Helpers, Inc.

CAREGIVER / WORKER EMPLOYMENT FORMS

Helpers, Inc., is an FMS Agency that serves as a payroll agent for Recipients on a Medicaid waiver in the State of Kansas. The Recipient you work with is your employer and makes all employment decisions including, but not limited to hiring, training, scheduling, managing, establishing the pay rate, and termination. **Helpers, Inc. is NOT your employer.**

In order to provide supports to a Recipient under the Medicaid Waiver Program, you must complete and submit the following employment forms and supply the following documents. COPIES OF THE FOLLOWING ID's MUST BE PROVIDED BEFORE WE CAN PROCESS YOUR PAPERWORK.

- **Driver's License**
- **Social Security Card or Birth Certificate or Passport, or other accepted I-9 documents**
- **Voided Check or Supporting Bank Documents as stated on the Payment Enrollment Form**

If you are working for someone on the TA Waiver, attach a copy of your high school or college diploma or official transcripts.

Full Legal Name _____
(First) (Middle Initial) (Last)

_____
Current Address Apt # City, State, Zip

_____
Permanent Address (if different from current address) City, State, Zip

_____ _____ _____
Email Cell Phone Alternate Phone

_____-_____-_____ _____
Social Security Number Date of Birth

_____
Name of Medicaid Recipient you will be working for

Are you at least 18 years old? _____Yes _____ No
**If you are working with someone on the IDD waiver, and are not a sibling, the minimum age is 16 yrs.old*

Do you have a high school diploma or GED? _____Yes _____ No
**This is a requirement to work for someone on the TA waiver and we must have a copy on file.*

Are you a licensed nurse? If yes, complete section below. _____Yes _____ No

*Kansas Nurse License Number_____ Date of Issue and Expiration: _____
*Legal and/or disciplinary action if any: _____

I hereby certify that the preceding information, and the information supplied in these forms is true, correct, and complete to the best of my knowledge. I understand that false or misleading information or material omissions on these forms may disqualify me from further consideration for employment or be grounds for immediate termination by the Recipient.

I authorize a thorough investigation of all information provided. Including, but not limited to, my prior employment, conviction history, references, and educational background. I understand that thorough background checks will be completed and must be clear of prohibited offenses in order to be a paid caregiver.

In the event of a workplace injury, I will provide notice to my employer as soon as I am able. If your employer has elected to carry workers compensation coverage, they should notify Helpers, Inc. within 3 business days of the accident. I understand that the Kansas Statue (K.S.A. 44-520) states my claim could be denied if I fail to provide notice by the earliest of the three following options:

- 30 calendar days from the date of the accident or the date of the injury by repetitive trauma
- 20 calendar days from the state medical treatment is sought for the injury
- 20 calendar days from my last day of work if I no longer work for this employer

I acknowledge that I have received the Helpers, Inc. Authenticare Timekeeping Policies and Instructions attached.

Also, I hereby release from liability and responsibility all persons or corporations requesting or supplying such information. I understand that if I am offered employment, my employment relationship with the Recipient will be at will and that either the Recipient or I may terminate the relationship at any time for any reason. I also understand that Helpers, Inc. is not my employer.

Worker Signature: **Date:**

When this complete packet is received, including supporting documents, and backgrounds checks are completed, you will receive an email notification with your Worker ID number and instructions for clocking in from Helpers, Inc.

****YOU CANNOT BEGIN WORKING UNTIL YOU RECEIVE YOUR ID NUMBER FROM US****
We will NOT back pay for time worked before your worker ID is released.

CAREGIVER DATA SHEET

Name of Worker: _____ Date of Birth: _____

Name of the Medicaid Recipient you work for: _____

What is your Relationship to the Medicaid Waiver Recipient: (Please select ONE)

- ☐ I am the Parent and Legal Guardian of the Recipient
- ☐ I am the Parent and Durable Power of Attorney (DPOA) of the Recipient
- ☐ I am the Parent, but NOT the Legal Guardian or DPOA of the Recipient
- ☐ I am the Legal Guardian of the Recipient but NOT Parent
- ☐ I am the DPOA of the Recipient but NOT Parent
- ☐ I am the Adoptive Parent of the Recipient
- ☐ I am the Step-Parent of the Recipient
- ☐ I am the Spouse of the Recipient
- ☐ I am the Ex-Spouse of the Recipient
- ☐ I am the Grandparent of the Recipient
- ☐ I am the Sibling of the Recipient
- ☐ I am the Child of the Recipient
- ☐ I am an Other family member of the Recipient: _____
- ☐ I have NO family relation to the Recipient

Disclosure of Physical Dwelling: (Please select ONE)

- ☐ I live in the same physical dwelling as the Recipient
- ☐ I do NOT live in the same physical dwelling as the Recipient

If you are the Legal Guardian, or DPOA, of the Recipient you are working for, you must designate a representative to direct these services, or get a court order that mitigates the conflict of interest. If this applies to you, please submit a copy of the state's Designated Representative form or a copy of the court order that mitigates conflict of interest.

