STUART T. WILSON CPA, PC
Fiscal Intermediary

A&D

Medicaid PROVIDER Paperwork for Self-Determination Participants

In order to be considered a Medicaid provider and be paid with Medicaid funds, this packet must be completed in its entirety. Do not provide any services prior to the notification of a clear background check.

The employment relationship is with the Participant and not with Stuart T. Wilson CPA, PC or the Waiver Agency.

IMPORTANT: Please ensure this checklist is completed prior to submission. There are portions of this packet that must be completed by the employer. If an incomplete packet is submitted payment may be delayed.

- ☐ W-4
- ☐ I-9 (Two forms of identification are required. Please refer to page three for all options.)
  - Employer Signature on Page 2
  - Copy of Driver's License or State Issued ID (current)
  - Copy of Social Security Card, Birth Certificate, or valid Passport
- ☐ Employment Agreement
  - Employer Signature
  - Employee Signature
- ☐ Medicaid Provider Agreement
  - Provider Signature (Employee is the provider)
  - Our office obtains the second signature after the paperwork is processed
- ☐ Employee Wage Information
- ☐ Job Description
- ☐ Payroll Procedures (Please read carefully)
  - Employee Signature
- ☐ Direct Deposit Application (Attachment required)
- ☐ Required Training (Training must be submitted with/by your first timesheet)

_____ _____

Employee Email Employee Phone #

If you have any questions, please feel free to contact the Personnel Department at 989-832-5400.

Return packet via Fax: 989-832-5404 Email: training@stuartwilsonfi.com Mail: Stuart T. Wilson CPA, PC Attn: Personnel 6300 Schade Dr. Midland, MI 48640.

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

2022

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 2022 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

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2022 if you meet both of the following conditions: you had no federal income tax liability in 2021 **and** you expect to have no federal income tax liability in 2022. You had no federal income tax liability in 2021 if (1) your total tax on line 24 on your 2021 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 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 2022 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, 2023.

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. 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 2022 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 2022 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:
- $25,900 if you're married filing jointly or qualifying widow(er)
- $19,400 if you're head of household
- $12,950 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	$110	$850	$860	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,770	$1,870
$10,000 - 19,999	110	1,110	1,860	2,060	2,220	2,220	2,220	2,220	2,220	2,970	3,970	4,070
$20,000 - 29,999	850	1,860	2,800	3,000	3,160	3,160	3,160	3,160	3,910	4,910	5,910	6,010
$30,000 - 39,999	860	2,060	3,000	3,200	3,360	3,360	3,360	4,110	5,110	6,110	7,110	7,210
$40,000 - 49,999	1,020	2,220	3,160	3,360	3,520	3,520	4,270	5,270	6,270	7,270	8,270	8,370
$50,000 - 59,999	1,020	2,220	3,160	3,360	3,520	4,270	5,270	6,270	7,270	8,270	9,270	9,370
$60,000 - 69,999	1,020	2,220	3,160	3,360	4,270	5,270	6,270	7,270	8,270	9,270	10,270	10,370
$70,000 - 79,999	1,020	2,220	3,160	4,110	5,270	6,270	7,270	8,270	9,270	10,270	11,270	11,370
$80,000 - 99,999	1,020	2,820	4,760	5,960	7,120	8,120	9,120	10,120	11,120	12,120	13,150	13,450
$100,000 - 149,999	1,870	4,070	6,010	7,210	8,370	9,370	10,510	11,710	12,910	14,110	15,310	15,600
$150,000 - 239,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	15,340	16,540	16,830
$240,000 - 259,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	15,340	16,540	17,590
$260,000 - 279,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	16,100	18,100	19,190
$280,000 - 299,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	13,700	15,700	17,700	19,700	20,790
$300,000 - 319,999	2,040	4,440	6,580	7,980	9,340	11,300	13,300	15,300	17,300	19,300	21,300	22,390
$320,000 - 364,999	2,100	5,300	8,240	10,440	12,600	14,600	16,600	18,600	20,600	22,600	24,870	26,260
$365,000 - 524,999	2,970	6,470	9,710	12,210	14,670	16,970	19,270	21,570	23,870	26,170	28,470	29,870
$525,000 and over	3,140	6,840	10,280	12,980	15,640	18,140	20,640	23,140	25,640	28,140	30,640	32,240

