCSR USE ONLY

Register online at www.health.mo.gov/safety/fcsr OR mail this form, copy of Social Security card, and payment to Missouri Dept. of Health and Senior Services, Fee Receipts, PO Box 570, Jefferson City, MO 65102.

REGISTRATION TYPE (Check all that apply. Complete column on right only if Long Term Care/Personal Care selected from left.)

- ☐ Adoptive Parent
Agency Name: _____
- ☐ Child Care
- ☐ Foster Parent/Family Member of Foster Parent
County Office: _____
- ☐ Hospital
- ☐ Long Term Care/Personal Care (Please choose subcategory at right ▶.)
- ☐ Mental Health/Psychiatric Hospital
- ☐ Voluntary (Select voluntary if no other registration type applies.)

Long Term Care / Personal Care Subcategories
(Complete if LTC/PC selected at left.)

- ☐ Adult Day Care
- ☐ Assisted Living Facility
- ☐ Hospice
- ☐ Hospital LTAC/Swing Bed
- ☐ Mental Health – Residential Facility/ICF
- ☐ Nursing Facility/Skilled Nursing
- ☐ Personal Care – Home Health
- ☐ Personal Care – In-Home Services
- ☐ Personal Care – Consumer Directed
Services/Center for Independent Living
- ☐ Personal Care – HCY/PDW/DDD/Other

A one-time registration fee of **\$14.00** applies to all categories except Foster Parents. Foster Parents must list the Children's Division county office.

Register only once. If you believe you have already registered, check our website at www.health.mo.gov/safety/fcsr or call, toll free, 866-422-6872.

SOCIAL SECURITY NUMBER (Mail copy of card with form.)

— —

PERSONAL INFORMATION (Provide all names you have used, starting with most recent. Include legal names and nicknames.)

| | | | |
|-----------------------------|--|----------------------------|---|
| LAST NAME | FIRST NAME | MIDDLE NAME | SUFFIX (JR., SR., II, III) |
| MAIDEN NAME (IF APPLICABLE) | PRIOR NAMES USED (IF APPLICABLE, LIST FIRST AND LAST NAMES.) | DATE OF BIRTH (MM-DD-YYYY) | GENDER <input type="checkbox"/> M <input type="checkbox"/> F |

CONTACT INFORMATION

MAILING ADDRESS (ENTER YOUR STREET ADDRESS OR POST OFFICE BOX. THIS ADDRESS MUST BE DIFFERENT FROM EMPLOYER ADDRESS.)

| | | | |
|-----------|--------------------------|---|--------|
| CITY | STATE | ZIP CODE | COUNTY |
| TELEPHONE | EMAIL ADDRESS (REQUIRED) | COUNTRY (COMPLETE ONLY IF OUTSIDE U.S.) | |

EMPLOYER ASSOCIATED WITH THIS REGISTRATION (Complete either left or right column, not both.)

| | | | |
|---|---|-----------------------|------------------------|
| <input type="checkbox"/> My current/potential child care, long term care or mental health care employer is: | <input type="checkbox"/> No Employer, because I am a(n): | | |
| EMPLOYER NAME | <input type="checkbox"/> Adoptive Parent <input type="checkbox"/> Foster Parent/Family Member <input type="checkbox"/> Home Child Care Provider <input type="checkbox"/> Private Pay/Private Duty <input type="checkbox"/> Student <input type="checkbox"/> Volunteer <input type="checkbox"/> Other (Explain: _____) | | |
| EMPLOYER ADDRESS | | | |
| EMPLOYER CITY | | STATE | ZIP |
| EMPLOYER TELEPHONE | | EMPLOYER CONTACT NAME | EMPLOYER CONTACT TITLE |

