Helpers FMS
Powered by Acumen/DCI

Direct Support Worker (DSW) Packet

IMPORTANT! PLEASE READ THIS PAGE FIRST

This packet contains forms required by the State of Kansas to be set up as a Direct Support Worker (DSW) for a Consumer enrolled in Kansas Medicaid waiver programs. Once set up, you will be an employee of the Consumer/Employer. The Financial Management Services Agency: Helpers, LLC (FMS) provides payroll services and human resources support to Consumers enrolled in Kansas Medicaid waiver programs. The FMS is NOT your employer.

All pages and required documents must be completed and returned to FMS for processing. Once processing is complete and all background check results have been received, FMS will contact your Consumer/Employer and give them a worker ID that you will use to record direct support services provided to your Consumer/Employer.

PLEASE NOTE: Federal and state law require each worker to have background checks completed prior to starting work. Background checks typically take 7-10 business days but can take longer. Do not start working before being given your worker ID. Thank you!

IN ADDITION TO THE COMPLETED PACKET, LEGIBLE COPIES OF EACH OF THE FOLLOWING DOCUMENTS ARE REQUIRED: (Click the paperclip to attach documents below)

- Valid Driver's License (DL). If your DL is not from KS or MO, please provide a driving record from that state's DMV.
  OR State-issued ID Card. Notify FMS if providing ID instead of DL, as you will need to sign a DMV Statement.
- Social Security Card.
- Voided Check, Bank letter, or Bank APP Screenshot with full routing and account numbers (For Payroll Disbursements).

THERE ARE 4 FORMS IN THIS PACKET THAT REQUIRE THE CONSUMER/EMPLOYER'S SIGNATURE:

- Pay Rate Election Form

- Verification of Training

- Employment Service Agreement

-Employment Eligibility Verification (Form I-9)

If you have any questions about this packet, please call us. We are happy to help!

Direct Support Worker (DSW) Information

BASIC INFORMATION

Legal First Name:_________________________ M. I: ______ Last Name:_________________________

Physical Street Address:____

City:__________________________State:__________Zip Code:__________County:_____________

Mailing Address (if different):____

Email Address:______________________________________

Social Security Number:_____________________ Date of Birth:____________________________

Cell Phone: _______________________________ Alternate Phone: _________________________

Driver's License Number:_____________________ OR State Identification Number: ____________

***If you do not have a valid Driver's License – you are not permitted to transport the Consumer/Employer.** Initial here that you have read and understand this statement:

Initials: _________

WORKER RELATION TO CONSUMER/EMPLOYER

Name of your Consumer/Employer:_____________________________ Waiver:________________

TA WAIVER REQUIREMENT NOTICE: (Diplomas NOT required for IDD/PD/FE or TBI waivers)

For individuals working for a Consumer on the TA (Technology Assisted) Waiver, you are required to have a High School Diploma or equivalent to provide PCA services to the Consumer/Employer.
Please chose one of the options below:

I have uploaded or will provide a copy of my High School Diploma or equivalent to the FMS.

I attest that I have a High School Diploma or Equivalent as required by the State of Kansas but am unable to produce the document due to extenuating circumstances. (Provide Explanation Below):

11806 W 77th St, Lenexa, KS 66214 Phone: 913-322-7212 Fax: 913-322-7250 Email: work@helpersinc.org

Direct Support Worker (DSW) Information

BACKGROUND CHECKS

Kansas law requires all potential Direct Support Workers to undergo background checks. The FMS, acting on the Consumer/Employer's behalf, will procure a background check report that is prepared by a consumer reporting agency, private investigating agency, police agency, or other provider (including Department of Motor Vehicle). The results of these background checks will be provided to the Consumer/Employer and appropriate State agencies, if requested. The FMS will cover the expense for all first-time background checks. Active workers will be charged a nominal fee every 2 years on the anniversary of their starting month as an automatic deduction from their pay to cover the expenses of the biennial background checks.

AUTHORIZATION

I certify under penalty of perjury that the information provided on this form is accurate and true. I authorize FMS to perform all required background checks as required by the State of Kansas. I further authorize FMS to share the results of the background check with the Consumer/Employer and State agencies.