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	$400	$930	$1,020	$1,020	$1,250	$1,870	$1,870	$1,870	$1,870	$1,970	$2,040	$2,040
$10,000 - 19,999	930	1,570	1,660	1,890	2,890	3,510	3,510	3,510	3,610	3,810	3,880	3,880
$20,000 - 29,999	1,020	1,660	1,990	2,990	3,990	4,610	4,610	4,710	4,910	5,110	5,180	5,180
$30,000 - 39,999	1,020	1,890	2,990	3,990	4,990	5,610	5,710	5,910	6,110	6,310	6,380	6,380
$40,000 - 59,999	1,870	3,510	4,610	5,610	6,680	7,500	7,700	7,900	8,100	8,300	8,370	8,370
$60,000 - 79,999	1,870	3,510	4,680	5,880	7,080	7,900	8,100	8,300	8,500	8,700	8,970	9,770
$80,000 - 99,999	1,940	3,780	5,080	6,280	7,480	8,300	8,500	8,700	9,100	10,100	10,970	11,770
$100,000 - 124,999	2,040	3,880	5,180	6,380	7,580	8,400	9,140	10,140	11,140	12,140	13,040	14,140
$125,000 - 149,999	2,040	3,880	5,180	6,520	8,520	10,140	11,140	12,140	13,320	14,620	15,790	16,890
$150,000 - 174,999	2,040	4,420	6,520	8,520	10,520	12,170	13,470	14,770	16,070	17,370	18,540	19,640
$175,000 - 199,999	2,720	5,360	7,460	9,630	11,930	13,860	15,160	16,460	17,760	19,060	20,230	21,330
$200,000 - 249,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,310
$250,000 - 399,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,310
$400,000 - 449,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,470
$450,000 and over	3,140	6,290	8,880	11,380	13,880	16,010	17,510	19,010	20,510	22,010	23,380	24,680

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	$760	$910	$1,020	$1,020	$1,020	$1,190	$1,870	$1,870	$1,870	$2,040	$2,040
$10,000 - 19,999	760	1,820	2,110	2,220	2,220	2,390	3,390	4,070	4,070	4,240	4,440	4,440
$20,000 - 29,999	910	2,110	2,400	2,510	2,680	3,680	4,680	5,360	5,530	5,730	5,930	5,930
$30,000 - 39,999	1,020	2,220	2,510	2,790	3,790	4,790	5,790	6,640	6,840	7,040	7,240	7,240
$40,000 - 59,999	1,020	2,240	3,530	4,640	5,640	6,780	7,980	8,860	9,060	9,260	9,460	9,460
$60,000 - 79,999	1,870	4,070	5,360	6,610	7,810	9,010	10,210	11,090	11,290	11,490	11,690	12,170
$80,000 - 99,999	1,870	4,210	5,700	7,010	8,210	9,410	10,610	11,490	11,690	12,380	13,370	14,170
$100,000 - 124,999	2,040	4,440	5,930	7,240	8,440	9,640	10,860	12,540	13,540	14,540	15,540	16,480
$125,000 - 149,999	2,040	4,440	5,930	7,240	8,860	10,860	12,860	14,540	15,540	16,830	18,130	19,230
$150,000 - 174,999	2,040	4,460	6,750	8,860	10,860	12,860	15,000	16,980	18,280	19,580	20,880	21,980
$175,000 - 199,999	2,720	5,920	8,210	10,320	12,600	14,900	17,200	19,180	20,480	21,780	23,080	24,180
$200,000 - 449,999	2,970	6,470	9,060	11,480	13,780	16,080	18,380	20,360	21,660	22,960	24,250	25,360
$450,000 and over	3,140	6,840	9,630	12,250	14,750	17,250	19,750	21,930	23,430	24,930	26,420	27,730

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		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
		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:		
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		**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.

A&D Home Health Care, Inc.
MI Choice Waiver Program - Waiver Division

Self Determination in Long Term Care Program

Employment Agreement

This agreement is made on: _____ (Date) between **Waiver Participant (Employer)**:

_____ and **Employee:**_____

To describe the supports that the employee will provide to the employer and the terms and conditions of employment.

Article I
Employee Responsibilities

I, the **employee**: _____ (Employee Name) am aware and agree that my employment is conditional on my employer's participation in the Self Determination in Long Term Care Program, administered by the waiver agent. If my employer ends their participation in the Self Determination in Long Term Care Program, my employment may end. I agree to the following terms of employment:

1. During the term of this Agreement, I shall provide support to my employer by performing the duties outlined in this agreement and any attachments to it.

2. I agree to assist my employer in maintaining the documentation and records required by my employer or A&D Home Health Care, Inc., Waiver Division, the waiver agent. I agree to complete all necessary paperwork to secure mandatory payroll deductions from my pay. All records I may have or assist in maintaining are the property of my employer. I will keep these records confidential, release them only with the consent of my employer, and return them to my employer if my employment ends. In addition, I will complete illness and incident reports when necessary as required or requested by the waiver agent or my **employer**: _____ _____ (Employer Name).