REGISTRATION AGREEMENT

The information provided is complete and accurate to the best of my knowledge. I understand it is unlawful to withhold or falsify information required on this form. I grant my permission for the Missouri Department of Health and Senior Services (DHSS) to obtain any and all background information authorized by law to process this request. Furthermore, I authorize the DHSS to release the fact that I am a registrant in the Family Care Safety Registry (FCSR) and any related background information to the requester of the FCSR for employment purposes only, as provided in §210.921, subsection 1, subdivisions (1) and (2), RSMo. For purposes of the FCSR, "employment purposes" includes direct employer/employee relationships, prospective employer/employee relationships, and screening and interviewing of persons or facilities by those persons contemplating the placement of an individual in a child care, elder care or personal care setting. I understand that if I dispute the information contained in the FCSR I have the right to appeal the accuracy of the transfer of information to the FCSR within thirty (30) days of receiving the results of the background screening.

NOTICE: The FCSR may choose to deposit the check enclosed electronically as an ACH debit entry to my designated bank account. I understand that my signature below authorizes my financial institution to deduct this payment from my account. In the event that DHSS or its subcontractor is unable to secure funds from my account or I provide insufficient or inaccurate information regarding my account, my obligation to the DHSS will remain unpaid and further collection action may be taken by the DHSS or its subcontractor, including, but not limited to, returned check fees.

| | |
|------------------------|--|
| SIGNATURE OF APPLICANT | DATE OF SIGNATURE (MUST BE WITHIN SIX MONTHS OF SUBMISSION.) |
|------------------------|--|

WHAT IS THE FAMILY CARE SAFETY REGISTRY?

The Family Care Safety Registry (FCSR), administered by the Missouri Department of Health and Senior Services (DHSS), provides families and employers with a method to obtain background screening information. The Registry, through various state agencies, offers several resources to screen child care, long term care and mental health workers:

- State criminal history and sex offender registry records maintained by the Missouri State Highway Patrol
- Child abuse/neglect records maintained by the Missouri Department of Social Services
- The Employee Disqualification List maintained by the Missouri Department of Health and Senior Services
- The Employee Disqualification Registry maintained by the Missouri Department of Mental Health
- Child care facility licensing records maintained by the Missouri Department of Health and Senior Services
- Foster parent records maintained by the Missouri Department of Social Services

WHO HAS TO REGISTER?

Any person hired on or after January 1, 2001, as a child care worker or elder care worker, hired on or after January 1, 2002, as a personal care worker, or hired on or after January 1, 2009, as a mental health worker, as provided in §210.906, RSMo, is required to make application for registration in the Family Care Safety Registry within fifteen (15) days of the beginning of employment. Such person who fails to submit a completed registration form to the DHSS without good cause, as determined by the department, is guilty of a class B misdemeanor. Employees and volunteers from non-state and/or federally regulated entities are NOT REQUIRED to register with the FCSR.

HOW DO I COMPLETE THE REGISTRATION FORM?

Registration Type – Check at least one box from the left column for type of registration that best describes your worker category. If no other type applies, select “Voluntary.” (A “voluntary registrant” is a person who is not mandated to register with the Family Care Safety Registry pursuant to §210.900 et seq., RSMo.) If you checked Long Term Care / Personal Care, please also make one or more selections from the column on the right for subcategory.

Social Security Number – You must provide your Social Security number pursuant to 19CSR 30-80.030(1). This identifying information, including Social Security number, will be used for internal identification purposes and to conduct background screenings for the resource information listed in paragraph one above.

Personal Information – List your current Last Name, First Name, Middle Name, and any suffix associated with your last name. List any other names by which you may have been known, including maiden names, past married names, and nicknames (attach additional sheets if needed). For identification purposes, list your gender and date of birth.

Contact Information – List your address, city, state, ZIP code, and county. Include your telephone number and email address. We will use this information to notify you of registration results and any background screenings conducted. Email notifications will be encrypted for improved security. To reduce postage costs, the Registry may contact you to request a personal email address if one is not provided.