Medicaid has strict policies regarding workers and their relationship and living situation to the Medicaid Waiver Recipient. If the worker's living situation or relationship status ever changes, it is your duty to notify Helpers, Inc.!

VERIFICATION OF TRAINING

The State of Kansas requires that all Workers receive training by the Medicaid Waiver Recipient, or their Guardian, to meet the Recipient's needs. By signing this form, I certify training has been provided to the Worker to meet the needs of the Recipient.

_____

Worker Signature Date

_____

Signature of Recipient/Guardian or Designated Rep Date

If the Caregiver is the Parent or Legal Guardian - the Designated Rep or someone else must sign and verify this form.

Helpers, Inc.

WORKER FMS AGREEMENT

BETWEEN THE WORKER AND HELPERS, INC.

UPDATED JANUARY 2019

WORKER:_____

This agreement is between Helpers, Inc., a Financial Management Service (FMS) Provider, and the Worker. The parties agree as follows:

Nature of Employment: The Recipient receives self-directed services under the Kansas Medicaid Waiver program, administered by the Kansas Department of Aging and Disabilities Services (KDADS) and contracts with Helpers, Inc. for FMS services. **The Recipient is the employer, not Helpers, Inc.**

- All positions with the Recipient are considered at-will and you may be dismissed at any time with or without cause by the Recipient (your employer).
- The Recipient is responsible for all employment decisions, including hiring, wage negotiations, training, scheduling, managing, and termination.
- If a Worker provides services for multiple Recipients, each Recipient served shall constitute a separate and independent instance of employment with the Recipient.
- In the event that the medical or developmental needs of the Recipient change resulting in changes to the funding received by Recipient and/or the required skills, tasks, scheduled hours or duration of employment of Worker, it is the responsibility of the Worker to become qualified to provide necessary services.
- The Worker or the Recipient may terminate the employment relationship at any time, without cause.

Integrated Service Plan (ISP): The Worker agrees to strictly comply with the Recipient's ISP and any and all other applicable Medicaid waiver program requirements and restrictions.

Policies and Procedures: The Worker agrees to strictly comply with any instructions, rules or policies maintained by the Recipient or Designated Representative/Guardian and Helpers, Inc. with regard to the Worker's billing and payment for services rendered.

- The Worker agrees to act within the guidelines of all Federal and State rules, including Department of Labor rules, with regards to employment.
- The Worker shall respect the privacy, personal boundaries and belongings of the Recipient or Designated Representative/Guardian.
- The Recipient or Designated Representative/Guardian is responsible for determining the work schedule.
- Worker shall comply with all instructions and complete all tasks during scheduled work hours, whether daily or ongoing, given by the Recipient or Designated Representative/Guardian, including but not limited to assistance with activities of daily living and instrumental activities of daily living. Any questions Worker may have regarding the nature or scope of such tasks shall be addressed to the Recipient or Designated Representative/Guardian.
- The Recipient or Designated Representative/Guardian will make all final decisions regarding hiring and termination of the Worker.

Payment for Services Rendered: Worker shall strictly comply with all rules, regulations and/or policies (State of Federal), including those maintained by Ks AuthentiCare®, regarding logging of units/hours of services provided on a daily basis in order to receive payment for services rendered. If the Worker fails to clock in and/or out using Ks AuthentiCare®, they understand that they will not be paid for time worked. Failure to provide accurate and truthful data regarding services rendered may result in termination by the Recipient and referral to State and/or Federal authorities for Medicaid Fraud, criminal prosecution or the like. Worker will not be paid overtime by the FMS provider through Ks AuthentiCare® reimbursement and shall hold harmless and indemnify the FMS provider, Helpers, Inc., from any claim for overtime pay arising under the Fair Labor Standards Act, 29 U.S.C. 201 *et seq.* and/or the Application of the Fair Labor Standards Act to Domestic Service; Final Rule, 78 FR 60454. Recipient is solely responsible for paying any

additional compensation, including overtime compensation which may become due for hours worked in excess of 40 hours in a week, or in excess of hours approved on the ISP or outside the waiver restriction limits.