3. **I shall immediately notify my employer's physician and/or call 9-1-1 if my employer experiences a medical emergency or illness.**

4. I agree to participate in any meetings if requested to do so by my employer.

5. I agree to abide by all of my employer's rules and the waiver agent regulations (described below) regarding my employment duties to the employer through the Self Determination in Long Term Care Program and I acknowledge receipt of the following rules and regulations:

    a. See Attachment A to this Agreement (job description).

    b. I am 18 years old or older, and a US Citizen or Legal Alien.

    c. I am able to demonstrate an ability to perform tasks employer requests. (Attachment A)

d. I will complete CPR, blood borne pathogens/universal precautions, and basic first aid training within 3 months of employment. (If the participant is a DNR, this requirement can be waived)

e. I am not a Participant's Representative for the Self Determination Program.

f. I am not a legally responsible relative (spouse/guardian).

g. I will document ***time in*** and ***time out*** for each shift using a standardized form which will be supplied by the employer or Fiscal Intermediary.

h. I will not submit timesheets for time I have not worked or that is not signed by the appropriate person. I understand that to do so constitutes as **MEDICAID FRAUD** that is punishable by law.

i. I understand that I will not be paid for the time the employer is in the hospital or being cared for by someone else.

j. I understand that all changes in the schedule must be approved by the employer.

6. I understand that this is an employment at will relationship which can be terminated by me or my employer at any time. However, my employer cannot terminate my employment on the basis of my race, religion, sex, disability, or other protected status under Federal or Michigan Law. In addition, I agree to give (seven) days written notice to my employer if I terminate my employment.

7. I understand and acknowledge that my employer is my sole employer and that I am not an employee of the waiver agent, who authorizes the supports I provide, or the fiscal intermediary, which is the financial administrator of the Choice Voucher System funds used to pay me.

8. I agree not to sue the fiscal intermediary for its role as the financial administrator of my employer's Self Determination in Long Term Care Program funds and the waiver agent for its role in administering the Self Determination in Long Term Care Program.

9. I agree to the following compensation for the services I shall perform: $ _____ per hour.

10. I agree to execute a Medicaid Provider Agreement with the waiver agent and acknowledge that this agreement does not alter the fact that the waiver agent is only the project administrator of the Self Determination in Long Term Care Program, and that: _____ (Employer Name) is my employer. I understand that my employment is contingent upon completing this agreement.

11. I understand that my employer has been approved for _____ **hours** of community living supports per **week.** I will not work over this amount unless my employer consults with their Case Manager/Supports Coordinator and the additional hours are approved.

12. I understand that if my employer goes into the hospital or other medical care setting, I cannot be paid during their absence.

13. I will not submit timesheets for any hours of work I have not performed. Falsifying timesheets is cause for legal proceedings to be pursued.

14. I will contact my employer as soon as I am aware that I am ill or for any other reason I am not able to arrive to provide services.

15. I will treat my employer with respect and dignity at all times.

Article I
Employer Responsibilities

I, the **employer**: _____ (Employer Name)

1. Will provide my Fiscal Intermediary with the necessary documentation to assure timely compensation of my employee.

2. Will compensate my employee in the following manner: $ _____ per **hour**. I understand it is my responsibility to monitor and review wages and hours on my quarterly budgets.

3. I understand I am approved for _____ **hours** of community living supports per **week** and that I will have to consult with my Case Manager/Supports Coordinator before I can allow my employee to work additional hours. I understand it is my responsibility to monitor and review wages and hours on my quarterly budgets.

4. Payroll will be handled by my Fiscal Intermediary which will withhold all necessary taxes, unemployment, and other withholdings from the employee's paycheck.

5. I will assure that my employee receives appropriate training.

6. I will evaluate the performance of my employee and provide appropriate feedback to assure that I am receiving quality supportive care.

7. I will assure that my employee executes a Medicaid Provider Agreement with the waiver agent.

8. I understand that if I go into the hospital or other medical care setting, my employee cannot be paid during that time.

9. I will sign/approve any timesheets for hours that my employee has worked. I will not sign/approve any timesheets for hours that my employee has not worked. Falsifying timesheets is cause for legal proceedings to be pursued. **I have received and understand information provided regarding Medicaid Fraud.**

10. I understand that I am not to copy blank timesheets containing my signature for employee use.

11. I will inform the Fiscal Intermediary and Waiver Agent of any changes to my workers as soon as possible.

12. I understand I must treat my employee(s) with respect and that I cannot solicit them for anything or harass them in any way (sexually or verbally).

