PO Box 242930
Little Rock, AR 72223
Toll Free 866.710.0456
Online: PalcoFirst.com

Family-Directed Services Community Support Worker Employment Packet

Welcome to self-direction and to Palco! This packet contains all the forms you need to enroll as an worker and begin providing services to your participant. Please follow all directions in this packet. You will not be paid for services until all forms are completed, Palco verifies all information, criminal checks, and clears you for hire, and you are notified that you are ready to provide service.

You must complete and return:

- ☐ Worker Intake Form
- ☐ Worker Qualification Form
- ☐ Participant/Worker Employment Agreement
- ☐ Medicaid/Worker Agreement
- ☐ Criminal History Check Waiver of Liability/Assumption of Risk
- ☐ US CIS Form I-9
- ☐ I-9 Supporting Documentation
- ☐ Copy of Social Security Card
- ☐ Payroll Information Worksheet
- ☐ IRS Form W-4
- ☐ Idaho State Form W-4
- ☐ Pay Selection & Direct Deposit Form

We encourage you to use the checklist above as a final review before you return the forms to Palco. Failure to return these forms will delay enrollment. The other documents, including information on how to complete forms, the payment schedule, Palco's Notice of Privacy Practices, F.A.Q. and similar instructional forms, are for informational purposes only and do not need to be returned to Palco. Send completed paper forms by fax, email or mail to Palco at the address below.

Fax: 501-821-0045
Email: enrollment@palcofirst.com
Palco, Inc.
Attn: Enrollment
P.O. Box 242930
Little Rock, AR 72223

Visit our website to download an intake form OR contact customer support to get connected to an enrollment specialist. You must complete a consent form before receiving an email with your login instructions. Follow the instructions in that email to complete your enrollment.

Should you need any assistance during this process, please contact a friendly customer support representative at 1.866.710.0456 or info@palcofirst.com.

We look forward to serving you!

Sincerely,
The Palco Team

Frequently Asked Questions

Palco serves individuals who participate in the self-directed model by providing various financial, customer support, and informational services. Below are frequently asked questions to help you understand our processes, your requirements, and how to receive assistance.

How do I complete forms if I am unable to sign?
We encourage you to enroll online, as there are plenty of accessible options on our website. However, if you are unable to use our online system, you may either sign with an X or a mark, then have a witness legibly sign the document on the line above the 'witnessed by'.

What if I need assistance in completing forms?
Online enrollment is the easiest method for completing forms. Palco customer support agents can assist you in gaining credentials to enroll online. Or, if you would prefer, our staff can provide in-person assistance with completing forms.

When can the worker begin providing services?
Palco will notify the employer and the worker once all requirements for enrollment have been met. The date of this notification is the date work can begin. Any work performed prior to that date will not be paid by the program.

Can a worker provide services to multiple participants?
Yes. However, a worker must abide by all program rules, especially those regarding overlapping claims for payment of services.

What happens if a worker wants to work for another employer?
Workers may be employed by as many employers as he or she would like. Each time he or she begins working for a new employer, a new worker packet must be completed, just like getting any new job. However, some requirements may be waived depending on the circumstances, such as providing a copy of Social Security cards or documentation related to receiving direct deposit. Generally, background checks can also transfer, but be sure to check with your program rules to make sure you understand all the requirements.

What happens if a worker stops providing services?
Anytime a worker stops providing service, Palco must be notified via an Employment Separation Notice, which can be found on our website. Even after termination, workers should keep Palco aware of any changes in contact information throughout the year, so that we can send correspondence, such as W-2s, to the correct address.

How does a participant change an employer of record?
A Designation of Surrogate Employer form must be completed. Be sure to include the date of the change at the top of the form.

How does an employer of record change impact existing workers?
Workers must re-complete some new hire forms, such as the I-9. Palco will notify you of the requirements. Be sure to complete any required forms so that your pay is not impacted.

Can someone correspond with Palco on my behalf?
Federal and state privacy laws prevent Palco from disclosing personal information to unauthorized individuals. Palco will only correspond with workers about that worker's particular account. Surrogate employers may receive all information about the worker's accounts and information about the participant necessary to carry out employer roles. Participants have unlimited access to information held by Palco on their account. Participants may appoint an authorized user by completing an Authorized User Designation form.

What if a worker doesn't receive the funds on the scheduled payday?
For direct deposited payments, please allow sufficient time for the pay to deposit into your account. We recommend allowing 24 hours after payday for the deposit

Will the worker receive a W-2 at year-end?
W-2s are available January 31. If receiving the W-2 by mail, please allow one week for delivery. All attendants receive a W-2. Workers who earn less than the annual domestic service threshold, per IRS Pub. 15 (Circular E), will also receive a refund of over collected FICA. The employer should encourage their workers to make sure that the correct address and direct deposit information is current with Palco prior to this date, even if the worker is no longer working.

How do I change my information with Palco?
The fastest and easiest method is to log into your account and change your information. Otherwise, you must complete the appropriate form and mail or fax it to Palco. All forms are found at palcofirst.com. For name and contact information changes, complete a Change of Information form and attach documentation to show proof of name change which can be driver's license, divorce degree or marriage license. For withholding changes, complete an IRS W-4, or Payroll Information Worksheet. To change payment information, complete a Direct Deposit Authorization. For any other changes, contact Palco customer support.

How can Palco be contacted?
Palco Customer Support representatives are available Monday through Friday, 8:00 a.m. to 5:00 p.m. CST, except state holidays. You may reach us by phone at 501.604.9936 or toll free at 1.866.710.0456, email to customersupport@palcofirst.com, fax to 501.821.0045 or mail to P.O. Box 242930, Little Rock, AR 72223. Palco has a range of translator and interpreter services at your request.