DSW Full Name: ____

DSW Signature: ____

Date: ______________

Direct Support Worker (DSW) Acknowledgement

The Direct Support Worker (DSW), an employee of the Medicaid beneficiary (Consumer) acknowledges the following:

1. Consumer is a participant in a Home and Community Based Services (HCBS) Self-Directed Waiver program administered by the Kansas Department for Aging and Disability Services (KDADS) and has selected DSW to be his/her support worker.
2. CONSUMER IS THE "SOLE-EMPLOYER" OF DSW. AS THE EMPLOYER, CONSUMER IS RESPONSIBLE FOR HIRING AND TERMINATING DSW, TRAINING DSW, SETTING THE DSW PAY RATE, SETTING THE WORK SCHEDULE, ENSURING TIME AND ATTENDANCE IS RECORDED CORRECTLY, EVALUATING DSW'S PERFORMANCE, AND ENSURING SERVICES ARE PROVIDED ACCORDING TO CONSUMER'S PLAN OF CARE (POC). IF CONSUMER HAS A GUARDIAN/REPRESENTATIVE, SUCH GUARDIAN/REPRESENTATIVE IS THE PERSON WHO ACTS ON BEHALF OF CONSUMER WHEN NECESSARY AND HAS THE AUTHORITY TO MAKE DECISIONS FOR CONSUMER, INCLUDING CONSUMER'S AUTHORITY AS THE EMPLOYER OF DSW.
3. Financial Management Services (FMS) are provided to Consumer.
4. DSW acknowledges that as the FMS provider provides payroll processing services to the Consumer as well as information processing and reporting services such as processing of state-required DSW background checks. DSW further understands and acknowledges that FMS has no authority to manage the DSW and that the Consumer has the sole authority to manage and direct their services and the DSW/employee.
5. DSW acknowledges (s)he is responsible for following all applicable HCBS waiver program requirements, and state and federal regulations, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA), and obligations related to Abuse, Neglect, and Exploitation.
6. DSW acknowledges and understands that DSW cannot be paid through State Medicaid for services provided to Consumer while Consumer is receiving other Medicaid services, including when Consumer is inpatient in a hospital setting.
7. DSW acknowledges (s)he is responsible for submitting time for all service visits using the DCI Mobile EVV App, DCI Web Portal or landline phone, as required by the State of Kansas. DSW acknowledges that the Consumer/Employer is responsible for approving any and all shifts in the DCI Web Portal.
8. DSW acknowledges and understands that adjustment requests to DCI Web Portal, DCI Mobile EVV App or landline records must be made in the DCI Web Portal within 5 business days of the service visit for any errors including but not limited to: Check-in/Check-out or Activity Codes. DSW further acknowledges that they are required to notify the Consumer of any errors made to service records.
9. DSW acknowledges and understands that FMS will process payroll twice per month on Consumer's behalf pursuant to FMS's agreement with Consumer, on dates specified by FMS and that payroll disbursement of Medicaid payments to the Consumer's DSW will occur after FMS has collected Medicaid payments on behalf of the Consumer.
10. DSW acknowledges that FMS will only provide payment for services provided to Consumer that are eligible for reimbursement by State Medicaid and that arrangement for payment of services that are not reimbursable through Medicaid is to be negotiated between Consumer and DSW through a separate agreement. DSW further acknowledges and understands that FMS is not responsible for any overtime pay as required under the Fair Labor Standards Act (FLSA) or other applicable state or federal law, with any such payment being the responsibility of the Consumer.
11. DSW acknowledges that Consumer and/or FMS will conduct and report background check results to appropriate government agencies.
12. DSW UNDERSTANDS AND ACKNOWLEDGES THAT (S)HE IS NOT ALLOWED TO PROVIDE MEDICAID SERVICES TO THE CONSUMER UNTIL AFTER THEY HAVE PASSED ALL STATE REQUIRED BACKGROUND CHECKS.
13. DSW acknowledges that (s)he is responsible for presenting all employment disputes, including wage disputes, to Consumer for whom the assistance is being provided.
14. DSW acknowledges that (s)he is responsible for reporting all work-related incidents that result in, or may result in, injury to the DSW or Consumer to FMS within 24 hours. **In the event of an emergency, DSW should contact 911 first.**
15. DSW acknowledges that FMS is not responsible or liable for injury or damages resulting from or occurring to either DSW or Consumer from any cause.
16. DSW ACKNOWLEDGES BY THE SIGNATURE BELOW THAT (S)HE HAS READ THIS DOCUMENT AND FULLY UNDERSTANDS EACH PARAGRAPH, INCLUDING, BUT NOT LIMITED TO THAT FMS IS NOT THE EMPLOYER OF DSW, AND AS SUCH, DSW IS NOT ENTITLED TO ANY OF THE BENEFITS OR PROVISIONS OF BEING AN EMPLOYEE OF FMS.