_____ _____
Employee Signature Date

_____ _____
Employer Signature Date

A&D Home Health Care, Inc.
MI Choice Waiver Program - Waiver Division

Self Determination in Long Term Care Program

Medicaid Provider Agreement

THIS AGREEMENT is entered into by and between the Waiver Agent, A&D Home Health Care, Inc., Waiver Division, herein referred to as Waiver Agent, and:

Participant Name: _____

And/or Other Representative: _____

Medicaid Provider: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: (____) _____ **Fax:** (_____) _____ **E-mail:** _____

Federal ID#: _____ **Social Security#:** _____ **Birth date:** _____

The purpose of this agreement is to define the roles and responsibilities of the above named parties. It is understood by and between the Medicaid Provider and Waiver Agent that a binding agreement shall commence on the date of acceptance as indicated by signatures on behalf of the Waiver Agent. This agreement shall remain in effect until such time it must be terminated or modified. Any party can initiate a termination or modification by providing written notice to the other of the desire to terminate or modify this agreement.

Upon receipt of this agreement, the Waiver Agent will certify the Medicaid Provider as available to provide services to individuals who are receiving services and/or supports in accordance with their service plans developed through the person centered planning process, authorized by the Waiver Agent or one of its subcontractors, and funded through the MI Choice Waiver/Project Choice.

The Medicaid Provider stipulates that it agrees to the following:

1. To keep any records required by the Participant or the Waiver Agent regarding the services provided to Participants and to provide such information and any related invoices or billings, upon request, to the Participant, Waiver Agent, the State Medicaid Agency, the Secretary of the Department of Health and Human Services or the State Medicaid fraud control unit.

2. To comply with the ownership disclosure requirements specified in 42 CFR 455, subpart B, as applicable.

3. To comply with intent of the advance directive requirements specified in 42 CFR 489, Subpart I and 42 CFR 417.436 (d), as applicable, by finding out if a Participant has an advance directive to refuse life-sustaining medical treatment, and informing the Participant, before the Provider starts work, whether or not the Provider will carry out that advance directive so the Participant can make an informed choice during the hiring process.[1]

Both parties expressly acknowledge that the sole purpose of this agreement is to assure compliance with 42 USC 1902 (a) 27. Further, both parties recognize and reaffirm that the Waiver Agent is not the employer of the Medicaid Provider, and that the Participant is the sole employer of the Medicaid Provider.

This agreement sets forth the entire understanding between the parties with respect to the subject matters, and supersedes any and all other agreements, either oral or in writing, between the parties pertaining to these matters. No change or modification of the terms of this agreement is valid unless it is in writing and signed by the parties.

Medicaid Provider Agency/Individual	Date
Executive Director, Waiver Agent	Date

This requirement applies to home health agencies and providers of home health care and personal care services as well as health care institutions. However, under Michigan law, certain health professionals cannot refuse to honor a Do Not Resuscitate order (MCL 333.1051 et. seq.).

Copy to Fiscal Intermediary: Date: _____ Name: _____

[1] This requirement applies to home health agencies and providers of home health care and personal care services as well as health care institutions. However, under Michigan law, certain health professionals cannot refuse to honor a Do Not Resuscitate order (MCL 333.1051 et. seq.).

A&D Home Health Care, Inc.
MI Choice Waiver Program - Waiver Division

Self Determination in Long Term Care Program

Home Health Aide/Personal Care Assistant Job Description/Task List

Employee Name: _____ **Date:** _____

Participant/Employer: _____ **Date:** _____

Qualifications/Training

☐ **CPR Training**
☐ **Universal Precautions**
☐ **Blood Borne Pathogen**
☐ **First Aid**
☐ **Additional Training Requirements:** ___
_____
_____
_____

Services Performed

☐ **CLS (personal care/ homemaking)**
☐ **Chore Service**
☐ **In Home Respite**

Personal Care & Homemaking Functions (including but not limited to)

☐ **Bathing/Assist**
☐ **Shampooing**
☐ **Skin Care/Nail Care**
☐ **Oral Hygiene**
☐ **Ambulation**
☐ **Shaving**
☐ **Dressing/Assist**
☐ **Toileting/Incontinence**
☐ **Linen Change**
☐ **Meal Preparation**
☐ **Feeding**
☐ **Laundry**
☐ **Cleaning**
☐ **Other:** _____
_____
_____

Chore Services (including, but not limited to)

☐ **Yard Work**
☐ **Snow Removal**

Transportation Needs: (drivers license confirmation required)

☐ **Yes** ☐ **No** ☐ **As Needed**

Scheduling (Days/Hours)

Contact employer if arriving more than 10 min. late or need to change schedule

☐ **Sun.** ☐ **Mon.** ☐ **Tue.** ☐ **Wed.** ☐ **Thur.** ☐ **Fri.** ☐ **Sat**

It is important to me that my worker: (e.g. does not smoke in my home, is punctual, treats me with respect, maintains confidentiality, honors my requests, etc.)