Time submitted through Ks AuthentiCare® for the 1st through the 15th of a month will be paid on the 5th of the following month. Time submitted through Ks AuthentiCare® for the 16th through the end of the month will be paid on the 20th of the following month. **All hours submitted must not exceed the approved ISP or waiver limits for the Recipient. Hours submitted that exceed the hours allotted on the Recipient's ISP or beyond waiver limits are not billable to Medicaid and therefore Helpers. Inc. cannot pay a Worker for those hours.** Helpers, Inc. will withhold all appropriate taxes, as applicable, and generate a W-2 for Worker at the end of the year.

Legal Compliance: Worker further agrees to strictly comply with any and all Federal and Kansas statutes, regulations or policies relating or pertaining to services provided to Medicaid Waiver program Recipients and for payment for such services.

- KDADS requires that all workers have a clear background check prior to their first day of employment. Helpers, Inc. will incur the cost of the first set of required background checks. Subsequent required background checks will be at the expense of the worker and will be deducted from the worker's paycheck.
- Services must be reported accurately through Ks AuthentiCare®. False reporting of hours worked is prohibited and will be reported to the Medicaid fraud hotline. Worker will not be paid for fraudulent time worked.
- Worker shall maintain confidentiality of the Recipient in full compliance with HIPAA standards. The Worker understands and agrees that any medical information shared regarding the Recipient is strictly confidential and is to be used solely for the care and benefit of the Recipient and shall not be discussed or utilized in any other manner.
- Worker shall immediately (within 24 hours) report suspected abuse, neglect, or exploitation of client to KDADS or other appropriate reporting authority. The Kansas Protection Report Center 24-hour hotline is 1-800-922-5330.
- Worker shall immediately report any suspected Medicaid fraud to the Medicaid fraud hotline. Examples of Medicaid fraud include; calling in time when not working, calling in time using someone else's ID, doing tasks not authorized by the ISP, or knowingly submitting false information, such as, employment documents. To report Medicaid fraud, call 1-866-551-6328.
- If Worker commits fraud, the Worker will be responsible to pay Helpers, Inc. back for any funds paid to the Worker.

Cooperation: Worker further agrees to cooperate with the Recipient's Targeted Case Manager, Care Coordinator, Helpers, Inc., KDADS, and any other entities regarding questions and/or inquiries about the Recipient's applicable HCBS Medicaid waiver and the services provided by Worker.

Work Related Injuries: Worker shall immediately (within 24 hours) report any injuries occurring during the course and scope of employment to the Recipient. If the Recipient has elected to carry Workman's Compensation Insurance through Helpers, Inc., the Recipient shall notify Helpers, Inc. of any such injury reported by Worker within 3 business days of the accident. The parties understand that the Kansas Statute (K.S.A. 44-520) states a claim could be denied for failure to provide notice by the earliest of the three following options:

30 calendar date from the date of the accident or the date of the injury by repetitive trauma
20 calendar days from the state medical treatment is sought for the injury
20 calendar days from my last day of work if I no longer work for this employer

Helpers, Inc. is the Recipient's FMS service provider and not your employer as a worker. The Recipient is your employer. If you are required to drive a motor vehicle as a condition of your employment by the recipient, you should consult with your personal automobile insurance carrier and the recipient's automobile insurance carrier to confirm coverage. Helpers, Inc. is unable to provide automobile insurance coverage for you or the recipient.

Grievance: Workers can address relevant issues, such as hours paid differing from hours worked, untimely pay checks, other FMS-related issues by contacting the Recipient and then Helpers, Inc. management. Unresolved issues may be escalated to KDADS.

Term of Agreement: This Agreement shall remain in effect pending the earlier occurrence of one of the following events: The denial of the Recipient's Medicaid eligibility; the termination/closure of the Recipient's applicable HCBS case; the termination of the Worker as the Recipient's self-directed Worker; or the termination of the Recipient's right to self-direct his or her care.

KDADS: Though KDADS is not a party to this Agreement, the parties specifically intend that KDADS be a third-party beneficiary and, as a result thereof, further acknowledge and agree that KDADS may, at its option, enforce the terms of this Agreement.