Notice of Privacy Practices

Palco may receive and create records concerning your medical and individually identifiable information ("PHI") and is required to maintain the privacy and security of your PHI. Please read this notice carefully. If you have questions or concerns, contact the Palco Privacy Officer at privacy@palcofirst.com. Palco will only use and disclose your information as allowed by law and as described below:

- **Help manage the health care treatment you receive.** We may disclose your information to provide treatment and administer services, including performing assessments, issuing workers' compensation and administering similar programs, and recommending services in some situations. We may disclose information to others who implement your health services. We may correspond with you and/or your designated representative (e.g., surrogate employer or authorized user). All emailed correspondence from Palco is encrypted and secure. By emailing Palco with your personal email account, you accept the risk that your correspondence may not be encrypted, nor secure.
- **Run our business, including payment for and administration of your health services.** We may use and disclose your information to receive and issue payment on your behalf and bill Medicaid, Medicare, Managed Care Organizations, the Veterans Administration, or other bodies, as required by your program.
- **Comply with federal and state law, including investigations by the United States Department of Health and Human Services (U.S. DHHS) and law enforcement.** Palco is required by law to comply with investigations by regulatory bodies and issues involving national security. Palco may be required to disclose your information to coroners and other officials at your death.
- **Respond to legal actions and health oversight, such as lawsuits or quality assurance reviews.** Palco may be required to respond to requests, including discovery, subpoenas, audits, and other legal or regulatory matters.

You have the right to:

- **Authorize the use and disclosure of your PHI for reasons not authorized by federal or state law.** Palco will seek your approval to disclose PHI for reasons not required at law, and you may reject disclosure.
- **Receive this notice of privacy practices**. You can request a copy of this notice or view the posting at palcofirst.com, in enrollment packets, and in program manuals, as applicable. Palco can change the terms of this notice at any time. Changes will apply to all of your medical records. Direct complaints to the Privacy Officer or the U.S. DHHS.
- **Review and receive copies of your records and a list of disclosures.** Requests must be on a Request for Sensitive Records. We will provide you with a copy or summary within 10 days of receiving your request. We may charge a reasonable, cost-based fee for collection of the records, including postage and labor. Palco may reject some requests if required by law.
- **Request amendments to your records.** Requests must be on a Request to Amend Sensitive Information. We will provide you with a copy or summary or a rejection within 15 days of receiving your request.
- **Request information in an alternate format or restrict access on your records**. Requests must be in writing on a Request for Additional Privacy. We will provide you with a copy or summary within 15 days of receiving your request. We may reject or terminate the request in certain limited cases and will notify you of rejections and terminations.
- **Be notified in case of a breach of your sensitive information.** You will be notified within 60 days by the Privacy Officer.
- **Choose someone to act on your behalf with regard to your records.** You must complete the appropriate forms and information to designate Authorized Users in order for those individuals to communicate with Palco on your behalf.

PALCO PAYMENT SCHEDULE - 2024

Idaho Programs

Service Period		Timesheets Due to Palco by 12 PM MST	Electronic Timesheets Due by 12 pm	Payments Made by Palco by 5pm
SUNDAY	SATURDAY	MONDAY	TUESDAY	FRIDAY
Start Date	End Date	Deadline	Deadline	Paid On
December 17, 2023	December 30, 2023	January 1, 2024	January 2, 2024	January 12, 2024
December 31, 2023	January 13, 2024	January 15, 2024	January 16, 2024	January 26, 2024
January 14, 2024	January 27, 2024	January 29, 2024	January 30, 2024	February 9, 2024
January 28, 2024	February 10, 2024	February 12, 2024	February 13, 2024	February 23, 2024
February 11, 2024	February 24, 2024	February 26, 2024	February 27, 2024	March 8, 2024
February 25, 2024	March 9, 2024	March 11, 2024	March 12, 2024	March 22, 2024
March 10, 2024	March 23, 2024	March 25, 2024	March 26, 2024	April 5, 2024
March 24, 2024	April 6, 2024	April 8, 2024	April 9, 2024	April 19, 2024
April 7, 2024	April 20, 2024	April 22, 2024	April 23, 2024	May 3, 2024
April 21, 2024	May 4, 2024	May 6, 2024	May 7, 2024	May 17, 2024
May 5, 2024	May 18, 2024	May 20, 2024	May 21, 2024	May 31, 2024
May 19, 2024	June 1, 2024	June 3, 2024	June 4, 2024	June 14, 2024
June 2, 2024	June 15, 2024	June 17, 2024	June 18, 2024	June 28, 2024
June 16, 2024	June 29, 2024	July 1, 2024	July 2, 2024	July 12, 2024
June 30, 2024	July 13, 2024	July 15, 2024	July 16, 2024	July 26, 2024
July 14, 2024	July 27, 2024	July 29, 2024	July 30, 2024	August 9, 2024
July 28, 2024	August 10, 2024	August 12, 2024	August 13, 2024	August 23, 2024
August 11, 2024	August 24, 2024	August 26, 2024	August 27, 2024	September 6, 2024
August 25, 2024	September 7, 2024	September 9, 2024	September 10, 2024	September 20, 2024
September 8, 2024	September 21, 2024	September 23, 2024	September 24, 2024	October 4, 2024
September 22, 2024	October 5, 2024	October 7, 2024	October 8, 2024	October 18, 2024
October 6, 2024	October 19, 2024	October 21, 2024	October 22, 2024	November 1, 2024
October 20, 2024	November 2, 2024	November 4, 2024	November 5, 2024	November 15, 2024
November 3, 2024	November 16, 2024	November 18, 2024	November 19, 2024	November 29, 2024
November 17, 2024	November 30, 2024	December 2, 2024	December 3, 2024	December 13, 2024
December 1, 2024	December 14, 2024	December 16, 2024	December 17, 2024	December 27, 2024
December 15, 2024	December 28, 2024	December 30, 2024	December 31, 2024	January 10, 2025
December 29, 2024	January 11, 2025	January 13, 2025	January 14, 2025	January 24, 2025

Late time submissions and mistakes may result in late payment!

2024 Office Closures

New Year's Day - Monday, January 1*
Martin Luther King, Jr Day – Monday, January 15
President's Day – Monday, February 19
Memorial Day - Monday, May 27*
Juneteenth Day – Wednesday, June 19
Independence Day - Thursday, July 4*
Labor Day - Monday, September 2*
Columbus Day – Monday, October 14
Veterans Day – Monday, November 11
Thanksgiving - Thursday-Friday, November 28-29*
Christmas - Tuesday-Wednesday, December 24-25*

*** Palco Office Closures**

Instructions for Worker Forms

Please use the instructions below to complete the attached Palco forms in order to become a worker through the self-directed program.