DSW Name (Please print) DSW Signature Date

11806 W 77th St, Lenexa, KS 66214 Phone: 913-322-7212 Fax: 913-322-7250 Email: work@helpersinc.org

Employment Eligibility Verification

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

USCIS Form I-9
OMB No.1615-0047
Expires 05/31/2027

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS

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

LIST A **Documents that Establish Both Identity and Employment Authorization**	OR	LIST B **Documents that Establish Identity**	AND	LIST C **Documents that Establish Employment Authorization**
1. U.S. Passport or U.S. Passport Card **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 an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. **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		**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		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION **2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) **3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal **4.** Native American tribal document **5.** U.S. Citizen ID Card (Form I-197) **6.** Identification Card for Use of Resident Citizen in the United States (Form I-179) **7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.

Acceptable Receipts

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

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

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

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

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

USCIS Form I-9 Supplement A
OMB No. 1615-0047
Expires 05/31/2027

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

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

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

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

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

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

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

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

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

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

Supplement B,
Reverification and Rehire (formerly Section 3)

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

USCIS Form I-9 Supplement B
OMB No. 1615-0047
Expires 05/31/2027

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

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

ADULT ABUSE, NEGLECT,
EXPLOITATION CENTRAL REGISTRY
RELEASE OF INFORMATION

OBI 10400
REV 4/22

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)* Helpers Application Dept **Phone** 913-322-7212

Agency name Helpers, LLC

Agency mailing address 11806 W 77th St, Lenexa, KS 66214

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
P.O. Box 751043
Topeka, Kansas 66675
(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
Child Abuse and Neglect Central Registry
P.O. Box 2637 ● Topeka, KS 66601 ● DCF.CentralRegistry@ks.gov

Release of Information

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 Application Dept   Agency/Org.: Helpers, LLC

Phone #: 913-322-7212   Address: 11806 W 77th St

Email: work@helpersinc.org   City/State/Zip: Lenexa, KS 66214

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:
☐ *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.)		

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2025

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

TIP: Consider using the estimator at *www.irs.gov/W4App* to determine the most accurate withholding for the rest of the year if: you are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

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, and when to use the estimator at *www.irs.gov/W4App*.

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 the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

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

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

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

Step 3: Claim Dependent and Other Credits

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

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

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

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

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

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

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

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 2025 if you meet both of the following conditions: you had no federal income tax liability in 2024 **and** you expect to have no federal income tax liability in 2025. You had no federal income tax liability in 2024 if (1) your total tax on line 24 on your 2024 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2025 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 17, 2026.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

1. Are submitting this form after the beginning of the year;

2. Expect to work only part of the year;

3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;

4. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

5. Prefer the most accurate withholding for multiple job situations.

TIP: Have your most recent pay stub(s) from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

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. Submit a separate Form W-4 for each job.

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

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

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

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2025 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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

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

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; 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 2025 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:
- $30,000 if you're married filing jointly or a qualifying surviving spouse
- $22,500 if you're head of household
- $15,000 if you're single or married filing separately