Modification: This agreement incorporates by reference all current rules, regulations and policies promulgated by all relevant State and Federal governmental, legislative and administrative agencies, including but not limited to KDADS, the Centers for Medicare and Medicaid Services ("CMS") and the U.S. Department of Labor. To the extent this agreement is inconsistent with such current rules, regulations and policies, such current rules, regulations and polices shall supersede and replace the terms of this agreement. Helpers, Inc. will make a good faith effort to post the most relevant of such rules, regulations and policies on its website. This agreement may be revised or amended by Helpers, Inc., in its sole discretion, to comply with current State and Federal rules, regulations and policies. Helpers, Inc. will provide notice to Recipient of such revision or amendment and publish the revised or amended agreement on its website. Recipient agrees to be bound by such revised or amended agreement unless Recipient provides timely written notice to Helpers, Inc. within thirty (30) days terminating this agreement. Is such case, Helpers, Inc. will immediately suspend all services to Recipient pursuant to this agreement.

Miscellaneous: The parties shall not assign, subcontract, or delegate any duties or obligations required by this Agreement to any other individual, agency, or organization. The invalidity or unenforceability of any provision of this Agreement shall not affect the other provisions hereof and this Agreement shall be construed in all respects as if such invalid or unenforceable provision were omitted. This Agreement supersedes all prior negotiations and agreements between the parties relative to the transaction and services contemplated by this Agreement, which contains the entire understanding of the parties. The terms and provisions of this Agreement shall be construed in accordance with and governed by the laws of the State of Kansas. In the event Judicial Intervention is necessary, the parties agree that venue shall solely be in the District Court for Johnson County, Kansas.

I have read and understand the terms and binding legal effect of this Agreement.

Worker Signature

Helpers, Inc.
Stacy W. Jones, President

Date

Form **W-4** (Rev. December 2020)
Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2021

Step 1: Enter Personal Information

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

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

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the estimator at *www.irs.gov/W4App*, 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 2021 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 total income will be $200,000 or less ($400,000 or less if married filing jointly):

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

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

Add the amounts above 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, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2021 if you meet both of the following conditions: you had no federal income tax liability in 2020 **and** you expect to have no federal income tax liability in 2021. You had no federal income tax liability in 2020 if (1) your total tax on line 24 on your 2020 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, 29, and 30), 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 2021 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2022.

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 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. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 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 2021 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 2021 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . 1 $ _____

2 Enter:
- $25,100 if you're married filing jointly or qualifying widow(er)
- $18,800 if you're head of household
- $12,550 if you're single or married filing separately

. . . . . 2 $ _____

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

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

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

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and 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	$190	$850	$890	$1,020	$1,020	$1,020	$1,020	$1,020	$1,100	$1,870	$1,870
$10,000 - 19,999	190	1,190	1,890	2,090	2,220	2,220	2,220	2,220	2,300	3,300	4,070	4,070
$20,000 - 29,999	850	1,890	2,750	2,950	3,080	3,080	3,080	3,160	4,160	5,160	5,930	5,930
$30,000 - 39,999	890	2,090	2,950	3,150	3,280	3,280	3,360	4,360	5,360	6,360	7,130	7,130
$40,000 - 49,999	1,020	2,220	3,080	3,280	3,410	3,490	4,490	5,490	6,490	7,490	8,260	8,260
$50,000 - 59,999	1,020	2,220	3,080	3,280	3,490	4,490	5,490	6,490	7,490	8,490	9,260	9,260
$60,000 - 69,999	1,020	2,220	3,080	3,360	4,490	5,490	6,490	7,490	8,490	9,490	10,260	10,260
$70,000 - 79,999	1,020	2,220	3,160	4,360	5,490	6,490	7,490	8,490	9,490	10,490	11,260	11,260
$80,000 - 99,999	1,020	3,150	5,010	6,210	7,340	8,340	9,340	10,340	11,340	12,340	13,260	13,460
$100,000 - 149,999	1,870	4,070	5,930	7,130	8,260	9,320	10,520	11,720	12,920	14,120	15,090	15,290
$150,000 - 239,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,830	14,030	15,230	16,190	16,400
$240,000 - 259,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,830	14,030	15,270	17,040	18,040
$260,000 - 279,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,870	14,870	16,870	18,640	19,640
$280,000 - 299,999	2,040	4,440	6,500	7,900	9,230	10,470	12,470	14,470	16,470	18,470	20,240	21,240
$300,000 - 319,999	2,040	4,440	6,500	7,940	10,070	12,070	14,070	16,070	18,070	20,070	21,840	22,840
$320,000 - 364,999	2,720	5,920	8,780	10,980	13,110	15,110	17,110	19,110	21,190	23,490	25,560	26,860
$365,000 - 524,999	2,970	6,470	9,630	12,130	14,560	16,860	19,160	21,460	23,760	26,060	28,130	29,430
$525,000 and over	3,140	6,840	10,200	12,900	15,530	18,030	20,530	23,030	25,530	28,030	30,300	31,800