- The **Worker Intake** is used to enroll the worker in the program and associate him or her with the employer and participant. Complete the entire form. Sign and date the highlighted fields on page 2. Please make sure your employer signs and dates the highlighted fields on page 2 as well.

- The **Worker Information & Qualification** notifies you of your duties associated with being a worker on the self-direction program. Please read this form carefully to make sure that you understand and will comply with the information therein. Complete the Worker Information box at the top of page 1. Sign and date the highlighted fields on page 2.

- The **Participant-Community Support Worker Employment Agreement** completed by the worker along with the participant to document the specific services the employee will perform. It also documents how often and how long the employee is to provide each service as well as the rate of pay.

- The **Medicaid-Community Support Worker Agreement** describes things that the worker will do as an employee. The employee agrees that the participant will pay only for work done in accordance with program rules and terms of the Participant-Community Support Worker Employment Agreement.

- The **Criminal History Check** is a mandatory requirement to perform a Criminal History Check on that employee. Under the My Voice, My Choice and Family-Directed Services programs a participant can choose to waive the background check requirement for community support workers by completing the Criminal History Check Waiver Form.

- The **Criminal History Check – Waiver of Liability/Assumption of Risk** is ONLY REQUIRED IF the participant/guardian wishes to waive the employee from being subject to a criminal history check prior to providing service.

PALCO
PO Box 242930
Little Rock, AR 72223
Toll Free 866.710.0456
Online: PalcoFirst.com

Applicant Worker Intake

Complete this form entirely to begin the enrollment process as a worker in the My Voice, My Choice program. Completion of this form does not constitute a hiring by the employer.

PARTICIPANT INFORMATION		
Full Name	SSN	Program:

WORKER (APPLICANT) INFORMATION			
First Name	Middle Name	Last Name	
Social Security Number	Email	Date of Birth (mm/dd/yyyy)	Gender ☐ Male ☐ Female
Is the worker-applicant related to the participant by blood or marriage? ☐ No ☐ Yes I am the participant's:_____ (specify relationship)			
Do you share a residence with the participant? ☐ No ☐ Yes Please specify who owns or rents the residence: _____			
Physical Address (Street Address, Including Apt. #)			
City	State	Zip	County
Mailing Address (Street Address, Including Apt. #) – *if different than the physical address*			
City	State	Zip	County
Phone1	Phone2	Preferred Method of Communication ☐ Email ☐ Mail ☐ Phone / Voicemail	

How would you like to continue the enrollment process?

☐ Complete Enrollment Paperwork Online. The worker will receive login instructions from Palco.

☐ Email a prepopulated PDF packet to the worker.

☐ Mail a prepopulated paper packet to the worker's address.

PO Box 242930
Little Rock, AR 72223
Toll Free 866.710.0456
Online: PalcoFirst.com

By signing below, the worker consents to complete enrollment electronically and has provided an email address and Social Security Number that belongs to him and her. The worker understands that Palco is not responsible for providing information to an incorrect email address supplied by him or her. The worker has read and agrees to Palco's Notice of Privacy Practices and the Terms and Conditions of Palco's online enrollment system. The worker agrees to receive information, notifications, and other correspondence electronically to the email address provided. Such correspondence may contain Personal Health Information as defined at 45 CFR 160.103 and other personally identifiable information. The worker accepts all risks associated with the transmission of such information via those channels. The worker understands that his or her consent is in effect until Palco is notified in writing that the worker withdraws such consent.

_____	_____
Worker Printed Name	**Employer Printed Name**
_____	_____
Worker Signature	**Employer Signature**
_____	_____
Date	**Date**

***Please return this form to Palco via email: enrollment@palcofirst.com* or via fax to 1.877.859.8757.**

PO Box 242930
Little Rock, AR 72223
Toll Free 866.710.0456
Online: PalcoFirst.com

Worker Information & Qualification

This form is required for all workers in self-direction. Please complete this form entirely.

WORKER (APPLICANT) INFORMATION	
Full Name	ID/Last 4 of SSN

As a worker in self-direction, you must agree to the following terms of employment:

- You understand that the participant, or his or her surrogate, is your employer. Neither Palco, nor program/state administrators, is your employer.
- This position is paid as an employee and not as an independent contractor.
- This document does not create an anticipation of, nor a contract of, employment.
- To adhere to all federal, state, local, and program laws, regulations, policies, and requirements throughout your employment. This includes staying current on information provided about the program throughout your employment.
- To accurately complete all enrollment documentation to ensure that you meet the program's eligibility requirements for providing services and is not prohibited in any manner from providing services.
- That your employment is contingent upon many factors, including successful completion and/or passing of required background checks, training, and credentialing.
- To report any changes in your ability to deliver services, including changes in your background history or qualifications required to perform services under this program.
- Being paid for services through the program is contingent upon the participant's eligibility for the program. Once eligibility terminates, you may no longer be paid through this program.
- Your employer is responsible for payment of services for activities not authorized in or exceeding the limitations established by the budget.
- Funds to pay for services are from public sources, and financial accountability and liability applies to the use of the funds. You understand that submitting false or fraudulent timesheets or submitting timesheets for tasks other than those approved on the authorized budget will be reported to the appropriate authorities for investigation and possible prosecution as fraud.
- That medical and personal information and data about the participant and the worker is confidential. You have read and agree to Palco's Privacy Practices.
- That neither Palco nor program/state administrators are responsible or liable for any negligent acts, work-related injuries, or omissions by me, the employer, participant, other workers or service providers, or authorized representatives.
- To report all critical incidents relating to the participant's health, safety, and welfare, including suspicion of fraud, abuse, or neglect.

_____
Worker Initials

PO Box 242930
Little Rock, AR 72223
Toll Free 866.710.0456
Online: PalcoFirst.com

You certify that you are at least 18 years of age. You give your permission for Palco to run federal and state Office of Inspector General Medicaid exclusion checks and to share the results with my employer, state and program administrators, and others who may be involved in the participant's care through this program. You understand that your employment is based on the outcome of these checks and that you cannot provide services, nor receive payment, until Palco has notified you that you have been cleared to do so. You hereby release your employer, Palco, and his/her agents from any and all liability, claims and/or demands, of whatever kind, related to the compilation or preparation of the checks hereby authorized.

☒ Office of Inspector General Medicaid exclusion check.
☒ List of Excluded Individuals and Entities (LEIE)
☒ Social Security Administration SSN check.
☒ U.S.CIS e-verify system.