- _____
- _____
- _____
- _____

I expect my worker to perform other related duties & responsibilities as deemed necessary.

Employer Signature: _____ **Date:** _____

Employee Signature: _____ **Date:** _____

STUART T. WILSON CPA, PC
Fiscal Intermediary

Employee Wage Information

Employee Name: _____

Employee Phone #: (_____) _____

Employee Email: _____

Is your address the same as your employer? ☐ yes ☐ no

Are you the parent or legal guardian of your employer? ☐ yes ☐ no

This portion to be completed by the employer/representative.
Employers, please review your budget to ensure accuracy.

Hourly Rate: _____

STUART T. WILSON CPA, PC
Fiscal Intermediary

PAYROLL PROCEDURES

In order to be paid correctly, avoid any delay, or forfeit the ability to be paid with Medicaid funds, the following payroll procedures must be followed:

Turning in Timesheets for Payment:

- **Please refer to the payroll calendar for scheduled pay days.**
  - All time worked must be reported within 14 days of the end of the pay period.
- **Timesheets received late and/or separate may not be paid on time.**
  - All timesheets for a Participant are to be faxed/e-mailed together **on the 1st & 16th**
- **Only correct timesheets will be processed.**
  - If a timesheet contains omissions or errors, it will be returned to the employer and payment may be delayed.
  - Overlapping time with another provider will not be processed
  - Only authorized hours will be paid
  - Insufficient documentation or progress notes will result in unpaid shifts
  - If a shift is paid that the funding agency deems ineligible due to insufficient documentation, funds will be recouped.
- **Mileage logs must be turned in on the 1st & 16th with the corresponding timesheet.**
- **No Photocopied signatures will be accepted.**
  - A new timesheet must be used each week. Duplicated timesheets are not accepted.
- **Do not include unauthorized hours on your timesheet.**
  - Unauthorized hours will not be paid

Payment Methods:

- **Mail-out checks**
  - Paychecks will be received within 2-4 days of the pay date.
- Missing checks may be reissued 10 business days from the date of the check. We do not reissue checks prior to that time.

- **Direct deposit**
  - Check stubs are sent via email.

- **Changes in payment method must be submitted in writing and may take 2-3 weeks to become effective.**
  - Do not close your bank account without providing our office with enough notification; otherwise your payment will be delayed.
  - Address changes must be submitted in writing.

_____ _____

Employee Signature Date

I have read and understand Stuart T. Wilson CPA, PC payroll procedures. Additionally, I understand that I am responsible for any information and/or notifications that are included with my paycheck/paystub.

STUART T. WILSON CPA, PC
Fiscal Intermediary

Direct Deposit Application

Name: _____ Email Address (**required**):_____

Employer's Name: _____ Organization: _____

When you apply for direct deposit you authorize Stuart T. Wilson CPA, PC to deposit your payroll automatically into your checking or savings account.

- Direct deposit may take 2-3 weeks for initial set-up. Likewise, it **may take 2-3 weeks to cancel.**
- All cancellations must be submitted in writing.
- **Do not close your bank account without providing our office with sufficient notification; otherwise your payment will be delayed.**
- On payday you will receive your check stub **via email**. This also serves as your notice of deposit. The email comes from no_reply@stuartwilsonfi.com. Please check your spam folder if you do not receive your notice.
- Stuart T. Wilson CPA, PC is not held accountable for any overdraft fees that you may incur for using funds prior to their **actual confirmed deposit.**
- Stuart T. Wilson CPA, PC is authorized to correct errors that may occur. This authority remains in effect until we are notified in writing that you no longer want direct deposit.

I have read and understood the terms of direct deposit with Stuart T. Wilson CPA, PC.

_____ _____

Signature Date Phone #

Bank Account Information:

Account Type: ☐ Checking ☐ Savings

- **You must provide a voided check, membership card or a letter from your bank. The document must include your routing and account number. This ensures account accuracy. Deposit slips or your personal bank statements are not accepted.**

- **Handwritten information on this page will not be accepted.**

- Return via Fax: 989-832-5404 Email: payroll@stuartwilsonfi.com
  Mail: Stuart T. Wilson CPA, PC Attn: Personnel 6300 Schade Dr. Midland, MI 48640

A&D Health Home Health Care, Inc.
Waiver Division

Dear Self Determination Employee,

As a Self Determination employee, there are certain safety procedures that you must have knowledge of to work with our clients.

The attached required Chest Compression Resuscitation (CPR), First Aid, and Bloodborne Pathogens/Universal Precaution training materials that must be read and the training record faxed to the Fiscal Intermediary before you can receive a paycheck.
You may chose to attend a full CPR training class if you wish, however, that training will be at your own expense.