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	$440	$940	$1,020	$1,020	$1,410	$1,870	$1,870	$1,870	$1,870	$2,030	$2,040	$2,040
$10,000 - 19,999	940	1,540	1,620	2,020	3,020	3,470	3,470	3,470	3,640	3,840	3,840	3,840
$20,000 - 29,999	1,020	1,620	2,100	3,100	4,100	4,550	4,550	4,720	4,920	5,120	5,120	5,120
$30,000 - 39,999	1,020	2,020	3,100	4,100	5,100	5,550	5,720	5,920	6,120	6,320	6,320	6,320
$40,000 - 59,999	1,870	3,470	4,550	5,550	6,690	7,340	7,540	7,740	7,940	8,140	8,150	8,150
$60,000 - 79,999	1,870	3,470	4,690	5,890	7,090	7,740	7,940	8,140	8,340	8,540	9,190	9,990
$80,000 - 99,999	2,000	3,810	5,090	6,290	7,490	8,140	8,340	8,540	9,390	10,390	11,190	11,990
$100,000 - 124,999	2,040	3,840	5,120	6,320	7,520	8,360	9,360	10,360	11,360	12,360	13,410	14,510
$125,000 - 149,999	2,040	3,840	5,120	6,910	8,910	10,360	11,360	12,450	13,750	15,050	16,160	17,260
$150,000 - 174,999	2,220	4,830	6,910	8,910	10,910	12,600	13,900	15,200	16,500	17,800	18,910	20,010
$175,000 - 199,999	2,720	5,320	7,490	9,790	12,090	13,850	15,150	16,450	17,750	19,050	20,150	21,250
$200,000 - 249,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,820	20,930	22,030
$250,000 - 399,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,820	20,930	22,030
$400,000 - 449,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,910	21,220	22,520
$450,000 and over	3,140	6,250	8,830	11,330	13,830	15,790	17,290	18,790	20,290	21,790	23,100	24,400

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	$820	$930	$1,020	$1,020	$1,020	$1,420	$1,870	$1,870	$1,910	$2,040	$2,040
$10,000 - 19,999	820	1,900	2,130	2,220	2,220	2,620	3,620	4,070	4,110	4,310	4,440	4,440
$20,000 - 29,999	930	2,130	2,360	2,450	2,850	3,850	4,850	5,340	5,540	5,740	5,870	5,870
$30,000 - 39,999	1,020	2,220	2,450	2,940	3,940	4,940	5,980	6,630	6,830	7,030	7,160	7,160
$40,000 - 59,999	1,020	2,470	3,700	4,790	5,800	7,000	8,200	8,850	9,050	9,250	9,380	9,380
$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,850	11,050	11,250	11,520	12,320
$80,000 - 99,999	1,880	4,280	5,710	7,000	8,200	9,400	10,600	11,250	11,590	12,590	13,520	14,320
$100,000 - 124,999	2,040	4,440	5,870	7,160	8,360	9,560	11,240	12,690	13,690	14,690	15,670	16,770
$125,000 - 149,999	2,040	4,440	5,870	7,240	9,240	11,240	13,240	14,690	15,890	17,190	18,420	19,520
$150,000 - 174,999	2,040	4,920	7,150	9,240	11,240	13,290	15,590	17,340	18,640	19,940	21,170	22,270
$175,000 - 199,999	2,720	5,920	8,150	10,440	12,740	15,040	17,340	19,090	20,390	21,690	22,920	24,020
$200,000 - 249,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,880	24,980
$250,000 - 349,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,880	24,980
$350,000 - 449,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,900	25,200
$450,000 and over	3,140	6,840	9,570	12,160	14,660	17,160	19,660	21,610	23,110	24,610	26,050	27,350

500518

K-4
(Rev. 11-18)

KANSAS
EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

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

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

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

Basic Instructions: If you are not exempt, complete the **Personal Allowance Worksheet** that follows. The total on line F should **not** exceed the total exemptions you claim under "Exemptions and Dependents" on your Kansas income tax return.
***NOTE**: Your status of "Single" or "Joint" may differ from your status claimed on your federal Form W-4).*

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

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

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

Personal Allowance Worksheet (Keep for your records)

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

B Enter "0" or "1" if you are married or single and no one else can claim you as a dependent (entering "0" may help you avoid having too little tax withheld) ..... **B** _____

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

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

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

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

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

Kansas Employee's Withholding Allowance Certificate

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

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

Mailing address	3 Allowance Rate Mark the allowance rate selected in Line A above. ☐ Single ☐ Joint

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

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

SIGN HERE ▶ **Date**

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

Helpers, Inc.