By signing below, you acknowledge that you have read this agreement and accept responsibility as a worker in self-direction, understand their responsibilities and duties associated with that role, and will comply with program policies and requirements. The information provided herein is true and accurate to the best of your knowledge. You further understand and agree that violation of this agreement will result in termination.

_____	_____	_____
Worker Printed Name	**Worker Signature**	**Date**

IDAHO DEPARTMENT OF
HEALTH & WELFARE

PARTICIPANT-COMMUNITY SUPPORT WORKER EMPLOYMENT AGREEMENT

This agreement is hereby made between _____, a Participant of
Participant's Name
the Family-Directed Community Supports (SDCS) Option, a Medicaid Option administered by the Department of Health and Welfare (Department), and _____,
CSW's Name
a Community Support Worker (CSW).

The Participant desires to engage CSW for services under the FDCS Option. In exchange, the CSW desires to be paid for services provided to the Participant. Both parties understand and agree that payment is made through a fiscal employer agent (FEA), using Medicaid monies and based on time sheets submitted by the CSW and approved by the Participant.

To these mutual purposes, the parties promise and agree as follows:

1. CSW services are to be provided in accordance with the Participant's FDCS Support and Spending Plan, and the Consumer Directed Community Supports rules, outlined in IDAPA 16.03.13, "Consumer-Directed Services."

2. It is mutually understood that CSW is the employee of the Participant, and that the Participant directs, controls and approves the CSW's work.

3. The CSW is hired to assist the Participant and assumes no legal liability for the Participant's conduct.

4. The CSW promises that he/she meets the following minimum qualifications to be a CSW, as outlined in Section 136 of IDAPA 16.03.13, "Consumer-Directed Services."

5. The parties mutually agree that CSW is an employee of the Participant and is not an employee of the FDCS Option or the Fiscal Employer Agent (FEA), and agree that the CSW is not entitled to nor will make claim for any employee benefits from the FDCS Option or the FEA, including but not limited to, worker's compensation, disability, life or health insurance.

6. The CSW agrees to notify the Participant immediately in the event he/she is unable to provide the agreed services due to sickness, injury or personal emergency. The CSW must obtain the Participant's written approval in advance for any pre-planned absence.

7. The Participant shall train the CSW on the duties and responsibilities of the CSW and shall be responsible for approving the accuracy of CSW's time records.

8. The CSW agrees to provide services in a safe, courteous and professional manner. The CSW acknowledges that any physical, sexual or mental abuse or neglect of the Participant by the CSW will result in the immediate termination of this Agreement and a report being made according to the requirements in Section 39-5303, Idaho Code.

9. The CSW agrees to report any observed physical, sexual or mental abuse, exploitation or neglect of Participant to adult protection authorities immediately.

10. The CSW understands and agrees that they cannot provide or bill for services until:

- an authorized Support and Spending Plan has been submitted to the FEA,
- the signed Employment Agreement has been submitted to the FEA
- the signed Medicaid-CSW Agreement has been submitted to the FEA

11. The CSW understands and agrees that no payment for services will be made until both the CSW and the Participant have signed the appropriate time sheets, acknowledging their accuracy, and have submitted them to the FEA.

12. It is mutually understood that Medicaid funding can only pay for services rendered. Under the FDCS option, the CSW will not receive payment for any vacation time, holiday time, overtime or sick time. Medicaid will not pay wages at an hourly amount in excess of this agreement.

☐ **Please check this box if the employer is requiring the Community Support Worker to specifically document activities that support billable time in writing in a manner agreed upon between the employer and the Community Support Worker.**

More than forty (40) hours per week of paid work are allowed only if the CSW meets the criteria for employees that are exempted from overtime pay and minimum wage requirements as per the Fair Labor Standards Act.

The participant must obtain and follow guidance from the Idaho Department of Labor and Commerce to determine if the CSW is exempt from these requirements. It is the responsibility of the participant to ensure that the CSW is exempt if the participant requires the CSW to work more than forty (40) hours per week.

The CSW will be paid only for the specific services authorized as per the Support and Spending Plan.

The signing of this Employment Agreement by the participant and the CSW signifies that the parties acknowledge that the criteria for exemption from overtime and minimum wage requirements will be met prior to scheduling work hours in excess of forty (40) hours per week or agreeing to wages less than minimum wage standards.

13. Terms and conditions of work. **Effective Date: ___________________.**

COLUMN A Service needed	B Type of Support ☑ **only one box per row**	C Number of hours per year OR Number of miles/year		D Wage per hour OR Wage per mile		E Annual Cost
	☐ Personal PSS ☐ Emotional ESS ☐ Job JSS ☐ Skilled Nursing SNS ☐ Transportation TSS (hourly) ☐ Relationship RSS ☐ Learning LSS ☐ Transportation Mileage Reimbursement (MR)		x		=	$ Sub-Total
	☐ Personal PSS ☐ Emotional ESS ☐ Job JSS ☐ Skilled Nursing SNS ☐ Transportation TSS (hourly) ☐ Relationship RSS ☐ Learning LSS ☐ Transportation Mileage Reimbursement (MR) ☐ **Code for second rate of pay / hour** _____ **Fill in code**		x		=	$ Sub-Total
	☐ Personal PSS ☐ Emotional ESS ☐ Job JSS ☐ Skilled Nursing SNS ☐ Transportation TSS (hourly) ☐ Relationship RSS ☐ Learning LSS ☐ Transportation Mileage Reimbursement (MR) ☐ **Code for second rate of pay / hour** _____ **Fill in code** ☐ **Code for third rate of pay / hour** _____ **Fill in code**		x		=	$ Sub-Total
	☐ Personal PSS ☐ Emotional ESS ☐ Job JSS ☐ Skilled Nursing SNS ☐ Transportation TSS (hourly) ☐ Relationship RSS ☐ Learning LSS ☐ Transportation Mileage Reimbursement (MR) ☐ **Code for second rate of pay / hour** _____ **Fill in code** ☐ **Code for third rate of pay / hour** _____ **Fill in code**		x		=	$ Sub-Total
	☐ Personal PSS ☐ Emotional ESS ☐ Job JSS ☐ Skilled Nursing SNS ☐ Transportation TSS (hourly) ☐ Relationship RSS ☐ Learning LSS ☐ Transportation Mileage Reimbursement (MR) ☐ **Code for second rate of pay / hour** _____ **Fill in code** ☐ **Code for third rate of pay / hour** _____ **Fill in code**		x		=	$ Sub-Total
	☐ Personal PSS ☐ Emotional ESS ☐ Job JSS ☐ Skilled Nursing SNS ☐ Transportation TSS (hourly) ☐ Relationship RSS ☐ Learning LSS ☐ Transportation Mileage Reimbursement (MR) ☐ **Code for second rate of pay / hour** _____ **Fill in code** ☐ **Code for third rate of pay / hour** _____ **Fill in code**		x		=	$ Sub-Total
				Total Cost of Agreement:		$