Employer Associated with this Registration - If you are currently employed by or are seeking employment with a child care or long term care provider, please list the facility name, address, telephone number, and contact person. If registration is not for employment purposes, make a selection from column on right. The employer entered in this section will not receive a copy of the registration notification. **Employers eligible to use the Registry for caregiver screenings must make a separate request for your background information.**

Registration Agreement – Sign and date the registration form. Your signature will authorize the Family Care Safety Registry to conduct the background screening outlined in §210.903.2, RSMo and to provide the information to requesters for employment purposes, as provided in §210.921.1, RSMo.

WHERE DO I SEND MY REGISTRATION FORM?

Send your completed registration form and photocopy of Social Security card and required fee to the **Missouri Department of Health and Senior Services, ATTN: Fee Receipts, P.O. Box 570, Jefferson City, MO 65102**. If you have questions, please call the Registry using the toll-free telephone number, **866-422-6872**.

WHEN WILL I KNOW THE RESULTS OF MY BACKGROUND SCREENING?

After the background screening has been completed, you will be notified in writing of the results that will be recorded in the Family Care Safety Registry. You will also be notified in writing each time background screening information is provided. The notification will contain the name and address of the person who made the request and the background information disclosed. The person making the request will be informed that information will be released for employment purposes only, pursuant to §210.921.1, RSMo. Any person using Registry information for any other purpose is guilty of a class B misdemeanor. In addition, state agencies can request information for licensure or regulatory purposes. Prior to disclosing information, the Registry obtains the name and address of the requester, and determines that the request is for employment or regulatory purposes. To ensure you receive these notifications, it will be important for you to notify the Family Care Safety Registry when you have a change in your contact information. Notify the Family Care Safety Registry of changes in personal or contact information using the toll-free telephone number, 866-422-6872, by email to fcsr@health.mo.gov, or by mail to FCSR, PO Box 570, Jefferson City, MO 65102.

WHAT IF I DON'T AGREE WITH THE RESULTS OF MY BACKGROUND SCREENING?

As provided in §210.912, RSMo, you have the right to appeal the information transferred to the Family Care Safety Registry. Your right to appeal is limited to the accuracy of the transfer of information from the state agency that maintains the background information and does not include a right to appeal the accuracy of the substance of the information transferred. An appeal must be filed in writing to the Office of the Director, Missouri Department of Health and Senior Services, P.O. Box 570, Jefferson City, MO, 65102, within 30 days of receiving the results of the background screening determination. An administrative appeal shall be set within 30 days of the filing of the appeal and a decision shall be made within 60 days. This right to appeal is in addition to any other appeal rights granted by state law.

WHAT INFORMATION WILL BE DISCLOSED BY THE FAMILY CARE SAFETY REGISTRY?

Disclosure of background information on a person registered in the Family Care Safety Registry will be limited. If the person is registered, the Registry worker will disclose whether the person's name is listed in any of the background checks pursuant to §210.903, subsection 2, RSMo, and if so, which one(s). Specific information will be disclosed by the Registry pursuant to §210.921, subsection 1, subdivision (2).

To complete the Employment Eligibility Verification form correctly, please follow the checklist below.

Section 1: Employee

- ☐ Enter your full legal name and any other names you have used (maiden names, birth names, etc.)
- ☐ Enter your home Address, Apt. Number, City or Town, State and Zip Code.
 - P.O. Box **Not** Acceptable
- ☐ Enter your Date of Birth, Social Security Number, E-mail Address and Telephone Number
 - E-mail address is optional
- ☐ Attest to your citizenship or immigration status by checking the appropriate box
- ☐ Sign your name
- ☐ Date the form
 - Date is date of signature

Section 2: Employer (or Designated Representative)