If you have any questions, please call the clients primary A&D Case Manager at:

Saginaw Office (989) 294-0929 or (800) 884-3335

MT. Pleasant (989) 775-5500 or (877) 718-1844

Pigeon Office (989) 453-2864 0r (888) 393-1706

The attached training record must be completed and faxed to the Fiscal Intermediary before a paycheck will be issued.

A&D Home Health Care, Inc.
MI Choice Waiver Program - Waiver Division

Self Determination in Long Term Care Program

Training Record

Employee Name: _____

Employer Name: _____

Please initial each training requirement when completed and sign the bottom of the form when you have all three requirements completed. Please return this document to the Fiscal Intermediary and A&D Home Health Care, Inc., Waiver Division will receive a copy for the Employer's chart.

Employee Initials:

1. I have completed the **CPR training** materials and feel I could perform CPR in case of an emergency. _____

2. I have read the material on **blood borne pathogens** and the use of **universal precautions** and feel I am well informed about blood borne pathogens and the use of universal precautions. _____

3. I have read the First Aid reference guide on **basic first aide** and feel I could perform basic first aid if needed. _____

I attest that the above information is true and that I have completed all three training requirements.

_____ _____
Employee Signature Date

I have further training in the following areas: Completion date:

_____ _____
_____ _____
_____ _____
_____ _____

Comments: _____
_____
_____
_____

A&D Home Health Care, Inc.
Waiver Division

CPR HANDS ON ONLY

CHECK AND CALL

1. Check the scene for safety, and then check the person.
2. Tap on the shoulder and shout, "Are you okay?"
3. CALL 911 if no response.
4. If unresponsive and not breathing normally, Begin Chest Compressions as follows.
5. Whenever possible use disposable gloves when giving care.

GIVE CHEST COMPRESSION

1. Place the heel of one hand on the center of the chest.
2. Place the heel of the other hand on top of the first hand, lacing your fingers together.
3. Keep your arms straight; position your shoulders directly over your hands.
4. Push hard, push fast.
    - Compress the chest at least 2 inches.
    - Compress at least 100 times per minute.
    - Let the chest rise completely before pushing down again.
5. Continue chest compressions.

DO NOT STOP

1. Except in one of these situations:
    - You see an obvious sign of life (normal breathing).
    - Another trained responder arrives and takes over.
    - EMS personnel arrive and take over.
    - You are too exhausted to continue.
    - The scene becomes unsafe.

A&D Home Health Care, Inc.
Waiver Division

Bloodborne Pathogens and Universal Precautions

This training module is designed to provide a basic understanding of bloodborne pathogens, common modes of their transmission, methods of prevention, and other pertinent information. This training material is designed to meet the requirements of Occupational Safety and Health Administration's (OSHA) bloodborne pathogens standard (29 CFR 1910.1030).

Bloodborne Disease

Bloodborne pathogens are disease-causing microorganisms such as viruses or bacteria that may be present in human blood and can cause disease in people. It is hepatitis B (HBV), hepatitis C (HCV) and human immunodeficiency virus (HIV) that may represent the greatest threat in our work environment and are addressed by the OSHA Bloodborne Pathogen Standard.

Modes of Transmission

HBV, HCV, and HIV can be transmitted through contact with infected human blood and other potentially infectious body fluids such as:

- Semen
- Vaginal secretions
- Bloody Saliva (in dental procedures)
- Any body fluid that is visible contaminated with blood,

Transmission of bloodborne pathogens can occur through the following routes:

- Mucous membrane – exposure through a mucous membrane in the eye, nose or mouth from a splash or spray of contaminated material.
- Parental exposure – the pathogen is introduced directly into the body through a break in the skin (cuts, sores, abrasions, dermatitis, sunburn or blisters), needle stick, or through a cut with a contaminated object.

Work Practice Controls

Work practice controls reduce the likelihood of exposure of blood and other potentially infectious material by altering the manner in which a task is performed.

Universal Precautions

Universal Precautions is the name used to describe a prevention strategy in which all blood and potentially infectious materials are treated as if they are, in fact, infectious, regardless of the perceived status of the source individual.

If you are working in an area where there is reasonable likelihood of exposure, you should never:

- Eat
- Drink
- Smoke
- Apply makeup or lip balm
- Handle contact lenses

Hand washing

Hand washing is one of the most important and easiest practices used for infection control and to prevent transmission of disease-causing organisms. Wash hands with soap and water:

- Before and after contact with each client
- Before applying and after removing gloves
- Before eating or drinking
- After contact with blood or other potentially infectious materials

If you are working in an area without access to such facilities, you may use an antiseptic cleanser or hand cleanser gel in conjunction with clean cloth/paper towels or antiseptic towelettes. If these alternative methods are used, hands should be washed with soap and running water as soon as possible.