04888

14. The CSW must meet the following specific qualifications in order to provide the following services including attaching copy of certification/licensure, if applicable, as outlined in IDAPA 16.03.13 Subsections 120.05 and 110.03:

_____

_____

_____

_____

Age Criteria for CSWs (applies to Non-Waiver and Waiver eligible participants):

- Minimum age of in-home worker, with adult caretaker present: 16
- Minimum age of community support, skill building or behavior management: 18
- Minimum age to transport into community: 18

☐ The CSW meets the above age criteria.

15. The CSW agrees to take all actions necessary to become Participant's employee, and to maintain the employment relationship by submitting necessary documents to the FEA, including:

- Completion of W-4, I-9 and other IRS required forms
- A copy of this agreement
- Time sheets approved by Participant recording hours worked.
- Completion of a criminal history check, including clearance in accordance with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks"
    - Unless the Criminal History Background Check is Waived, the CSW has applied for a Criminal History Background Check through the Department of Health and Welfare. **The CSW will list the Department as the agency/employer, using identification number 1710.**

☐ The CSW gives permission to the fiscal employer agent to notify the Participant (Employer) of the results of the Criminal History Background Check. _____
CSW Signature

☐ I am waiving the Criminal History Check requirement. I have completed the attached Waiver of Liability form. I understand that even if CHC is waived the CSW cannot receive Medicaid dollars if he is on a federal or state Medicaid exclusion list. _____
Parent or Legal Guardian Signature

The provisions of this agreement represent the entirety of the agreement between the parties. It may be amended only in writing with both parties consenting by their signatures. It is mutually understood that this is employment at will. Either party may terminate the employment relationship without cause upon two weeks notice. This agreement may be terminated at any time by the Participant due to unsatisfactory CSW performance.

PARTICIPANT Date

LEGAL GUARDIAN (IF APPLICABLE) Date

CSW Date

04889

IDAHO DEPARTMENT OF HEALTH & WELFARE

Idaho Department of Health and Welfare
Self ~ Directed Community Supports Option

MEDICAID – COMMUNITY SUPPORT WORKER AGREEMENT

This agreement is hereby made between the Self Directed Community Supports (SDCS) Option, a Medicaid Option administered by the Department of Health and Welfare (Department), and

_____, a Community Support Worker (CSW).

This CSW is associated with an Agency. ☐ Yes ☐ No.

The CSW acknowledges that even though he/she is the employee of a participant in the SDCS Option, the Department, through the Fiscal Employer Agent (FEA) is the source of payment for the CSW's wages for services performed under the SDCS Option. Because of the unique relationships of the participant, the Department, and the FEA the CSW acknowledges and agrees to the following:

1. Services provided to any participant under the SDCS Option will be provided in compliance with the rules contained in IDAPA 16.03.13, "Consumer Directed Services."

2. Payment will not be requested through the FEA or the Department for any service not performed in accordance with the SDCS rules, the employment agreement with the participant of the participant's Support and Spending Plan. It is understood that neither the FEA nor the Department is liable to pay for any service performed that is not in conformance with the SDCS rules, the employment agreement with the participant of the participant's Support and Spending Plan.

3. The CSW acknowledges that even though he/she is the employee of the Participant, they are also a Medicaid provider under the SDCS Option. As a provider the CSW agrees to accept payment received by the FEA as payment in full for services rendered under the SDCS Option.

4. The CSW acknowledges they are an employee of the participant and not an employee of the Department or the Fiscal/Employer Agent (F/EA) and agrees that the CSW is not entitled to nor will make claim for any employee benefits from the Department of the FEA, including but not limited to, workers' compensation, disability life and/or health insurance.

5. To protect the confidentiality of personal and health information relating to the participant and his participation in the Medicaid Option, and to release that information only on request of the participant or as otherwise allowed by law.

00860

I have read the foregoing agreement, I understand it, and agree to abide by its terms and conditions. I further understand and agree that violation of any of the terms or conditions of this agreement or the rules may result in termination of this Agreement, and thereby the source of payment for my employment to any SDCS participant.

_____

Printed name of CSW

_____

Signature of CSW Date

Note: Each CSW must sign personally.

00861

IDAHO DEPARTMENT OF
HEALTH & WELFARE

Criminal History Check
Waiver of Liability - Assumption of Risk

Participant Name: _____**MID #** _____ **Date:** _____

Waiver: I do not want (name of community support worker) _____ to be subject to

Criminal History Check requirements.

Relationship to the Participant: _____

Description of Service: _____

Reason:

_____

_____

_____

I Will Make Sure I am Healthy and Safe by: _____

_____

Release of Liability means that I am giving up my right to sue the Department of Health and Welfare or make them pay for any costs associated with things such damages, liabilities, and attorney fees that happen because of my choice.

Assumption of Risk means that I understand that there things such as personal injury, property loss, abuse, neglect and exploitation that could happen in my life as a result of my choice even if I try to prevent them from happening.

I have read the definitions above and have talked to my Support Broker and/or Circle of Support and I understand the risks of what could happen if I decide not to make the provider of my Self-Directed services have a Criminal History Check. I agree that my choice is voluntary and that I knowingly assume all such risks.

_____ _____
Signature of Individual Date Signature of Legal Guardian (if applicable) Date

I have provided education and counseling to _____ regarding the risks of waiving a criminal history check for this individual.