Payment Enrollment Form

We offer two options to receive your payment for time worked. Select one of these options below.

Option 1: Direct Deposit

A VOIDED CHECK OR BANK ACCT. CONFIRMATION LETTER MUST BE ATTACHED!

If depositing into an account of your choice, ***attach a voided check for each account (not a deposit slip) or a letter from the bank on official letterhead verifying the ABA routing and account number. We must have one of these documents.***

Bank Name:_____Checking _____ Savings _____

Routing/Transit # (9 digits):_____ Account Number: _____

I hereby authorize Helpers, Inc. to deposit any amounts owed to me by initiating credit entries to my accounts at the financial institutions (Bank) indicated on this form. Further, I authorized Bank to accept and to credit any credit entries indicated by Helpers, Inc. to my accounts. Unless prohibited by applicable law, if Helpers, Inc. deposits funds erroneously into my account, I authorized Helpers, Inc., either directly or through its payroll service provider, to debit my account for an amount not to exceed the original amount of the erroneous credit.

Option 2: Paycard

___ Please issue me a Paycard.

I hereby elect and consent to receive my wages by electronic transfer of wages to a paycard. In addition, to the extent permitted by applicable law, I hereby authorize Helpers, Inc. to make all my deposits and deposit adjustments, and I authorize the bank where such funds are deposited to accept such deposits and make such adjustments. Once enrolled, a temporary card will be mailed to me.

Features of the Paycard: No bank account needed, no credit check, guaranteed approval.

Workers are paid twice a month.
To calculate when you will receive payment, use the chart below:

Dates Worked		Pay Date
1st-15th		5th of the following month
16th-31st		20th of the following month

Instructions for viewing your paystubs will be sent you to after your first clock-in. Please read and sign before completing and submitting.

Worker Name: _____ **SSN#:** _____

Worker Signature: _____ **Date:**_____

If Direct Deposit is chosen, a voided check or bank letter must be attached.

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):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

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

STOP *Employer Completes Next Page* STOP

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

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

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
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**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		**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
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		**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		

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

Refer to the instructions for more information about acceptable receipts.

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

ADULT ABUSE, NEGLECT, EXPLOITATION CENTRAL REGISTRY RELEASE OF INFORMATION

OBI 10400
REV 4/21

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

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

Contact Person(s)* Application Processing Dept. **Phone** 913-322-7212

Agency name Helpers, Inc.

Agency mailing address 15540 South Pflumm Rd, Olathe, KS 66062

Email address: Will return via Encrypted email unless marked otherwise work@helpersinc.org

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

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

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

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

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

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

RETURN TO:

Email: DCF.APSRegistry@ks.gov

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

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

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

KANSAS DEPARTMENT FOR CHILDREN AND FAMILIES

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

Release of Information

OBI 1011
9/2018
Page 1 OF 1

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

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

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

Contact Person: Helpers Inc. Application Dept
Agency/Org.: Helpers, Inc.
Phone #: 913-322-7212
Address: 15540 South Pflumm Road
Email: work@helpersinc.org
City/State/Zip: Olathe, KS 66062

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

Payment/Account Information (check box which applies)

☐ *Fee included*	$10 per request. Check, Money Order (payable to DCF) or cash. ***Postal mail only.***	
☐ *Online Payment**	www.dcf.ks.gov – 'Online DCF Payments' icon at bottom of page. Submit receipt with ROI form(s).	
☒ *Pre-Pay Account**	Agency/Org. has Pre-Pay Account.	FEIN: 20-8619789
☐ *Mentoring Account**	As listed in the Kansas Mentors' Partner Directory. http://mentorkansas.org/Find-a-Program	
☐ *Exempt**	No fee for State government agencies (Sub-contracting agencies not included).	

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

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

FIRST, MIDDLE, LAST NAME: _____

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

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

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

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

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

CURRENT ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE: _____ **EMAIL:** _____

SIGNATURE: _____ **DATE:** _____

DCF ONLY:

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

EMPLOYMENT AGREEMENT

BETWEEN MEDICAID WAIVER RECIPIENT AND THEIR WORKER

UPDATED JANUARY 2019

This Employment Agreement ("Agreement") is made and entered into between the Medicaid Recipient (Employer), either personally or by and through Recipient's Designated Representative or Guardian, and the Worker to provide services for the benefit of the Medicaid Recipient.