Broken Glassware

- Broken glassware that has been visibly contaminated with blood must be decontaminated with an approved disinfectant solution before it is disturbed or cleaned up.

- Glassware that has been decontaminated may be disposed of in an appropriate sharps container: i.e., closable, puncture-resistant, leak-proof on sides and bottom.

- Broken glassware should not be picked up directly with the hands. Sweep or brush the material into a dustpan.

- Uncontaminated broken glassware may be disposed of in a closable, puncture resistant container such as a cardboard box or coffee can.

Personal Protective Equipment

Personal protective equipment (PPE) is worn to prohibit blood or other potentially infectious material from passing through to clothing, skin, eyes or mucous membranes. PPE must be removed before leaving the work area and disposed of or laundered properly.

Rules to follow

- Always wear PPE in exposure situations
- Remove and replace PPE that is torn/punctured, or has lost its ability to function as a barrier to bloodborne pathogens.
- Remove PPE before leaving the work area.

If you work in an area with routine exposure to blood or potentially infectious materials, the necessary PPE should be readily accessible. Contaminated gloves, clothing, PPE, or other materials should be placed in appropriately labeled bags or containers until it is disposed or, decontaminated, or laundered.

Gloves

If gloves are thin or flimsy, double glove (2pair). If you have cuts or sores on your hands, you should cover them with a bandage as an additional precaution before putting on gloves. Always inspect your gloves for tears or punctures before putting them on. If a glove is damaged, do not use. When removing contaminated gloves, do so carefully. Make sure you do not tough the outside of the gloves with any bare skin, and be sure to dispose of them in a proper container so that no one else will come in contact with them.

Clothing

Normal clothing that becomes contaminated with blood or other body fluids should be removed as soon as possible because fluids can seep through the cloth to come into contact with skin. Contaminated laundry should be handled as little as possible, and it should be placed in an appropriately labeled bag or container until it is decontaminated, disposed of, or laundered.

Blood Spills

To clean up a blood spill, first be sure to put on your gloves. Then carefully cover the spill with paper towels or rage, prepare a mixture of a quarter cup of bleach per one gallon of water, then gently pour the solution over the towels or rags and leave it for at least 10 minutes.

Emergency Procedures

In an emergency situation involving blood or potentially infectious materials, you should always use Universal Precautions. If you are exposed, you should do the following:

1. Wash the exposed area thoroughly with soap and running water. Use non-abrasive, antibacterial soap if possible.
2. If blood is splashed in the eyes or mucous membranes, flush affected area with running water for at least 15 minutes.
3. Report exposure to your physician as soon as possible

Source of information: Bloodborne Pathogen Training Module, 2007, Washington State Region 2 Medical Reserve Corps by Kitsap County Health District

A&D Home Health Care, Inc.
Waiver Division

FIRST AID

CHECKING AN INJURED OR ILL PERSON

1. Check scene for safety, and then check the person
2. Obtain verbal consent to provide assistance.
3. Call 911 for any life threatening conditions.
4. Ask the person the following
    - What is your name?
    - What happened?
    - Where do you feel pain or discomfort?
    - Do you have any allergies to medication/latex etc?
    - Are you taking medications for any medical conditions?
    - When was your last dose?
    - When did you last eat or drink anything?
5. Check head to toe for the following:
    - Bleeding, fluids or wounds.
    - Skin color changes and temperature.
    - Medical ID bracelets or necklaces.
    - Observable signals of pain
6. Continue to monitor breathing, circulation.

SEVERE ALLERGIC REACTION

WHAT TO LOOK FOR

- Occurs suddenly after contact with the substance.
- Contact area swells and turns red.
- Hives, itching or rash.
- Weakness, nausea, vomiting or stomach cramps.
- Dizziness.
- Difficulty breathing including coughing and wheezing.

WHAT TO DO

After determining a person is having a severe allergic reaction, obtain person verbal consent, and assist with prescribed medication if available. When possible use disposable gloves.

- If assisting with medications, verify person's name, medication directions and expiration date.
- Continue to monitor breathing and circulation until help arrive.

WHAT TO LOOK FOR

- Coughing or wheezing noises.
- Difficulty breathing, shortness of breath.
- Rapid, shallow breathing or sweating.
- Tightness in the chest.
- Unable to talk without stopping for breath.
- Feeling or fear or confusion.

