

Michigan Program

Worker Employment Packet

Welcome to self-direction and to Palco! This packet contains all the forms you need to enroll as a 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 & Attestation Form | ☐ IRS Form W-4 |
| ☐ Worker Information & Qualification Form | ☐ MI W-4 State Withholding Form |
| ☐ U.S.CIS Form I-9 | ☐ Pay Selection and Direct Deposit Form |
| ☐ I-9 supporting documentation | ☐ Worker Pay Rate Information |
| ☐ Payroll Information Worksheet | |

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 13260
Maumelle, AR 72113

You can also complete the packet online if you do not wish to complete these forms by hand. To do so, contact our customer support team and request to enroll online or send us the Worker Intake form with the online option selected.

Should you need any assistance during this process, please contact a friendly customer support representative at 1.866.710.0456 or info@palcofirst.com. Customer support is available 8:00 am - 5:00 pm EST, Monday through Friday, except on state and federal holidays. Please visit our website at www.palcofirst.com for more information on forms and frequently asked questions.

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.

Are there limitations on when services can be provided?

All services are expected to be delivered when the participant is awake and face-to-face.

Can a worker provide services to multiple participants?

Two services cannot be provided at the same time. It is important to coordinate with other service providers regarding your start and stop times to prevent overlapping claims and ensure services can be paid.

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 services, 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 information on their account. Participants may appoint an authorized user by completing an Authorized User Designation form.

How are timesheets submitted?

Timesheets can be submitted online via our portal, by fax, by mail or email. When using the online portal, submit all time properly. Both the employer and the worker must approve all time before it can be processed for payment by Palco. Additional instructions can be found in our Online Registration Packet. When submitting a paper timesheet, follow all instructions to reduce submission errors. A properly submitted timesheet must be received before the deadline to ensure a worker's pay is not delayed.

When does a worker submit timesheets?

The employer is provided with a payroll schedule that shows the deadlines for submitting timesheets and scheduled payday. The payroll schedule for specific programs can also be found at palcofirst.com.

How will I know a timesheet was received and approved?

The online portal will display approval messages in real time. For other methods of submission, contact Palco Customer Support 48 hours after submission to allow time for processing.

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 workers 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.

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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 decree 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 INFO@palcofirst.com, fax to 877.859.8757 or mail to P.O. Box 13260, Maumelle, AR 72113. 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 SEMI-MONTHLY PAYMENT SCHEDULE - 2025

Michigan Program

Service Period		Timesheets Due to Palco By 5:00 PM	Payment Date
		Deadline	
December 16, 2024	December 31, 2024	January 1, 2025	January 10, 2025
January 1, 2025	January 15, 2025	January 16, 2025	January 27, 2025
January 16, 2025	January 31, 2025	February 1, 2025	February 10, 2025
February 1, 2025	February 15, 2025	February 16, 2025	February 25, 2025
February 16, 2025	February 28, 2025	March 1, 2025	March 10, 2025
March 1, 2025	March 15, 2025	March 16, 2025	March 25, 2025
March 16, 2025	March 31, 2025	April 1, 2025	April 10, 2025
April 1, 2025	April 15, 2025	April 16, 2025	April 25, 2025
April 16, 2025	April 30, 2025	May 1, 2025	May 12, 2025
May 1, 2025	May 15, 2025	May 16, 2025	May 27, 2025
May 16, 2025	May 31, 2025	June 1, 2025	June 10, 2025
June 1, 2025	June 15, 2025	June 16, 2025	June 25, 2025
June 16, 2025	June 30, 2025	July 1, 2025	July 10, 2025
July 1, 2025	July 15, 2025	July 16, 2025	July 25, 2025
July 16, 2025	July 31, 2025	August 1, 2025	August 11, 2025
August 1, 2025	August 15, 2025	August 16, 2025	August 25, 2025
August 16, 2025	August 31, 2025	September 1, 2025	September 10, 2025
September 1, 2025	September 15, 2025	September 16, 2025	September 25, 2025
September 16, 2025	September 30, 2025	October 1, 2025	October 10, 2025
October 1, 2025	October 15, 2025	October 16, 2025	October 27, 2025
October 16, 2025	October 31, 2025	November 1, 2025	November 10, 2025
November 1, 2025	November 15, 2025	November 16, 2025	November 25, 2025
November 16, 2025	November 30, 2025	December 1, 2025	December 10, 2025
December 1, 2025	December 15, 2025	December 16, 2025	December 26, 2025
December 16, 2025	December 31, 2025	January 1, 2026	January 12, 2026

Late time submissions and mistakes may result in late payment!