- ☐ Enter the employee's name at the top of section 2
- ☐ Enter the document title(s), issuing authority, document number, and the expiration date from the original documents. Copies of these documents must be sent to Public Partnerships.
 - Expired documents are not acceptable
 - **If using List A documents, List B and C are not required**
 - **If using List B documents, must also supply List C documents**
 - **List A** Acceptable Documents:
 - U.S. Passport or Passport Card
 - **List B** Acceptable Documents: (If using List B documents, must also supply List C documents)
 - Driver's License
 - Military Issued ID
 - School ID card with a photograph
 - Voter's Registration Card
 - **List C** Acceptable Documents:
 - Social Security Card
 - Birth Certificate
 - U.S. Citizen ID Card
- ☐ Enter the first day of employment (date completing form) in the space for "The employee's first day of employment (mm/dd/yyyy)"
 - While the first day of employment will not occur until the employee is given the "Good to Go" this date needs to be entered to have this form be completed. This date will indicate the date of the beginning of the employment process.
- ☐ Employer signs and dates to attest to examining the documents provided
- ☐ Enter Title of Employer or Authorized Representative
 - Depending on role of signature enter: "Employer" or "Designated Representative"
- ☐ Enter Last Name and First Name of Employer
- ☐ Enter Employer's Business or Organization Name
 - Enter "Household Employer"
- ☐ Enter the Employer (or Individual's, if Designated Representative is signing) Address

Remember to include copies of the employees List A, B, and/or C documents when sending in the application to Public Partnerships



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 (Family Name) | | First Name (Given Name) | | Middle Initial | Other Last Names Used (if any) | |
| Address (Street Number and Name) | | | Apt. Number | City or Town | | State ZIP Code |
| Date of Birth (mm/dd/yyyy) | 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> | |
| <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> | |
| 1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____ | |
| QR Code - Section 1 Do Not Write In This Space | |

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

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



Employer Completes Next Page





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.")

| | | | | |
|--|-------------------------|--|------------|---|
| Employee Info from Section 1 | Last Name (Family Name) | First Name (Given Name) | M.I. | Citizenship/Immigration Status |
| 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 | | <div>Additional Information</div> <div>QR Code - Sections 2 & 3 Do Not Write In This Space</div> | | |
| Issuing Authority | | | | |
| Document Number | | | | |
| Expiration Date (if any) (mm/dd/yyyy) | | | | |
| Document Title | | | | |
| 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.)

| | | | | |
|------------------------------------|--|-------------------------|--|-------------------|
| A. New Name (if applicable) | | | B. Date of Rehire (if applicable) | |
| 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 |
|--|---------------------------|---|

LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

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

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

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

Refer to the instructions for more information about acceptable receipts.

Employee's Withholding Certificate**2020**

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

**Step 1:
Enter
Personal
Information**

| | | |
|---|-----------|--|
| (a) First name and middle initial | 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) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly (or Qualifying widow(er)) <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.) | | |

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

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

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

Do **only one** of the following.

- (a) Use the estimator at www.irs.gov/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.)

**Step 3:
Claim
Dependents**

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

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

Multiply the number of other dependents by \$500 ▶ \$ _____

Add the amounts above and enter the total here **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

Future Developments

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

Purpose of Form

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

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

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

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

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

Specific Instructions

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

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

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

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



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

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

Step 4 (optional).

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

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

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

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

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

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

- 1 Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 **1** \$ _____
- 2 Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.
 - a** Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a **2a** \$ _____
 - b** Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b **2b** \$ _____
 - c** Add the amounts from lines 2a and 2b and enter the result on line 2c **2c** \$ _____
- 3** Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3** _____
- 4 Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) **4** \$ _____

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

- 1** Enter an estimate of your 2020 itemized deductions (from Schedule A (Form 1040 or 1040-SR)). Such deductions may include qualifying 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: $\left\{ \begin{array}{l} \bullet \$24,800 \text{ if you're married filing jointly or qualifying widow(er)} \\ \bullet \$18,650 \text{ if you're head of household} \\ \bullet \$12,400 \text{ if you're single or married filing separately} \end{array} \right\}$ **2** \$ _____
- 3** If line 1 is greater than line 2, subtract line 2 from line 1. If line 2 is greater than line 1, enter "-0-" . . . **3** \$ _____
- 4** Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040 or 1040-SR)). See Pub. 505 for more information . . . **4** \$ _____
- 5 Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 **5** \$ _____