Comments:

_____

_____
Signature of Support Broker Date

IDAHO DEPARTMENT OF
HEALTH & WELFARE

Criminal History Check
Waiver of Liability - Assumption of Risk – Failed Criminal History Check

Participant Name: _____**MID #** _____ **Date:** _____

Waiver: I choose to hire (name of community support worker) _____ as my community support worker. I understand that they have failed the criminal history check per requirements at IDAPA 15.05.06, "Rules Governing Mandatory Criminal History Checks".

Relationship to the Participant: _____

Description of Service: _____

Reason: _____

_____

_____

I Will Make Sure I am Healthy and Safe by: _____

_____

_____

Release of Liability means that I am giving up my right to sue the Department of Health and Welfare or make them pay for any costs associated with things such damages, liabilities, and attorney fees that happen because of my choice.

Assumption of Risk means that I understand that there things such as personal injury, property loss, abuse, neglect and exploitation that could happen in my life as a result of my choice even if I try to prevent them from happening.

I have read the definitions above and have talked to my Support Broker and/or Circle of Support and I understand the risks of what could happen if I decide to hire a provider of my Self-Directed services who has a criminal history that would be precluded from providing services in the Idaho Medicaid program. I agree that my choice is voluntary and that I knowingly assume all such risks.

_____ _____
Signature of Individual Date Signature of Legal Guardian (if applicable) Date

I have provided education and counseling to _____ regarding the risks of waiving a criminal history check for this individual.

Comments:

_____

_____
Signature of Support Broker Date

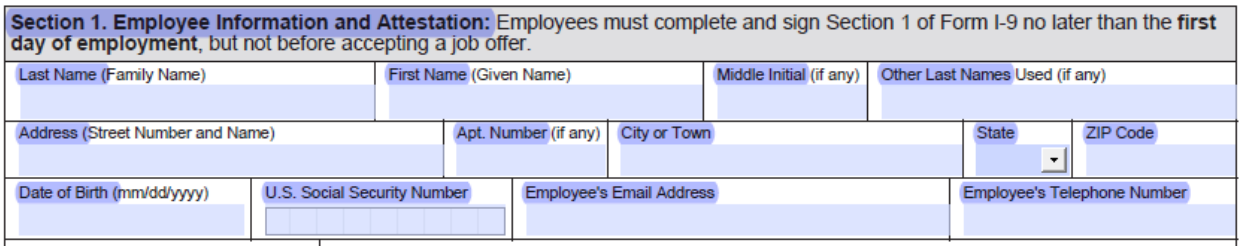
Instructions for I-9

The United States Department of Homeland Security, Citizenship, and Immigration Services (CIS) department, requires all U.S. employers and workers to complete the I-9. The purpose is to verify that the applicant worker can be legally employed in the United States. Palco verifies all workers through the U.S. CIS online system.

Use the instructions and checklist below to guide you through completing this form. The applicant worker should complete all fields highlighted in blue. The employer should complete all fields highlighted in yellow.

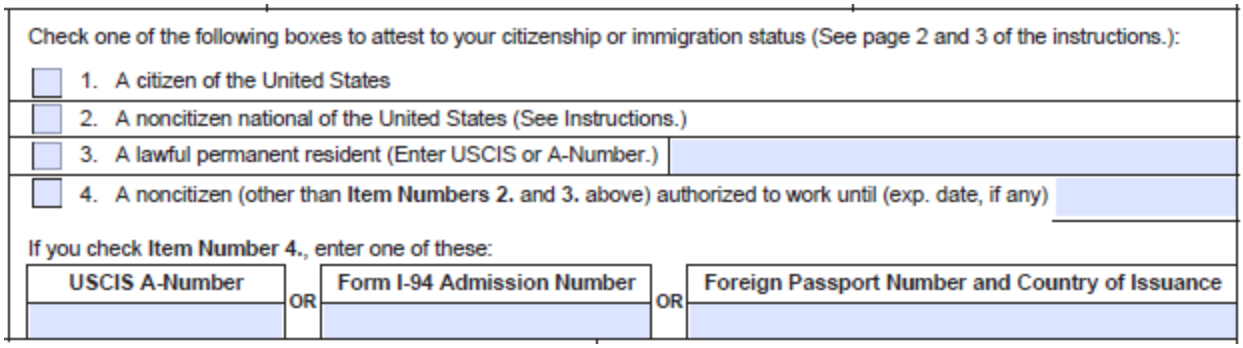
1. Complete Section 1 at the top of page 1.Must be completed by the applicant worker.

☐ Complete all fields in Section 1. The name here must match the name on your verification documents. (See #3 on this checklist.)

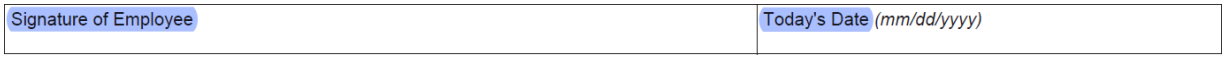


☐ Select the following box that applies to you.

- If you select box 3, supply your alien registration or USCIS number.
- If you select box 4, supply your work expiration date and complete any one of the three fields that follow.



☐ Sign and date.



☐ If necessary, complete the Preparer and/or Translator Certification boxes on page 3.

2. Complete Section 2 at the bottom of page 1. Must be completed by the employer.

☐ Refer to page 2 of the I-9 for appropriate verification documents. Complete all lines associated with the documents provided in the space designated. You must complete one, but not both, of the following two options for submission:

- ☐ One document from List A.
- ☐ One document from List B **and** One document from List C.

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

☐ Attach copies of the verification documents listed on page 1 of the I-9. The employer must review the worker's verification documents.

☐ Provide the employee's first day of employment in the space provided. This date must match the date the worker signed on page 1.

The employee's first day of employment *(mm/dd/yyyy)*: _____

☐ Complete the next two rows of information in Section 2, including signing and dating the form.

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

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

☐ Complete page 4 *only* if the worker had a name or citizenship status change, or if the worker previously worked for the employer within the last three years. If none of these apply, leave page 4 blank.

For more information and assistance on how to complete this form, visit https://www.uscis.gov/i-9.