MEDICAID WAIVER RECIPIENT (EMPLOYER): _____

PERSON DIRECTING SERVICES: _____

WORKER: _____

Recipient and Worker (the "Parties") agree to the following terms and conditions:

Home and Community Based Services Medicaid Waiver Recipient: The Recipient receives services under the Kansas Medicaid waiver program, administered by the Kansas Department of Aging and Disability Services (KDADS), and is the employer. As such, both parties agree that they will comply with the specifics outlined in the Recipient's Integrated Service Plan (ISP). The Recipient has selected Helpers, Inc. as their Financial Management Service (FMS) Provider.

Self-Directed Services: The Recipient has elected to self-direct his/her Medicaid HCBS waiver services. Through the state definition of self-direction, both parties understand that the Recipient, and/or their Designated Representative/Guardian are the employer.

Employment: The Worker agrees that he/she will at all times faithfully, industriously and truthfully perform all of the duties required of his/her position. Recipient is solely responsible for scheduling Worker's shifts and work hours. In carrying out these duties and responsibilities, the Worker shall comply with all Recipient directives, both written and oral, and the ISP. It is also understood and agreed to by the Worker that his/her assignment, duties and responsibilities and reporting arrangements may be changed by the Recipient without causing termination of this agreement; provided however, such duties shall be subject to the contents and hourly limitations as contained in Recipient's ISP. The State of Kansas mandates that all time worked must be submitted using the Ks AuthentiCare® IVR system. Recipients are required to provide a phone for the Worker to utilize the system.

Employment Orientation: Before the Worker can begin working, Worker shall contact the Recipient's Financial Management Service (FMS) provider, Helpers, Inc., to complete all employment paperwork, payroll information, to receive information and instruction regarding the use of Ks AuthentiCare®, and to provide information regarding a required background check. Use of Ks AuthentiCare® is a state mandate. If the Worker fails to clock in and out using Ks AuthentiCare®, they understand that they will not be paid for time worked by Helpers, Inc. Worker shall abide by directions, policies and procedures established by the Recipient and Helpers, Inc.

HCBS Medicaid Integrated Service Plan (ISP) Provisions: Worker acknowledges that attendant care hours and services provided shall be performed as specified in the Recipient's ISP. Worker further agrees and understands that the ISP is subject to change based on the Recipient's health and welfare needs. Any work done outside the ISP will not be paid by Helpers, Inc. and may qualify as Medicaid fraud. If work is paid by Helpers, Inc., and at a later date determined not to be within the scope of the ISP, the Worker agrees to pay Helpers, Inc. back for such work.

Compensation: As full compensation for services provided, Worker shall be paid at the rate to be negotiated by the Recipient within the Medicaid waiver guidelines. Such payments shall be subject to such normal statutory deductions and/or adjustments (State and Federal), as applicable, by Helpers, Inc.

Compliance with Federal/State Laws and HCBS Medicaid Program Waiver/Policies: The Worker agrees to strictly comply with any applicable statutes, regulations or policies, state or federal, which relate or pertain to Medicaid Waiver services. The Recipient and the Worker must act within all Federal and State rules with regard to employment. This includes the Department of Labor ruling effective January 1, 2015. Failure to do so could result in recoupment for payments. NOTE: Should the Worker or the Recipient commit fraud and record time that is not actually worked, the Worker and/or the Recipient will be held responsible for the repayment to Helpers, Inc.

Payment for Services Rendered: Worker shall strictly comply with all rules, regulations and/or policies (State or Federal), including those maintained by AuthentiCare® KS, regarding logging of units/hours of services provided on a daily basis in order to receive payment for services rendered. If the Worker fails to clock in and/or out using AuthentiCare® KS, they understand that they will not be paid for time worked by Helpers, Inc. Failure to provide accurate and truthful data regarding services rendered may result in termination and referral to State and/or Federal authorities for Medicaid Fraud, criminal prosecution or the like. Worker will not be paid overtime by the FMS provider through AuthentiCare® KS reimbursement and shall hold harmless and indemnify the FMS provider, Helpers, Inc., from any claim for overtime pay arising under the Fair Labor Standards Act, 29 U.S.C. 201 *et seq.* and/or the Application of the Fair Labor Standards Act to Domestic Service; Final Rule, 78 FR 60454. Recipient is solely responsible for paying any additional compensation, including overtime compensation which may become due for hours worked in excess of 40 in a week, or in excess of hours approved on the Recipient's ISP or beyond the waiver limitations outlined in the Recipient's ISP.