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(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 |



Missouri Department of Revenue
Employee's Withholding Certificate

This certificate is for income tax withholding and child support enforcement purposes only. Type or print.

| | | | | |
|--|--|--|------------------------|----------------|
| Employee | Full Name | | Social Security Number | |
| | Home Address (Number and Street or Rural Route) | | City or Town | State ZIP Code |
| | 1. Filing Status: Check the appropriate filing status below. <input type="checkbox"/> Single or Married Spouse Works or Married Filing Separate <input type="checkbox"/> Married (Spouse does not work) <input type="checkbox"/> Head of Household | | | |
| | 2. Additional withholding: If you expect to have a balance due (as a result of interest income, dividends, income from a part-time job, etc.) on your tax return, you may request your employer to withhold an additional amount of tax from each pay period. To calculate the amount needed, divide the amount of the expected tax by the number of pay periods in a year. Enter the additional amount to be withheld each pay period on line 2. 2 | | | |
| 3. Reduced withholding: If you expect to receive a refund (as a result of itemized deductions, modifications or tax credits) on your tax return, you may direct your employer to only withhold the amount indicated on line 3. Your employer will not use the standard calculations for withholding. If you designate an amount that is too low, it could result in you being under withheld. To calculate the amount needed, divide the amount of your expected tax by the number of pay periods in a year. Enter the amount to be withheld instead of the standard calculation. If no amount is indicated on line 3, the standard calculations will be used.. 3 | | | | |
| 4. Exempt Status: Select the appropriate reason you are claiming an exemption from withholding below and indicate EXEMPT on line 4. 4 | | | | |
| <input type="checkbox"/> I am exempt because I had a right to a refund of all Missouri income tax withheld last year and expect to have no tax liability this year. A new MO W-4 must be completed annually if you wish to continue the exemption. | | | | |
| <input type="checkbox"/> I am exempt because I meet the conditions set forth under the Servicemember Civil Relief Act, as amended by the Military Spouses Residency Relief Act and have no Missouri tax liability. | | | | |
| <input type="checkbox"/> I am exempt because my income is earned as a member of any active duty component of the Armed Forces of the United States and I am eligible for the military income deduction. | | | | |

| | | |
|------------------|--|-------------------------------------|
| Signature | Under penalties of perjury, I certify that the information provided on this form is true and accurate. | |
| | Employee's Signature (Form is not valid unless you sign it) | Date (MM/DD/YYYY) ____/____/____ |

| | | | | |
|-----------------|--|--|--|--|
| Employer | Employer's Name | | Employer's Address | |
| | City | State | ZIP Code | |
| | Date Services for Pay First Performed by Employee (MM/DD/YYYY) ____/____/____ | Federal Employer I.D. Number _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ | Missouri Tax Identification Number _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ | |

Notice To Employer:

Within 20 days of hiring a new employee, send a copy of Form MO W-4 to the Missouri Department of Revenue, P.O. Box 3340, Jefferson City, MO 65105-3340 or fax to (573) 526-8079.

Please visit <http://dss.mo.gov/child-support/employers/new-hire-reporting.htm> for additional information regarding new hire reporting.

Employee Information

Visit our online withholding calculator <https://mytax.mo.gov/rptp/portal/home/withholding-calculator>.

Items to Remember:

- Employees must complete a new form if their filing status changes or to adjust the amount of withholding.
- If you are claiming an "Exempt" status due to the Military Spouses Residency Relief Act you must provide one of the following to your employer: Leave and Earnings Statement of the non-resident military servicemember, Form W-2 issued to the nonresident military servicemember, a military identification card, or specific military orders received by the servicemember. You must also provide verification of residency such as a copy of your state income tax return filed in your state of residence, a property tax receipt from the state of residence, a current drivers license, vehicle registration or voter ID card.
- Additional information can be found at <https://dor.mo.gov/business/>.