Employment Eligibility Verification

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

USCIS Form I-9
OMB No.1615-0047
Expires 07/31/2026

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

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

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

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

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

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

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

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

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

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

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

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

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

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

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**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 an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**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 For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
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				

Acceptable Receipts

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

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

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

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

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

USCIS Form I-9 Supplement A
OMB No. 1615-0047
Expires 07/31/2026

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

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

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

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

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

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

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

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

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

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

Supplement B,

Reverification and Rehire (formerly Section 3)

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

USCIS Form I-9 Supplement B
OMB No. 1615-0047
Expires 07/31/2026

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

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

Instructions for Worker Payroll Forms

Please complete the appropriate IRS, state withholding, and additional forms in order to become a worker on the self-directed program. Follow the instructions listed below. All areas highlighted must be signed.

- The **Payroll Information Worksheet** is used to determine any exemptions you qualify for in order for Palco to calculate the proper payroll and payroll tax for you and your employer. Please remember to complete all fields in the Required Information section and sign and date the form. Any missing information could cause a delay in enrollment.

- The **IRS Form W-4** is used by Palco to withhold the proper amount of federal income tax from your paycheck. Complete Steps 1-4, then sign and date the bottom of the form. Additional instructions are included on page two of this form.

- The **State of Idaho Form W-4** tells Palco the correct amount of state income tax to withhold from your paycheck. Page two of the form has instructions for determining the number of allowances to claim and a worksheet to determine if you wish to have any additional amount of money deducted from each paycheck.
  - ☐ Check only one box, A, B, or C for your withholding status.
  - ☐ Include the total number of dependents you would like to claim on Line 1.
  - ☐ If you claim any exemptions, write EXEMPT on Line 1.
  - ☐ Indicate any additional dollar amount to be withheld each pay cycle on Line 2.
  - ☐ Enter your Social Security Number, name and address in the boxes provided.
  - ☐ Sign and date the bottom of the form.

- The **Pay Selection and Direct Deposit Authorization Agreement** is used to inform Palco how you would like to be paid and gives Palco the authority to pay you via electronic funds transfer. Please select one of the two choices (Direct Deposit or Money Network Services). If you select the Direct Deposit option, please follow the instructions on the form. If you choose to enroll in the Money Network Services option, Palco will enroll you with our partners at First Data, Money Network Services.

Payroll Information Worksheet

As a home care worker in self-direction, your payroll tax withholdings are subject to special tax rules, and your residency may impact your benefits under labor laws. Completing this form accurately will ensure that your taxes and benefits are calculated properly. *Note: This is our standard Payroll Information Worksheet. We know some programs can include other exemptions including Difficulty of Care, Companionship, or Live-in Exemptions and are subject to change per program requirements.

REQUIRED INFORMATION	
Employee Name	ID
Employer Name	Participant Name (If different from Employer)

Select the following box that applies:

This form is part of your **first-time enrollment** with Palco.

You are already enrolled with Palco and need to **change** your information

Part A: FICA (Social Security and Medicare) Taxes

The IRS exempts some employers and workers from paying FICA (Social Security and Medicare) taxes.

Select the appropriate response:

- ☐ **Non-Exempt.** None of the selections apply.
- ☐ **Exempt.** I am under 18 and a fulltime student.
- ☐ **Exempt.** I am a non-resident alien holding a visa for household services.
- ☐ **Exempt.** I am the spouse of my employer.
- ☐ **Exempt.** I am the child of my employer and under 21.
- ☐ **Exempt.** I am the parent of my employer who is an adult. This includes adoptive and stepparents.

Exception: If you are the parent of the employer and select any of the following you are non-exempt

- ☐ I am the parent of the employer and I also provide care for my grandchild or step-grandchild in my child's home.
- ☐ I am the parent of the employer, and my grandchild or step-grandchild is under 18 or has a physical or mental condition that requires personal care of an adult for at least four weeks in a row during the calendar quarter in which services are performed.
- ☐ I am the parent of the employer, and my child (son or daughter) is widowed, divorced, not remarried or living with a spouse who has a mental or physical condition so the spouse cannot care for my grandchild for at least four weeks in a row during the calendar quarter in which services are performed. By choosing this.

Part B: Unemployment Tax Exemption

The IRS and State tax agencies exempt some wages from FUTA (Federal Unemployment) or SUTA (State Unemployment) taxes.

Select the appropriate response:

- ☐ **Exempt.** I am the child of my employer and under 21.
- ☐ **Exempt.** I am the parent of my employer who is an adult. This includes adoptive and stepparents.
- ☐ **Exempt.** I am the spouse of my employer.
- ☐ **Exempt.** I am a non-resident alien holding a visa for household services.
- ☐ **Non-Exempt.** None of the selections apply.

Part C: Overtime Payments

There are several factors that may qualify you as being exempt from overtime payments or ineligible for overtime based on program specific rules. Please check the box that applies below:

Exempt from overtime pay for any reason, including program rules or that I meet the DOL Home Care Rule Exclusion qualifications, which means that I am a live-in caregiver, or I reside at the participant's residence at least 5 days per week. (See 29 CFR §552.102 and DOL Fact Sheet #79B). *By checking this box, I understand that, if my employer or the program allows me to work more than 40 hours per week, any hours that I do work over 40 in a work week, will NOT be paid at overtime rates.*

Non-Exempt. I do not qualify for any exemptions and understand that I will be paid overtime rates for time worked beyond 40 in a work week.

If any of the information in this document changes at any time, please complete a new document and submit to Palco immediately. Failure to notify Palco may result in a tax bill to you or other employment-related matters from your employer. Palco is not responsible for incorrectly calculating or withholding pay due to your failure to complete and submit a new Payroll Information Worksheet. By signing below, you certify that the information in this document is correct and understand that you have the burden to notify Palco immediately of any changes in this information, and you hold Palco harmless for any incorrect information supplied herein.

_____

Employee Printed Name

_____ _____

Employee Signature **Date**

Please return this form to Palco via email to enrollment@palcofirst.com or via fax to 501-821-0045.

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

2024

Step 1: Enter Personal Information

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

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

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

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

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

Step 3: Claim Dependent and Other Credits

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

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

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

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

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

General Instructions

Section references are to the Internal Revenue Code.

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 2024 if you meet both of the following conditions: you had no federal income tax liability in 2023 **and** you expect to have no federal income tax liability in 2024. You had no federal income tax liability in 2023 if (1) your total tax on line 24 on your 2023 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2024 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, 2025.

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

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

1. Expect to work only part of the year;

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

3. 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.

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

CAUTION

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 2024 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.

