



## AAAWMI

### 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
- Job Description
- Employee Wage Information
- Employee Eligibility Checklist
- Payroll Procedures (Please read carefully)
  - Employee Signature
- Direct Deposit Application (Attachment required)
- Required Training (Training must be submitted with/by your first timesheet)

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Employee Email

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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](mailto:training@stuartwilsonfi.com)

Mail: Stuart T. Wilson CPA, PC Attn: *Personnel* 6300 Schade Dr. Midland, MI 48640

# Employee's Withholding Certificate

**2022**

▶ **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.**

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

**Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5.** See page 2 for more information on each step, who can claim exemption from withholding, when to use the estimator at [www.irs.gov/W4App](http://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](http://www.irs.gov/W4App) for most accurate withholding for this step (and Steps 3–4); **or**

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

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

**TIP:** To be accurate, submit a 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.)

<b>Step 3:</b> <b>Claim Dependents</b>	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 . . . . .		<b>3</b>	\$ _____
<b>Step 4 (optional): Other Adjustments</b>	(a) <b>Other income (not from jobs).</b> If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . .	<b>4(a)</b>	\$ _____
	(b) <b>Deductions.</b> If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . .	<b>4(b)</b>	\$ _____
	(c) <b>Extra withholding.</b> Enter any additional tax you want withheld each <b>pay period</b> . . . . .	<b>4(c)</b>	\$ _____

**Step 5: Sign Here**

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

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

▶ **Date**

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

## General Instructions

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](http://www.irs.gov/FormW4).

### Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, 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](http://www.irs.gov/W4App) if you:

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

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

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

## Specific Instructions

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

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

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

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



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

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

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



- 1 Enter an estimate of your 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
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 }
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-"
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
5 Add lines 3 and 4. Enter the result here and in Step 4(b) of Form W-4

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

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

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

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

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

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$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 <i>(Family Name)</i>		First Name <i>(Given Name)</i>		Middle Initial	Other Last Names Used <i>(if any)</i>	
Address <i>(Street Number and Name)</i>			Apt. Number	City or Town		State ZIP Code
Date of Birth <i>(mm/dd/yyyy)</i>	U.S. Social Security Number □□□□ - □□ - □□□□		Employee's E-mail Address		Employee's Telephone Number	

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

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

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

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

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

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

STOP *Employer Completes Next Page* STOP



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

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

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

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

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

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

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

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

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

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

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

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

**I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.**

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

## LISTS OF ACCEPTABLE DOCUMENTS

### All documents must be UNEXPIRED

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

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

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

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

Participant Name: \_\_\_\_\_

## Employment Agreement

This agreement is made on (date): \_\_\_\_\_ between Waiver participant/employer and employee to describe supports that the employee will provide to the employer and the terms and conditions of employment.

### Article I Employee Responsibilities

I, (employee name) \_\_\_\_\_, am aware and agree that my employment is conditional to my employer's participation in the Self Determination (SD) Program administered by Area Agency on Aging of Western Michigan (AAAWM). If my employer ends participation in the Self Determination 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 and AAWM. 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 AAWM or my employer.
3. I shall immediately notify my employer's physician and/or call 9-1-1 if my employer experiences a medical emergency or illness or follow other emergency plan as indicated by my employer.
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 AAWM's regulations regarding employment duties to the employer through the Self Determination Program. I acknowledge receipt of the following rules and regulations:
  - a. Job description
  - b. I am 18 years of age or older, and a US Citizen or legal alien
  - c. I am able to demonstrate an ability to perform tasks my employer has designated in the job description
  - d. I will complete CPR, first aid and blood borne pathogens/universal precautions training prior to employment. If participant has a Do Not Resuscitate (DNR) Order the CPR training 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. I agree to use a standardized form which will be supplied by either the employer or Fiscal Intermediary
6. I understand that this is an at will employment relationship which can be terminated by me or by 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 7 (seven) days written notice to my employer if I choose to terminate my employment.