2025 Bank and/or Palco Office Closures

New Year's Day – Monday, January 1*
 Martin Luther King, Jr. Day – Monday January 20
 President's Day – Monday, February 17
 Memorial Day – Monday, May 26*
 Juneteenth Day – Thursday, June 19
 Independence Day – Friday, July 4

Labor Day – Monday, September 1*
 Columbus Day – Monday, October 13
 Veterans Day – Tuesday, November 11
 Thanksgiving – Thursday/Friday, November 27-28*
 Christmas – Wednesday/Thursday, December 24-25*

* Palco Office Closures

Program: Michigan

Worker/Applicant Intake

Complete this form entirely to begin the enrollment process. All information on this form is required in order to enroll. Completion of this form does not constitute hiring by the employer. Services should not begin until you receive a notification from Palco that enrollment is approved.

PARTICIPANT/CLIENT INFORMATION

Full Name	Palco ID
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WORKER INFORMATION

First Name	Middle Name	Last Name	
Social Security Number	Email	Date of Birth (mm/dd/yyyy)	Gender: ☐ Female ☐ Male
Is the worker related to the participant/client by blood or marriage? ☐ No ☐ Yes, I am the participant/client's: _____ (specify relationship)			
Do you share a residence with the participant/client? ☐ No ☐ Yes			
Is the worker at least 18 years of age? ☐ No ☐ Yes			
Have you lived in any other state other than Michigan within the last 5 years? ☐ Yes ☐ No If yes, which state/s have you lived in: _____			
Will you be providing transportation services to the Participant? ☐ Yes ☐ No			
Will you be administering medication to the Participant? ☐ Yes ☐ No			
The Participant IPOS requires training for Non-Aversive techniques for prevention (MANDT/CPI) and treatment of challenging behavior? ☐ Yes ☐ No			
Mailing Address			
City	State	Zip	County
Physical Address (Street Address, including Apt #, if different from mailing)			
City	State	Zip	County
Phone	Preferred Method of Communication ☐ Email ☐ Mail ☐ Phone/Voicemail		

Palco has a fully online enrollment process that is quick and easy. The worker will receive login instructions from Palco via email within 3-5 business days. Once you receive the email, complete your enrollment right away to avoid any delays.

☐ Check this box If you are unable to complete Palco's online enrollment process and an enrollment specialist will contact you for further assistance.

Worker Printed Name

Participant/Employer Printed Name

Worker Signature

Date

Participant/Employer Signature

Date

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

SELF DIRECTED SERVICES EMPLOYMENT AGREEMENT

This agreement is made on _____ (Date) between _____ (“Employer”) and _____ (“Employee”) to describe the supports that hat employee will provide to the employer and the terms and conditions of employment.

Article I

EMPLOYEE RESPONSIBILITIES

I, _____ (Employee) acknowledge and agree that the employment conditioned on my employer’s participation in the Self Directed Services Arrangement /Choice Voucher System administered by the PIHP/CMHSP. If my employer ends participation in the Self Directed Services Arrangement /Choice Voucher System, my employment may end. I agree to the following terms of employment:

1. During the term of this agreement, I shall provide support to my employer by performing the duties outlined in this agreement and any attachments to it.
2. I agree to assist my employer in maintaining the documentation and records required by my employer or the PIHP/CMHSP. I agree to complete all necessary paperwork to secure mandatory payroll deductions from my pay day. All records I may have or assist in maintaining are the property of my employer. I will keep these records confidential, release them only with the consent of my employer, and return them to my employer if my employment ends. In addition, I will complete illness and incident reports, when necessary, as required or requested by the PIHP/CMHSP or my employer.
3. In the event pf a medical emergency I agree to notify my employer’s contact person and to provide immediate medical attention. I will also notify my employer’s contact person before taking my employer to the physician, except in case of an emergency.
4. I agree to participate in any meetings if requested to do so by my employer.
5. I agree to abide by all my employer’s rules and PIHP/CMHSP regulations (described below) regarding my employment duties to the employer through the Self Directed Services Arrangement /Choice Voucher System, and I acknowledge receipt of the following rules and regulations:
 - a. Attachment A to this agreement which outlines the supports that I will provide to my employer.
 - b. Recipient Rights Booklet, I agree to assist my employer in filing right complaints upon request. I also understand that I have a responsibility to report rights violations of which I am aware or any potential abusive or neglectful situations I

observe, I understand that I may be requested to cooperate with a recipient rights investigation and/or assist my employer with exercising his or her rights.

c. Employer House Rules, any additional rules will be given by employer.

d. Additional information and procedures that the Self-Directed Services Arrangement/Choice Voucher System issues by the PIHP/CMHSP.

e. Reporting and documentation requirements for verifying hours worked.