IDAHO State Tax Commission

Form ID W-4
Employee's Withholding Allowance Certificate

Complete Form ID W-4 so your employer can withhold the correct amount of state income tax from your paycheck. Sign the form and give it to your employer. **Use the information on the back** to calculate your Idaho allowances and any additional amount you need withheld from each paycheck. If you plan to itemize deductions, use the worksheet at **tax.idaho.gov/w4**.

Withholding Status

Check the "**A**" box (Single) if you're:

- Single with one job or single with multiple jobs
- Filing as head of household

Check the "**B**" box (Married) if you're:

- Married filing jointly with one job and your spouse doesn't work
- A qualifying widow(er)

Check the "**C**" box (Married, but withhold at Single rate) if you're:

- Married filing jointly and both people work (or you have multiple jobs)
- Married filing separately

IDAHO State Tax Commission

Form ID W-4
Employee's Withholding Allowance Certificate

WITHHOLDING STATUS (see information above)

A ☐ (Single) **B** ☐ (Married) **C** ☐ (Married, but withhold at Single rate)

1. Total number of Idaho allowances you're claiming ..... _____

2. Additional amount (if any) you need withheld from each paycheck (Enter whole dollars) ..... _____

		Your Social Security number (required)
Your first name and initial	Last name	
Current mailing address		
City	State	ZIP code

Under penalties of perjury, I declare that to the best of my knowledge and belief I can claim the number of withholding allowances on line 1 above.

Your signature	Date

1. Total number of allowances you're claiming.

Enter the number of children in your household age 16 or under as of December 31, 2022. If you have no qualifying children, enter "0." If your filing status will be head of household on your tax return, add "2" to the number of qualifying children. **Don't claim allowances for you or your spouse**. You can claim fewer allowances but not more.

If you're married, claim your allowances on the W-4 for the highest-paying job for the most accurate withholding. If you're married filing jointly, only one of you should claim the allowances. The other should claim zero allowances.

If you work for more than one employer at the same time, you should claim zero allowances on your W-4 with any employer other than your principal employer.

Write **Exempt** on line 1 if you meet **both** of the following conditions:

- Last year I had no Idaho income tax liability **and**
- This year I expect to have no Idaho income tax liability

Nonresident Aliens

Exempt income. If you're a nonresident alien and all your income is exempt from withholding, write "Exempt" on line 1.

Exempt income from a treaty. If a treaty exempts a portion of your income from withholding, complete federal Form 8233 to claim your treaty benefits, and complete the Idaho W-4 to withhold on income that's not exempt by your treaty.

Idaho taxable income. If you're a nonresident alien and have Idaho taxable income, do all of these:

1. Check the "Single" withholding status box regardless of your marital status.
2. Enter 0 on line 1.
3. Using the Pay Period table below, enter the additional amount of income tax to be withheld for each pay period on line 2. *Exception*: If you're a student or business apprentice from India, report $0 on line 2.

Pay Period Table				
If your pay period is:	Weekly	Biweekly	Semimonthly	Monthly
Enter this amount on line 2:	$16	$31	$34	$68

The withholding table calculations for employers include the standard deduction. Because nonresident aliens don't qualify for the standard deduction, the Pay Period table helps ensure that employers withhold enough.

2. Additional amount, if any, you need withheld from each paycheck.

If you're single or married filing separately and have more than one job at a time, complete the worksheet below to calculate any additional amount you need withheld from each paycheck.

1. Other than your primary job, how many jobs do you expect to have at the same time during 2022? (Don't count your primary job.) ..... _____
2. Multiply the number on line 1 by $12,550 ..... _____
3. Enter an estimate of your 2022 income from other jobs (not including your primary job) ..... _____
4. Enter the smaller of lines 2 or 3 ..... _____
5. If you completed the itemized deduction worksheet for Idaho (**tax.idaho.gov/w4**), enter the number from line 4. Otherwise, enter "0" ..... _____
6. Multiply the number on line 5 by $3,154..... _____
7. Subtract line 6 from line 4 ..... _____
8. Multiply line 7 by 6.5% (.065). This is the additional amount you need to withhold annually ..... _____
9. Divide the amount on line 8 by the number of your remaining pay periods in 2022. Enter the number on line 2 of the W-4 as the additional amount you need withheld from each paycheck ..... _____

Contact us:
In the Boise area: (208) 334-7660 | Toll free: (800) 972-7660
Hearing impaired (TDD) (800) 377-3529
tax.idaho.gov/contact

Pay Selection and Direct Deposit Authorization Agreement

HOW WOULD YOU LIKE TO BE PAID?
Payment Selection: (please check only one box) ☐ Direct Deposit: ☐ Money Network Services.* *If you choose the Money Network Services Option, Palco will enroll you with our partners at First Data: Money Network Services. You will need to sign an additional Money Network Services Form to enroll.

Request Type (check one):

☐ New Account Setup ☐ Change in Existing Account ☒ Cancellation

DIRECT DEPOSIT ACCOUNT INFORMATION		
Account Holder's Full Name		ID or Last 4 of SSN
Financial Institution	Routing Number	Account Number
Type of Account (select one): ☐ Checking ☐ Savings ☐ Pre-paid card		

REQUIRED The following validating documentation is attached:

☐ Voided check with account holder name printed on the check.
Check cannot be a temporary check.

OR

☐ Official documentation from financial institution listing account holder name, account, and routing number. This includes letters from banks and paperwork from pre-paid cards.

I authorize Palco, Inc. to initiate deposits and debit entries for the purpose of correcting an erroneous deposit to the account indicated herein. In the event Palco is unable to initiate debit entries, I authorize the repayment to Palco from future amounts owed to me. I understand Palco is not responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account. I understand that it is my responsibility to verify the crediting of funds by my financial institution prior to initiating debits against my account. I understand the risks of sharing an account with others, including my employer or worker. Palco is not responsible for any charges I incur from my financial institution. Any changes to my account must be submitted to Palco immediately. This authorization will remain in full force and effect until Palco has received written cancellation in such time and in such manner as to afford Palco and all appropriate financial institutions a reasonable opportunity to act on it.

_____

Printed Name

_____ _____

Signature **Date**

***Please return this form to Palco via email: enrollment@palcofirst.com* or via fax to 1.877.859.8757.**