Agreement Term: This Agreement shall remain in effect pending the earlier occurrence of one of the following events: The denial of the Recipient's Medicaid eligibility: the termination/closure of the Recipient's Medicaid case: the termination of the Worker as the Recipient's self-directed worker- (voluntary or involuntary): or the termination of the Recipient's right to self-direct his or her care.

Termination: The Worker acknowledges that he/she is a Worker at will, and that Recipient may terminate this agreement at any time.

Benefits and Insurance: No benefits (health insurance, life insurance, sick pay) shall be paid under this Agreement. Helpers, Inc, as the recipient's FMS service, is not the worker's employer. The recipient is the worker's employer. If the worker is required to drive a motor vehicle as a condition of the worker's employment, then both recipient and worker should consult with their respective automobile insurance carriers to confirm coverage. Helpers, Inc. is unable to provide automobile insurance coverage for the recipient or the worker.

Background Checks: The Parties acknowledge that Worker's employment is subject to passing background checks. Worker shall cooperate in providing requisite information regarding the same. Helpers, Inc. will incur the cost of the first set of background checks. Subsequent required background checks will be at the expense of the worker and will be deducted from the worker's paycheck.

Work Related Injuries: Worker shall immediately (within 24 hours) report any injuries occurring during the course and scope of employment to the Recipient. If the Recipient has elected to carry Workman's Compensation Insurance through Helpers, Inc., the Recipient shall notify Helpers, Inc. within 3 business days of the accident. The parties understand that the Kansas Statue (K.S.A. 44-520) states a claim could be denied for failure to provide notice by the earliest of the three following options:

30 calendar days from the date of the accident or the date of the injury by repetitive trauma
20 calendar days from the state medical treatment is sought for the injury
20 calendar days from my last day of work if I no longer work for this employer

Grievance: Workers can address relevant issues, such as hours paid differing from hours worked, untimely pay checks, other FMS-related issues by contacting the Recipient and then Helpers, Inc. management if necessary. Unresolved issues may be escalated to KDADS.

Cooperation: Worker agrees to cooperate with Recipient's FMS provider, Helpers, Inc.; Targeted Case Manager; MCO Care Coordinator; KDADS; and any other relevant official agency or organization regarding any investigation, questions or inquiries arising from Recipient's case.

Modification: This agreement incorporates by reference all current rules, regulations and policies promulgated by all relevant State and Federal governmental, legislative and administrative agencies, including but not limited to KDADS, the Centers for Medicare and Medicaid Services ("CMS") and the U.S. Department of Labor. To the extent this agreement is inconsistent with such current rules, regulations and policies, such current rules, regulations and polices shall supersede and replace the terms of this agreement. This agreement may be revised or amended by the Recipient, in his or her sole discretion, to comply with current State and Federal rules, regulations and policies. The Recipient will provide notice to Worker of such revision or amendment. Worker agrees to be bound by such revised or amended agreement unless Worker provides timely written notice to the Recipient within thirty (30) days terminating this agreement. Is such case, Workers employment with the Recipient will immediately end.

Miscellaneous: The Parties shall not assign, subcontract, or delegate any duties or obligations required by this Agreement to any other individual, agency, or organization. The invalidity or unenforceability of any provision of this Agreement shall not affect the other provisions hereof, and this Agreement shall be construed in all respects as if such invalid or unenforceable provision were omitted. This Agreement supersedes all prior negotiations and agreements between the parties relative to the transaction and services contemplated by this Agreement (written or oral), which contains the entire understanding of the parties. Helpers, Inc. will make a good faith effort to post the most relevant of such rules, regulations and policies on its website. This agreement may be revised or amended by Helpers, Inc., in its sole discretion, to comply with current State and Federal rules, regulations and policies. Helpers, Inc. will provide notice to Recipient of such revision or amendment and publish the revised or amended agreement on its website. Recipient agrees to be bound by such revised or amended agreement unless Recipient provides timely written notice to Helpers, Inc. within thirty (30) days terminating this agreement. Is such case, Helpers, Inc. will immediately suspend all services to Recipient pursuant to this agreement.

The terms and provisions of this Agreement shall be construed in accordance with and governed by the laws of the State of Kansas. In the event Judicial Intervention is necessary, the Parties agree that venue shall solely be in the District Court for Johnson County, Kansas.

I have read and understand the terms and binding legal effect of this Agreement.

WORKER SIGNATURE	SIGNATURE OF WAIVER RECIPIENT, DESIGNATED REPRESENTATIVE OR GUARDIAN
DATE	NAME OF DESIGNATED REPRESENTATIVE OR GUARDIAN SIGNING ABOVE