6. I understand that this is an employment at will 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 _____ days written notice to my employer if I terminate my employment.

7. I understand and acknowledge that my employer is my sole employer and that I am not an employee of the PIHP/CMHSP, which authorizes the supports I provide, or the fiscal intermediary, which is the financial administrator of Self-Directed Services Arrangement/Choice Voucher System funds used to pay me.

8. I agree not to sue the fiscal intermediary for its role as the financial administrator of my employer's Self-Directed Services Arrangement/Choice Voucher System funds and the PIHP/CMHSP for its role in administering the Self-Directed Services Arrangement/Choice Voucher System.

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

Benefits: (If any): _____

10. I agree to execute a Medicaid Provider Agreement with the PIHP/CMHSP and acknowledge that this agreement does not alter the fact that the PIHP/CMHSP is only the project administrator of the Self-Directed Services Arrangement/Choice Voucher System, and that my employer is _____ (employer). I understand that my employment is contingent on completing this agreement.

Article II

EMPLOYER RESPONSIBILITIES

I, _____ (Employer) agree to the following:

1. I will provide my fiscal intermediary with the necessary documentation to assure timely compensation of my employee.

2. I will compensate my employee in the following manner: \$ _____/hour.

Benefits will include: _____

Payroll will be handled by my fiscal intermediary _____, which will withhold all necessary tax, unemployment, and other withholdings from the employee's paychecks.

3. I will assure my employee receives appropriate training.

4. I will evaluate the performance of my employees and provide appropriate feedback on an annual basis to assure that I am receiving quality supports.

5. I will assure that my employee executes as Medicaid Provider Agreement with PIHP/CMHSP.

Employee Signature: _____ Date: _____

Employer Signature: _____ Date: _____

SDS Staff Job Description

Date	
Employee Name	
Consumer Name	
Position/Title	Community Living Support/Respite Care Provider/Direct Care Support Staff

Position Summary

Provides Medicaid covered Community Living Support and/or Respite Services under the direction of a client and/or authorized guardian or representative (Employer of Record).

Standard Requirements

1. Must be at least 18 years of age at the time of hire
2. Must obtain a criminal records clearance from Community Mental Health Agency
3. Has completed trainings required by Community Mental Health
4. Understand and abide by HIPAA and Recipient Rights
5. Is knowledgeable of the individualized service plan (IPOS) for the customer and ensure supports are provided to the customer according to the service plan
6. Ability to lift 20 pounds
7. Ability and willingness to toilet (including changing undergarment) several times daily without the support of another staff/family member if needed.
9. If required, staff must have the ability to implement the IPOS and Positive Behavioral Support Plan as written and make needed adjustments as changes are made by VBCMH.

Essential Functions

- Implements IPOS (and if needed the PBSP) as written
- Provides skill development related to activities of daily living by assisting, reminding, observing, guiding, or training the customer with:
 - o Activities of daily living such as, but not limited to, bathing, eating, dressing, toileting, personal hygiene etc.
 - o Routine household care and maintenance including Meal Planning/Preparation, Laundry, Cleaning, Shopping for food and other necessities of daily living
 - o Skill developmental to achieve or maintain mobility, sensory-motor, communication, and socialization.
 - o Implementation of goals and objectives listed in the most current IPOS and PBSP
- Ensures accurate documentation of skill development or lack thereof following IPOS, Medicaid Standards and SDS Arrangement Criteria
- Always stays alert and attentive knowing customers' whereabouts
- Responds appropriately in and emergency situation to ensure the safety of the customer, community and staff.
- Performs other related duties and responsibilities as deemed necessary/requested by supervisor.

Employee Signature

Date

MEDICAID PROVIDER AGREEMENT

This agreement is made on (Date) _____ between Van Buren Community Mental Health PIHP/CMHSP and (Employee Name/Medicaid Provider) _____
Employee/Medicaid Provider.

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 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. This agreement should not be finalized until the provider has met any additional requirements to provide Medicaid Services (i.e. background check, training). Should the provider fail to meet Medicaid requirements, the Host Agency may suspend or terminate this agreement.

Upon receipt of this agreement, the PIHP/CMHSP will certify the Medicaid Provider as available to provide services to individuals who receive services and/or supports in accordance with their individual plans of services and supports developed in a person-centered planning process, authorized by the PIHP/CMHSP or one of its subcontractors, and financed through Michigan's Medicaid Specialty Pre-Paid Mental Health Plan.