Mail to: Taxation Division
P.O. Box 3340
Jefferson City, MO 65105-3340

Phone: (573) 751-8750
Fax: (573) 526-8079



Missouri Department of Revenue
**Certificate of Nonresidence or
Allocation of Withholding Tax**

This form is to be completed by a nonresident who performs a determinable percentage of services within Missouri.

Employer: For information on how this allocation may be determined, please refer to the website listed below.

Employee: This form is to be filed with your employer. Do not send it to the Department of Revenue.

| | | | | | | |
|-----------------|------------------|------|------------------------|----------|--|--|
| Employee | Name of Employee | | Social Security Number | | | |
| | | | | | | |
| | Street Address | City | State | ZIP Code | | |
| | | | | | | |

I estimate the proportion of services performed within Missouri and subject to the withholding tax to be _____%.

I will notify my employer within 10 days of any substantial change in proportion, or a change in status to resident of Missouri.

| | | |
|------------------|--|-------------------------------------|
| Signature | Under penalties of perjury, I declare that the above information and any attached supplement is true, complete, and correct. I also declare that I am a nonresident of the State of Missouri, and reside at the address stated above and perform services partly within and partly without Missouri. | |
| | Signature | Title |
| | Printed Name | Date (MM/DD/YYYY) ____/____/____ |

Taxation Division
P.O. Box 999
Jefferson City, MO 65108-0999

Phone: (573) 751-8750
TTY: (800) 735-2966
Fax: (573) 522-6816
E-mail: withholding@dor.mo.gov

Visit <http://www.dor.mo.gov/business/withhold>
for additional information.

Form MO W-4A (Revised 11-2013)



All employees must complete additional trainings within 30 days of employment. Resources needed to complete these trainings will be made available through your employer. Once you complete the trainings you and your employer must fill out and submit this form to PCG Public Partnerships (PPL). Employees who do not complete the Missouri Department of Mental Health, Division of Developmental Disabilities training requirements listed below within 30 days will not be eligible for on-going employment.

| EMPLOYEE INFORMATION | |
|-----------------------|---------------------|
| Employee Name: | Employee ID: |

| INDIVIDUAL INFORMATION | |
|-------------------------|-----------------------|
| Individual Name: | Individual ID: |

All employees must have training in the following areas:

I acknowledged I have reviewed the Employee Handbook www.publicpartnerships.com with provides information on:

- ✓ Procedures and expectations related to the waiver service requirements;
- ✓ Procedures for reporting an employee injury;
- ✓ Rights and responsibilities of the employee and the individual to be served;
- ✓ Procedures for billing and payment;
- ✓ Service Documentation;
- ✓ Respecting the served individuals confidentiality;
- ✓ Procedures for arranging backup when needed;
- ✓ Who to contact within the Regional Office in- case of an emergency or unusual event.

I acknowledged I have reviewed the **Individual Service Plan (ISP)** with provides information on:

- ✓ Information about the specific condition and needs of the individual to be served, including his or her physical, psychological or behavioral challenges, his or her capabilities, and his or her support needs and preferences relate to that support. Also includes training on following the ISP.
- ✓ Training in communication skills, in understanding and respecting the individual's choice and direction, cultural and ethnic diversity, personal property and familial and social relationships and in handling conflict and complaints.
- ✓ Training in assisting with activities of daily living, as needed by the individual and identified by the planning team.

SIGNATURES

| | |
|---|-------------|
| EMPLOYER/DESIGNATED REPRESENTATIVE SIGNATURE | DATE |
|---|-------------|

| | |
|---------------------------|-------------|
| EMPLOYEE SIGNATURE | DATE |
|---------------------------|-------------|

By signing above the employer/designated representative and employee certify that the Missouri Department of Mental Health, Division of Developmental Disabilities additional trainings were completed within 30 days of employment. Employees who fail to complete the additional trainings within 30days will not be eligible for on-going employment.