WHAT TO DO

Obtain consent to assist with care; wash hands before and after giving care, and wear gloves. Assist with prescribed medications if necessary by the doing the following:

- Verify person's name, medication name, directions and expiration date.
- If person using and inhaler, shake inhaler and assist person to remove cap.
- Assist person to attach any needed equipment in place to facilitate inhaler use.
- Instruct person to breathe out and place lips around mouthpiece.
- Instruct person to press down on the inhaler, inhale deeply, hold breath and count to 10.
- Instruct person to exhale and rinse mouth out with water.
- Continue to monitor breathing and seek additional help if needed.

SEIZURE

1. Check the scene for safety, then check the person and obtain consent.
2. Remove nearby objects.
    - DO NOT hold or restrain person.
    - DO NOT place anything between person's teeth or in person's mouth.
3. Protect the person's head by placing a thin folded towel or clothing under it.
4. Check breathing, circulation.
5. Place in recover position (in recovery position the mouth is downward so that fluid can drain from the patient's airway, keeping the chin up, arms and legs are locked to stabilize the patient's position.
6. Call 911 if the patient has any of the following:
    - Does not regain consciousness.
    - Is pregnant
    - Is a known diabetic
    - Has sustained an injury
    - Shows life-threatening conditions
    - Has never had a seizure before, seizure lasts longer than 5 minutes or seizure is repeated

POISONING

WHAT TO LOOK FOR

- Breathing difficulty
- Nausea, vomiting or diarrhea
- Chest or abdominal pain
- Sweating
- Changes in consciousness
- Seizure
- Headache or dizziness
- Irregular pupil size
- Burning/tearing of the eyes
- Change in skin color
- Burns around the lips, tongue or on the skin

WHAT TO DO

- Check the scene for safety, then check the person and obtain consent
- If unconscious, not breathing or a change in consciousness
- If conscious, call the **National Poison Control Center (PCC) at 800-222-1222** for instructions
- Do not give anything to eat or drink unless instructed to do so by EMS or PCC
- If possible find out the following from the person:
    1. What type of poison taken
    2. How much was taken
    3. When it was taken
    4. How poison entered the body (mouth or other routes)

SHOCK

WHAT TO LOOK FOR

- Restlessness, irritability or confusion
- Altered level of consciousness
- Pale or ashen, cool, moist skin
- Rapid breathing and pulse
- Excessive thirst
- Nausea or vomiting

WHAT TO DO

- Check the scene for safety then check the person and obtain consent
- Call 911
- Check breathing and circulation
- Control any bleeding
- Keep person from getting chilled or overheated
- Raise legs 8-12 inches if you do not suspect a head, neck, back injury, or broken bones in hips or legs.
- If broken bones are suspected, do not move person

STROKE

1. Check the scene for safety then check the person and obtain consent

Sudden signals of Stroke – THINK F.A.S.T.

- Face – weakness on one side of the face. Ask person to smile.
- Arm – weakness or numbness in one arm. Ask person to raise both arms.
- Speech – slurred speech or trouble getting words out. Ask person to say a simple sentence.
- Time – note time signs first observed and Call 911.

CONTROLLING VISIBLE BLEEDING

Be sure to use blood before caring for person bleeding.

1. Check the scene for safety, then check the person and obtain consent.
2. Cover the wound with a sterile dressing,
3. Apply direct pressure until bleeding stops then cover with dressing and bandage
4. If bleeding does not stop, do the following:
    - Apply additional dressings and bandages
    - Take steps to prevent Shock (see section on Shock) and call 911

BURN CARE

Call 911 for serious burns.

1. Check the scene for safety then check the person and obtain consent if possible.
2. Cool the burn with cold running water until pain is relieved.
3. Cover the burn loosely with a sterile dressing.
4. Prevent Shock (see section on Shock).
5. Do not break blisters but loosely cover blisters with a sterile dressing.

HEAD, NECK OR BACK INJURIES

WHAT TO LOOK FOR

- Involved in an auto accident
- Injury resulting from a fall distance greater that standing height
- Complaints of neck or back pain, tingling or weakness in arms or legs
- Person not fully alert
- Person appears intoxicated
- Person appears frail or over 65 years of age

WHAT TO DO

- Check the scene for safety then check the person and obtain consent
- Call 911
- Try to keep person as still as possible
- Support the head in position find person
- DO NOT MOVE HEAD OR PERSON

SPLINTING

Splint injured body part only if person must be moved and it does not cause pain

WHAT TO DO

- Check the scene for safety, then check person and obtain consent
- Check inured body part for circulation, feeling, warmth and color
- Splint injured body part in position found
- Recheck circulation
- If there is an obvious deformity, suspected fracture of person cannot bear weight call 911
- General care for muscle, bone or joint injuries includes R.I.C.E.
    1. Rest
    2. Immobilize
    3. Cold
    4. Elevation