The Medicaid Provider stipulates that it agrees to the following:

1. To keep any records required by the participant or the PIHP/CMHSP regarding the services provided to participants and to provide such information and any related invoices or billings, upon request, to the participant, PIHP/CMHSP, the state Medicaid Agency, the Secretary of the Department of Health and Human Services or the state Medicaid fraud control unit.
2. To comply with the ownership disclosure requirements specified in 42 CFR 455, subpart B, as applicable.
3. To comply with intent of the advance directive requirements specified in 42 CFR 489, Subpart I and 42 CFR 417.436 (d), as applicable, by finding out if a participant has an advance directive to refuse life sustaining medical treatment, and informing the participant, before the provider starts work, whether or not the provider will carry out that advance directive so the participant can make an informed choice during the hiring process.

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

This agreement sets forth the entire understanding between the parties with respect to the subject matters, and supersedes any and all other arrangements, 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.

Executive Director or Self-Determination Coordinator

Date

Medicaid Provider Agency/Individual (Employee)

Date

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, 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 to me 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/or 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

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.

- ☒ Certified Record Check.
- ☒ 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 _____

Worker Initials

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.)

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

- 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.

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

- Sign and date.

Signature of Employee	Today's Date (mm/dd/yyyy)
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- 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)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (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)		Additional Information			
Issuing Authority		Check here if you used an alternative procedure authorized by DHS to examine documents.			
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
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.					
Last Name, First Name and Title of Employer or Authorized Representative			Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)
Employer's Business or Organization Name			Employer's Business or Organization Address, City or Town, State, ZIP Code		

For reverification or rehire, complete [Supplement B, Reverification and Rehire](#) on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.

* Documents extended by the issuing authority are considered unexpired.

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

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority For persons under age 18 who are unable to present a document listed above: 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record	1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security For examples, see Section 7 and Section 13 of the M-274 on uscis.gov/i-9-central. The Form I-766, Employment Authorization Document, is a List A, Item Number 4. document, not a List C document.
Acceptable Receipts May be presented in lieu of a document listed above for a temporary period. For receipt validity dates, see the M-274.			
• 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.
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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 (<i>Family Name</i>) from Section 1.	First Name (<i>Given Name</i>) from Section 1.	Middle initial (if any) from Section 1.
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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 (<i>if applicable</i>)	New Name (<i>if applicable</i>)		
Date (<i>mm/dd/yyyy</i>)	Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)	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) (<i>mm/dd/yyyy</i>)
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 (<i>mm/dd/yyyy</i>)
Additional Information (Initial and date each notation.)			☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire (<i>if applicable</i>)	New Name (<i>if applicable</i>)		
Date (<i>mm/dd/yyyy</i>)	Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)	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) (<i>mm/dd/yyyy</i>)
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 (<i>mm/dd/yyyy</i>)
Additional Information (Initial and date each notation.)			☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire (<i>if applicable</i>)	New Name (<i>if applicable</i>)		
Date (<i>mm/dd/yyyy</i>)	Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)	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) (<i>mm/dd/yyyy</i>)
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 (<i>mm/dd/yyyy</i>)
Additional Information (Initial and date each notation.)			☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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.

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.

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 877-859-8757.

Employee's Withholding Certificate

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

OMB No. 1545-0074

2025

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

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

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

Step 2: Multiple Jobs or Spouse Works	Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs. Do only one of the following. (a) Use the estimator at www.irs.gov/W4App for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; or (b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; or (c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate ☐
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Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits	If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly): Multiply the number of qualifying children under age 17 by \$2,000 \$ _____ Multiply the number of other dependents by \$500 \$ _____ Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here	3	\$
Step 4 (optional): Other Adjustments	(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income	4(a)	\$
	(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here	4(b)	\$
	(c) Extra withholding. Enter any additional tax you want withheld each pay period . .	4(c)	\$

Step 5: Sign Here	Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.		
	Employee's signature (This form is not valid unless you sign it.)		Date
Employers Only	Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

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

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2025 if you meet both of the following conditions: you had no federal income tax liability in 2024 **and** you expect to have no federal income tax liability in 2025. You had no federal income tax liability in 2024 if (1) your total tax on line 24 on your 2024 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2025 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 17, 2026.

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

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

1. Are submitting this form after the beginning of the year;
2. Expect to work only part of the year;
3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;
4. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or
5. Prefer the most accurate withholding for multiple job situations.

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

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

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

Specific Instructions

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

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work. Submit a separate Form W-4 for each job.