7. I understand and acknowledge that \_\_\_\_\_ is my employer and I am not an employee of AAAWM, who authorizes the supports I provide, nor the fiscal intermediary, who is the financial administrator of the Self Determination Programs funds that are used to pay me.
8. I agree to not sue the fiscal intermediary for its role as the financial administrator of my employer's Self Determination funds or AAAWM for its role in administering the Self Determination Program.
9. I agree to compensation of \_\_\_\_\_ per hour for my services.
10. I understand that my compensation rate may be available for an increase as funds become available through the MI Choice Waiver Program. I will be notified of any approved wage changes by my employer.
11. I agree to execute a Medicaid Provider Agreement with AAAWM and acknowledge that this agreement does not alter the fact that AAAWM is only the project administrator of the SD Program and that my employer is \_\_\_\_\_. I understand that my employment is contingent upon completion this agreement.
12. I understand that the participant has been approved for a total of \_\_\_\_\_ hours of community living supports per month, or a total of \_\_\_\_\_ hours community living supports per week. Combined with other work hours, I will not work over this amount unless my employer consults the Care Manager from AAAWM the additional hours are approved in the budget.
13. I understand that the authorized hours of community living supports are established by the waiver agency based on the needs of my employer. This authorization can adjust (either increase or decrease) based on those needs. I will be notified by my employer if/when community living support hours are adjusted and affect my work schedule.
14. I understand my hours will be reduced if a skilled home care or hospice agency becomes involved in the care of my employer as they will provide a home health aide under his/her Medicare benefit and services cannot be duplicated.
15. I also understand that if my employer is admitted to the hospital or any other medical care setting I cannot be paid during their absence and to submit time slips for this time constitutes Medicaid fraud and are grounds for termination.
16. I will not submit time sheets for any hours of work I have not performed and I realize that if I falsify timesheet documents it is fraud and legal proceedings may be pursued. I also understand it is grounds for termination.

## Article II Employer Responsibilities

I, (Employer name) \_\_\_\_\_, agree to become an employer in the Self Determination Program and accept the responsibility to perform or designate the duties of the employer for my employees:

1. I will provide the fiscal intermediary with the necessary documentation to assure timely compensation of my employee(s).
2. I will compensate my employee(s) in the following manner: \_\_\_\_\_ per hour.
3. I understand I am approved for \_\_\_\_\_ hours of community living supports per month and that I will have to consult with my Care Manager before I can allow my employee(s) to work additional hours.
4. Payroll will be handled by my fiscal intermediary who will withhold all necessary tax, unemployment insurance and other required withholdings from the employee's paychecks.
5. I will assure my employee receives appropriate training. I can choose to waive CPR training if I have a Do Not Resuscitate (DNR) order in place. I understand that AAAMM requires me to provide them with a copy of the DNR for their records.
6. I will evaluate the performance of my employee(s) and provide appropriate feedback to my employee(s) to assure that I am receiving quality supports.
7. I will assure that my employee(s) executes a Medicaid Provider Agreement with AAAMM.
8. I understand that if a skilled home care or hospice agency becomes involved in my care, my employee(s) hours will be reduced as I will be provided with home health aide from this skilled agency under my Medicare benefit.
9. I understand that if I go into the hospital or other medical care setting, my employee(s) cannot be paid during my absence.
10. I will not sign nor approve any timesheets for hours of work that my employee has not performed. I understand that falsifying timesheets is a criminal offense.
11. 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 otherwise). I will ensure that no illegal activity occurs in the presence of my employee(s).
12. I understand that self-determination may be terminated when problems arise due to my inability to effectively direct services and supports.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employer Signature

\_\_\_\_\_  
Date

## Medicaid Provider Agreement

The purpose of the Medicaid Provider Agreement is to assure that all providers of services and supports funded by Medicaid agree to comply with the federal Medicaid Requirements. Every Medicaid Provider must complete the Medicaid Provider Agreement and this agreement must be on file with the fiscal intermediary prior to the first payment for services.

# Medicaid Provider Agreement

This agreement is made on \_\_\_\_\_ between AAAMM (the Waiver Agent) and \_\_\_\_\_  
(Date) Medicaid Provider for \_\_\_\_\_  
(Employee) (Participant)

The purpose of this agreement is to define the roles and responsibilities of the above named parties. This agreement shall remain in effect until such a 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 identified in this document is 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.

The Medicaid Provider stipulates that he/she agrees to the following:

1. To keep any records required by the Participant or the Waiver Agent regarding the services provided to Participant(s) and to provide such information to 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 45, subpart B, as applicable.
3. To comply with the 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 Medical Provider will carry out that advance directive so the Participant can make an informed choice during the hiring process.

1

Both parties recognize and acknowledge that the sole purpose of this agreement is to assure compliance with 42 USC 1902 (a) 27.

Both parties recognize and reaffirm that the waiver agent is *not the* employer of the Medicaid Provider, and that the participant, or his/her designee, is the sole employer of the Medicaid Provider.

This agreement sets forth the entire understanding between the parties and 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.

\_\_\_\_\_  
AAAMM Manager

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee of SD participant

\_\_\_\_\_  
Date

<sup>1</sup> 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).



The Source for Seniors

## SELF DETERMINATION PROGRAM EMPLOYEE JOB DESCRIPTION

Position: Community Living Assistant

Employee Name: \_\_\_\_\_

Participant/Employer Name: \_\_\_\_\_

Are you a family member of the participant?  Yes  No

If yes, what is your relation? \_\_\_\_\_

**SERVICES TO BE PERFORMED:** (\*These duties are specific to the participant and are not authorized for any other members of the household.)