. . . . . . **2** $

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

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

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

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000- 109,999	$110,000- 120,000
$0 - 9,999	$0	$0	$700	$850	$910	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020
$10,000 - 19,999	0	700	1,700	1,910	2,110	2,220	2,220	2,220	2,220	2,220	2,220	3,220
$20,000 - 29,999	700	1,700	2,760	3,110	3,310	3,420	3,420	3,420	3,420	3,420	4,420	5,420
$30,000 - 39,999	850	1,910	3,110	3,460	3,660	3,770	3,770	3,770	3,770	4,770	5,770	6,770
$40,000 - 49,999	910	2,110	3,310	3,660	3,860	3,970	3,970	3,970	4,970	5,970	6,970	7,970
$50,000 - 59,999	1,020	2,220	3,420	3,770	3,970	4,080	4,080	5,080	6,080	7,080	8,080	9,080
$60,000 - 69,999	1,020	2,220	3,420	3,770	3,970	4,080	5,080	6,080	7,080	8,080	9,080	10,080
$70,000 - 79,999	1,020	2,220	3,420	3,770	3,970	5,080	6,080	7,080	8,080	9,080	10,080	11,080
$80,000 - 99,999	1,020	2,220	3,420	4,620	5,820	6,930	7,930	8,930	9,930	10,930	11,930	12,930
$100,000 - 149,999	1,870	4,070	6,270	7,620	8,820	9,930	10,930	11,930	12,930	14,010	15,210	16,410
$150,000 - 239,999	1,870	4,240	6,640	8,190	9,590	10,890	12,090	13,290	14,490	15,690	16,890	18,090
$240,000 - 259,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$260,000 - 279,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$280,000 - 299,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$300,000 - 319,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,170	19,170
$320,000 - 364,999	2,040	4,440	6,840	8,390	9,790	11,100	12,470	14,470	16,470	18,470	20,470	22,470
$365,000 - 524,999	2,790	6,290	9,790	12,440	14,940	17,350	19,650	21,950	24,250	26,550	28,850	31,150
$525,000 and over	3,140	6,840	10,540	13,390	16,090	18,700	21,200	23,700	26,200	28,700	31,200	33,700

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	$200	$850	$1,020	$1,020	$1,020	$1,370	$1,870	$1,870	$1,870	$1,870	$1,870	$2,040
$10,000 - 19,999	850	1,700	1,870	1,870	2,220	3,220	3,720	3,720	3,720	3,720	3,890	4,090
$20,000 - 29,999	1,020	1,870	2,040	2,390	3,390	4,390	4,890	4,890	4,890	5,060	5,260	5,460
$30,000 - 39,999	1,020	1,870	2,390	3,390	4,390	5,390	5,890	5,890	6,060	6,260	6,460	6,660
$40,000 - 59,999	1,220	3,070	4,240	5,240	6,240	7,240	7,880	8,080	8,280	8,480	8,680	8,880
$60,000 - 79,999	1,870	3,720	4,890	5,890	7,030	8,230	8,930	9,130	9,330	9,530	9,730	9,930
$80,000 - 99,999	1,870	3,720	5,030	6,230	7,430	8,630	9,330	9,530	9,730	9,930	10,130	10,580
$100,000 - 124,999	2,040	4,090	5,460	6,660	7,860	9,060	9,760	9,960	10,160	10,950	11,950	12,950
$125,000 - 149,999	2,040	4,090	5,460	6,660	7,860	9,060	9,950	10,950	11,950	12,950	13,950	14,950
$150,000 - 174,999	2,040	4,090	5,460	6,660	8,450	10,450	11,950	12,950	13,950	15,080	16,380	17,680
$175,000 - 199,999	2,040	4,290	6,450	8,450	10,450	12,450	13,950	15,230	16,530	17,830	19,130	20,430
$200,000 - 249,999	2,720	5,570	7,900	10,200	12,500	14,800	16,600	17,900	19,200	20,500	21,800	23,100
$250,000 - 399,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$400,000 - 449,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$450,000 and over	3,140	6,490	9,160	11,660	14,160	16,660	18,660	20,160	21,660	23,160	24,660	26,160

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	$450	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,870	$1,870	$1,870	$1,890
$10,000 - 19,999	450	1,450	2,000	2,200	2,220	2,220	2,220	3,180	4,070	4,070	4,090	4,290
$20,000 - 29,999	850	2,000	2,600	2,800	2,820	2,820	3,780	4,780	5,670	5,690	5,890	6,090
$30,000 - 39,999	1,000	2,200	2,800	3,000	3,020	3,980	4,980	5,980	6,890	7,090	7,290	7,490
$40,000 - 59,999	1,020	2,220	2,820	3,830	4,850	5,850	6,850	8,050	9,130	9,330	9,530	9,730
$60,000 - 79,999	1,020	3,030	4,630	5,830	6,850	8,050	9,250	10,450	11,530	11,730	11,930	12,130
$80,000 - 99,999	1,870	4,070	5,670	7,060	8,280	9,480	10,680	11,880	12,970	13,170	13,370	13,570
$100,000 - 124,999	1,950	4,350	6,150	7,550	8,770	9,970	11,170	12,370	13,450	13,650	14,650	15,650
$125,000 - 149,999	2,040	4,440	6,240	7,640	8,860	10,060	11,260	12,860	14,740	15,740	16,740	17,740
$150,000 - 174,999	2,040	4,440	6,240	7,640	8,860	10,860	12,860	14,860	16,740	17,740	18,940	20,240
$175,000 - 199,999	2,040	4,440	6,640	8,840	10,860	12,860	14,860	16,910	19,090	20,390	21,690	22,990
$200,000 - 249,999	2,720	5,920	8,520	10,960	13,280	15,580	17,880	20,180	22,360	23,660	24,960	26,260
$250,000 - 449,999	2,970	6,470	9,370	11,870	14,190	16,490	18,790	21,090	23,280	24,580	25,880	27,180
$450,000 and over	3,140	6,840	9,940	12,640	15,160	17,660	20,160	22,660	25,050	26,550	28,050	29,550