Bathing (specify type):	Med Self-Administration (remind/assist/observe/document)
Dressing	Linen Change, Laundry, Bedroom*
Personal Hygiene (including Hair care, Mouth care, Skin care and personal grooming)	General cleaning (incl. dusting, vacuuming, floors (sweep/mop), removing trash)*
Ambulation/Mobility	Meal Prep/Assist with feeding/Encourage fluids
Range of Motion/Exercises	Clean Bathroom and Kitchen (incl. washing dishes)*
Assist with toileting (including Bathroom, Commode, Bedpan, and Incontinent Products)	Transportation to community activities (excludes medical care)*
Catheter Care (cleansing only)	Errands/Shopping (mainly for food and necessities)*
Empty/Rinse Ostomy Bag	Respite: To relieve primary caregiver of identified activities*
Turning/Repositioning	Other:

**SCHEDULING (DAYS/HRS):**

YOU ARE A  FULL-TIME (18 hours or more)  PART-TIME WORKER (17 hours or less)

Contact employer if you need to request any schedule changes.

MON	TUES	WED	THU	FRI	SAT	SUN

**TRANSPORTATION NEEDS:** (driver’s license confirmation required) must be approved by AAAWM.

a. \_\_\_\_\_ b. \_\_\_\_\_

**IT IS IMPORTANT TO ME THAT MY WORKER:** (i.e. does not smoke in my home, maintain confidentiality, be punctual, etc.)

a. \_\_\_\_\_ b. \_\_\_\_\_

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

My worker understands that his/her performance will be evaluated by me periodically. He/she also understands that unsatisfactory performance can result in termination of employment with me.

\_\_\_\_\_  
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: \_\_\_\_\_



**Employee Eligibility Checklist**

Please fill out and sign below to validate that Stuart Wilson FI has informed you on prohibited conflicts of interest based on Medicaid requirements.

**Please check if any apply to you.** If you **do** check any of the items below, you are **NOT** qualified to work for that “employer” (person receiving the service). If you have any questions please call your Supports Coordinator/Case Manager.

**1. Community Living Supports (CLS) may not be provided by the following individuals.**

**Are you:**

- A spouse of the employer?
- Parent of an employer who is a minor child?
- The guardian of the employer, or co-guardian or alternate/standby guardian of employer?
- Spouse of the employer’s guardian or spouse of employer’s co-guardian or alternate/standby guardian?
- Individual designated by the employer as attorney-in-fact, or an alternate attorney-in-fact under a durable power of attorney?

**2. Respite Care may not be provided by any of the persons listed above or the following.**

**Are you:**

- Any of the persons listed above in section 1?
- Unpaid primary caregiver of the person receiving services?

**3. Stricter rules apply if your employer is enrolled in Children’s Waiver (CW). CLS or Respite Care may not be provided by the following if your employer is enrolled in CW.**

**Are you:**

- Any of the persons listed above in sections 1 or 2?
- Living in the same home as the employer?

**If none of the above pertains to you, please check here \_\_\_\_\_**

\_\_\_\_\_  
**Employee Signature**

\_\_\_\_\_  
**Date**

If at any time the above mentioned conditions should change, it is the responsibility of the employee to notify the supports coordinator/case manager.



## 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 1<sup>st</sup> & 16<sup>th</sup>**
- **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 1<sup>st</sup> & 16<sup>th</sup> 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.*



### 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](mailto: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](mailto:payroll@stuartwilsonfi.com)  
Mail: Stuart T. Wilson CPA, PC Attn: Personnel 6300 Schade Dr. Midland, MI 48640



The Source for Seniors

# SELF DETERMINATION PROGRAM EMPLOYEE TRAINING ACKNOWLEDGMENT

Participant Name: \_\_\_\_\_

Employee Name: \_\_\_\_\_

Please check only those that apply:

1. I am CPR certified. **(Must provide proof of certification.)**

\_\_\_\_\_ (employee initials)      \_\_\_\_\_ (expiration date)

2. I have read the CPR training materials. I feel I could perform CPR in case of an emergency.

\_\_\_\_\_ (employee initials)      \_\_\_\_\_ (date)

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

\_\_\_\_\_ (employee initials)      \_\_\_\_\_ (date)

4. I have read the First aid reference guide on basic first aid. I feel I could perform basic first aid if needed.

\_\_\_\_\_ (employee initials)      \_\_\_\_\_ (date)

5. I am certified in nursing assistance. **(Must provide proof of certification.)**

\_\_\_\_\_ (employee initials)      \_\_\_\_\_ (expiration date)

I have specialized training in the following areas:

\_\_\_\_\_

\_\_\_\_\_  
Employee/Provider Signature

\_\_\_\_\_  
Date

**A SIGNATURE IS REQUIRED HERE ONLY IF A DNR IS IN PLACE.**

I have waived the CPR requirement for my employee because I have a Do Not Resuscitate (DNR) order in place. **(A copy of this document must be provided to the waiver agency for the file.)**

\_\_\_\_\_  
Employer Signature

\_\_\_\_\_  
Date