K-4

(Rev. 7-24)

KANSAS
EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

K-4 Attach 500524

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 have income mark "Joint" ..... **A** ☐ Single ☐ Joint

B Enter "0" or "1" if you are married or single(entering "0" may help you avoid having too little tax withheld) ..... **B** ________

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

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

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

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

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

K-4

(Rev. 7-24)

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)

Payment Enrollment Election

The FMS only uses direct deposit for disbursing wages on behalf of the Consumer/Employer. The following are options for using Direct Deposit:

Option 1: Use your Current Account

If you have a personal checking/savings account and wish to receive direct deposits – please provide proof of the active account. ***Please note** proof must include employee's name (as an owner of the account), routing number and account number on the institution's letterhead or screenshots from your mobile banking app.

Account Type: Checking Savings

Name of Banking Institution: ____

Option 2: Request a Pay Card/ Use a Current Pay Card

If you wish to use a Pay Card, please complete the following:

Mailing Address:_______________________________(P.O. Boxes are NOT allowed)

City/State/Zip:_________________________________

Your pay card will arrive via U.S. Mail the week before your first paycheck. Included in the mailing will be the cardholder agreement, which will be in effect upon using the card. You will need to activate the Pay Card before the first use.

Authorization:

I hereby authorize FMS to credit any amounts owed to me, by initiating credit entries to my bank account or pay card. If FMS loads funds erroneously into my account, I authorize FMS to debit my account for an amount not to exceed the original amount of the erroneous credit.

____

Print Name

____ ____________________________________

Direct Support Worker Signature Date

Direct Support Worker Pay Rate Election

This form is to specify a Direct Support Worker (DSW) pay rate for Personal Care Services (PCS), Enhanced Care Services (ECS)/Overnight Respite (ONR) and the relationship between the Consumer/Employer and the DSW/Employee. When completing this form, the Consumer/Employer should first consider all employer wage and tax requirements/exemptions including, but not limited to, those covered by the IRS Household Employers tax guide and the Department of Labor (DOL) requirements under the Fair Labor Standards Act (FLSA).

Relationship of DSW to Consumer/Employer:

Birth Parent AND Guardian	Adoptive Parent AND Guardian	Step-Parent AND Guardian
Birth Parent NOT Guardian	Adoptive Parent NOT Guardian	Step-Parent NOT Guardian
Child	Sibling	Spouse
Not Related	Other (please specify)	

Please note: Wages paid to a parent of a domestic employer may be exempt from Social Security and Medicare tax.

Shared Living (Notify FMS if this status changes):

Yes, I live in the same physical dwelling as the Consumer/Employer.

No, I do not live in the same physical dwelling as the Consumer/Employer.

DSW Pay Rate (selected by the Consumer/Employer):

My DSW/Employee is NOT exempt from withholding taxes. I will manage my DSW's schedule to maintain compliance with DOL regulations (at or below 40 hours per week). I elect the Highest Available Rate.*

My DSW/Employee is EXEMPT from withholding taxes (Bio/Adoptive Parent of Consumer/Spouse of Consumer/Minor). I will manage my DSW's schedule to maintain compliance with DOL regulations (at or below 40 hours per week). I elect the Highest Available Rate.*

I elect the following hourly rate** for my DSW/Employee: $_____________. I will manage my DSW's schedule to maintain compliance with DOL regulations (at or below 40 hours per week).

The Highest Available Rate is determined by the State of Kansas reimbursement rate for the service, less applicable employer payroll taxes and expenses for the service provided. Selecting this rate will ensure maximum distribution of available funds on a per pay period basis for the Consumer/Employer's DSW/Employee.

****Hourly pay rate must be at least federal minimum wage and at most the Highest Available Rate. The minimum hours of services for ECS/ONR is currently 6 hours per night. Please contact FMS if you have questions or need additional information regarding the Hourly Rates for ECS/ONR services.***

The FMS will only disburse up to the maximum available reimbursed funds after applicable employer taxes and expenses are paid on the Consumer/Employer's behalf. Any wages due to the Consumer/Employer's DSW/Employee in excess will be the sole responsibility of the Consumer/Employer and will be paid through a separate payroll processing not performed by FMS. The Consumer/Employer understands that he/she is the Employer of the DSW/Employee and is solely responsible for ensuring that the DSW/Employee is paid properly in accordance with State and Federal Law. The Consumer/Employer acknowledges that FMS is not an employer of any DSW employed by Consumer/Employer and the FMS simply provides pay master type services for Consumer/Employer pursuant to their agreement.

BY SIGNING THIS FORM, THE CONSUMER/EMPLOYER GUARANTEES THAT ALL INFORMATION PROVIDED IS ACCURATE AND TRUE.

Consumer/Employer Name (Print)	Consumer/Employer Signature	Date

Helpers FMS
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Direct Support Worker (DSW) Training Checklist

The State of Kansas requires Direct Support Workers (DSWs) to receive personal care training from their Consumer/Employer on the tasks to be performed by the DSW. A copy of this training log must be kept on file by the FMS provider and submitted to the Managed Care Organizations or CDDO upon request.
Please note: This is NOT a timesheet.

DSW Name: ____________________________ Consumer Name: _____________________________

Please indicate by checking YES or NO to the tasks for which the DSW received training.

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

Notes:
____
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____

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

DSW Signature: ________________________________ Date: _________________

Consumer/Guardian/Representative Signature: ________________________ Date: _________________

11806 W 77th St, Lenexa, KS 66214 Phone: 913-322-7212 Fax: 913-322-7250 Email: work@helpersinc.org

Employment Service Agreement

This Employment Service Agreement (this “Agreement”) is made between the Consumer, _______________________ and (DSW) ______________________________, all of whom may collectively be referred to as the parties. For good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree as follows:

1. Consumer is a participant in a Home and Community Based Services (HCBS) Waiver program administered by the Kansas Department of Aging and Disability Services (KDADS).
2. Consumer is the sole-employer of the DSW.
3. Consumer has selected DSW to be his/her support worker for applicable and approved HCBS Waiver services.
4. The Guardian/Representative, if any, is the person who acts on behalf of Consumer when necessary and has the authority to make decisions for Consumer.
5. Consumer is the beneficiary of the services and is the sole-employer of DSW.
6. As the sole-employer, Consumer has the following responsibilities:

6.1. Act as the sole-employer for DSW, or designate a representative, to manage or help manage DSW.

6.2. Select the Direct Support Worker(s), called a DSW, who is a non-professional attendant hired by Consumer to assist with non-medical daily living activities, including but not limited to bathing, transferring, dressing, eating, preparing meals, light housekeeping , as well as other activities related to the health, safety, and welfare of Consumer in the home, such as acting as a companion in the home or community, providing incidental teaching (following the guidelines of the "home program") and providing services under the approved Plan of Care (POC) developed by Consumer's case manager.

6.3. Ref er DSW to the Consumer's Financial Management Services (FMS) provider for completion of required human resources and payroll documentation. In cooperation with the Consumer's FMS provider, ensure all employment verification and payroll forms are completed prior to the DSW starting as an employee of the Consumer.

6.4. Provide or arrange for appropriate orientation and training of DSW.

6.5. Determine schedules of DSW(s).

6.6. Determine tasks to be performed by DSW, as well as where and when they are to be performed in accordance with the approved and authorized POC.

6.7. Manage and supervise the day-to-day HCBS activities of DSW.

6.8. Verify tasks completed and times worked by DSW are in accordance with the POC.

6.9. Verify time and attendance is accurately recorded through the DCI Mobile EVV App, DCI Web Portal or landline phone.

6.10. Abide by and ensure accurate submission of required documentation of services to the Consumer's FMS provider for processing and payment in accordance with established FMS, state, and federal requirements. The time and attendance records will be reflective of actual hours worked in accordance with an approved POC, and in accordance with applicable procedures of the Fair Labor Standards Act (FLSA) or other applicable state or federal regulations.

6.11. Assure all appropriate service documentation is recorded as required by the State of Kansas HCBS Waiver program policies, procedures, or by the Medicaid Provider Agreement.

Employment Service Agreement

7. DSW has the following responsibilities:
   7.1. Complete all documentation, including human resource and payroll forms, and submit completed forms to the Consumer's FMS provider for processing.
   7.2. Follow all training and personal care instructions of Consumer and comply with all reasonable requests of Consumer. All assistance being provided must be included the POC.
   7.3. Submit all time and attendance on a per visit basis using the DCI Mobile EVV App or landline phone at the beginning of a shift to check-in and again at the end of a shift to check-out. At the time of check-out, DSW shall enter the activity codes for the tasks performed during that shift. The Application is downloaded on the DSW's smartphone. Or by entering the shift as a historical entry within 5 business days of service visit.
   7.4. Confer with Consumer concerning the work schedule and the maximum number of hours DSW is allowed to work based on the POC. DSW shall limit hours submitted through the DCI system to the number of hours authorized on the POC.
   7.5. Direct any questions regarding work schedule or hours worked for a given period to Consumer. Questions regarding access to paystubs or tax withholding information may be directed to the Consumer's FMS provider.
   7.6. Obtain written approval from Consumer regarding any pre-planned absences. Missing work without approval of Consumer may result in termination of employment by Consumer.
   7.7. Arrive at the job site as scheduled by Consumer. DSW is required to provide Consumer advance notice of any necessary changes in scheduled arrival or departure time to or from work.
   7.8. Perform services in a courteous, safe, and professional manner always.
   7.9. Follow generally accepted safety procedures while performing personal assistance tasks.
   7.10. Present all employment disputes, including wage disputes, to Consumer for whom the assistance is being provided.
   7.11. Report work-related incidents that result in, or may result in, injury to DSW or Consumer to Consumer, the Consumer's FMS provider, and Consumer's case manager.
   7.12. Report any change in Consumer's condition *immediately* to Consumer's case manager and Consumer's FMS provider.
8. DSW understands (s)he is considered an "employee at will" and may be terminated at any time with or without cause by Consumer. DSW understands that (s)he will be required to successfully undergo a background check as required by state law. DSW authorizes Consumer and/or the Consumer's FMS provider to report background results to appropriate government agencies. DSW cannot by state law, under any circumstances, be employed by Consumer if DSW has been convicted of abuse, neglect, or exploitation of a child or a vulnerable adult; DSW will be notified of such findings.
9. DSW shall always be responsible for his/her own accident/disability and automobile insurance coverage.
10. Both Consumer and DSW agree any overtime hours worked will be paid at one and one-half times the hourly non-overtime rate established for the service type being performed during such overtime hours.
11. Both Consumer and DSW agree to strictly comply with the POC and any and all other applicable HCBS program requirements.
12. DSW and Consumer understand that claims that are non-reimbursable or are subject to recoupment will not be processed by the Consumer's FMS and payment to DSW for these claims is the responsibility of Consumer.

Employment Service Agreement

13. DSW shall obtain the written consent of Consumer prior to providing any services over the POC limit or that violate service requirements defined by KDADS. Additionally, if DSW performs services prior to final approval of the POC and payments are made to DSW pending approval of the POC, DSW will be obliged to reimburse Consumer or Consumer's FMS for payments made that are not reimbursable either because the POC is not approved, the POC is revised in connection with final approval of the POC, or in the case of fraud.
14. Both Consumer and DSW agree to strictly comply with any instructions, rules, or policies maintained by the Consumer's FMS provider with regard to DSW's billing and payment for services rendered.
15. Both Consumer and DSW agree to strictly comply with any and all Kansas statutes, regulations, or policies relating or pertaining to services provided to an HCBS waiver program consumer and for payment for such services.
16. DSW further agrees to cooperate with Consumer's case manager and KDADS regarding any questions and/or inquiries regarding Consumer's HCBS case.
17. This Agreement shall remain in effect pending the earlier occurrence of one of the following events: the denial of Consumer's Medicaid eligibility; the termination/closure of Consumer's applicable HCBS case; the termination of DSW as Consumer's self-directed support worker; or the termination of Consumer's right to self-direct his/her care.

DSW Signature: ____ Date: _________________

Consumer/Guardian/Authorized Representative Signature: __________________________________

Date: _________________