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

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



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

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

Step 4 (optional).

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

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

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

MI-W4

(Rev. 12-20)

EMPLOYEE'S MICHIGAN WITHHOLDING EXEMPTION CERTIFICATE STATE OF MICHIGAN - DEPARTMENT OF TREASURY

This certificate is for Michigan income tax withholding purposes only. **Read instructions on page 2 before completing this form.**

Issued under P.A. 281 of 1967.

▶ 3. Name (First, Middle Initial, Last)			▶ 1. Full Social Security Number		▶ 2. Date of Birth	
			4. Driver's License Number or State ID			
Home Address (No., Street, P.O. Box or Rural Route)			▶ 5. Are you a new employee?		(mm/dd/yyyy)	
City or Town			State		ZIP Code	
			☐ Yes If Yes, enter date of hire.....			
			☐ No			
6. Enter the number of personal and dependent exemptions (see instructions) ▶ 6.						
7. Additional amount you want deducted from each pay (if employer agrees) 7. \$.00						
8. I claim exemption from withholding because (see instructions):						
a. ☐ A Michigan income tax liability is not expected this year.						
b. ☐ Wages are exempt from withholding. Explain: _____						
c. ☐ Permanent home (domicile) is located in the following Renaissance Zone: _____						
EMPLOYEE: If you fail or refuse to file this form, your employer must withhold Michigan income tax from your wages without allowance for any exemptions. Keep a copy of this form for your records. See additional instructions on page 2.						
<i>Under penalty of perjury, I certify that the number of withholding exemptions claimed on this certificate does not exceed the number I am allowed to claim. If claiming exemption from withholding, I certify that I do not anticipate a Michigan income tax liability this year.</i>						
9. Employee's Signature					▶ Date	

EMPLOYER: Complete the below section.			
10. Employer's Name		▶ 11. Federal Employer Identification Number	
Address (No., Street, P.O. Box or Rural Route)		City or Town	State
Name of Contact Person		Contact Phone Number	ZIP Code
INSTRUCTIONS TO EMPLOYER: Keep a copy of this certificate with your records. All new hires must be reported to the State of Michigan. See www.mi-newhire.com for information.			
In addition, a copy of this form must be sent to the Michigan Department of Treasury if the employee claims 10 or more exemptions or claims they are exempt from withholding. Send a copy to:			
Michigan Department of Treasury Tax Technical Section P.O. Box 30477 Lansing, MI 48909			

INSTRUCTIONS TO EMPLOYEE'S MICHIGAN WITHHOLDING EXEMPTION CERTIFICATE (Form MI-W4)

You must submit a Michigan withholding exemption certificate (form MI-W4) to your employer on or before the date that employment begins. If you fail or refuse to submit this certificate, your employer must withhold tax from your compensation without allowance for any exemptions. Your employer is required to notify the Michigan Department of Treasury if you have claimed 10 or more personal or dependency exemptions or claimed that you are exempt from withholding.

You **MUST** provide a new MI-W4 to your employer within 10 days if your residency status changes or if your exemptions decrease because: a) your spouse, for whom you have been claiming an exemption, is divorced or legally separated from you or claims his/her own exemption(s) on a separate certificate, or b) a dependent no longer qualifies under the Internal Revenue Code.

Line 5: If you check "Yes," enter your date of hire.

Line 6: Personal and dependency exemptions. The number of exemptions claimed here may not exceed the number of exemptions you are entitled to claim on a *Michigan Individual Income Tax Return* (Form MI-1040). Dependents include qualifying children and qualifying relatives under the Internal Revenue Code, even if your AGI exceeds the limits to claim federal tax credits for them.

Do not claim the same exemptions more than once or tax will be under-withheld. Specifically, **do not claim:**

- Your personal exemption if someone else will claim you as their dependent.
- Your personal exemption with more than one employer at a time.
- Your spouse's personal exemption if they claim it with their employer.
- Your dependency exemptions if someone else (for example, your spouse) is claiming them with their employer.

Line 7: You may designate additional withholding if you expect to owe more than the amount withheld.

Line 8a: You may claim exemption from Michigan income tax withholding if all of the following conditions are met:

- i) Your employment is intermittent, temporary, or less than full time;
- ii) Your personal and dependency exemptions exceed your annual taxable compensation;
- iii) You claimed exemption from federal withholding; and
- iv) You did not incur a Michigan income tax liability for the previous year.

Line 8b: Reasons wages might be exempt from withholding include:

- You are a nonresident spouse of military personnel stationed in Michigan.
- You are a resident of one of the following reciprocal states while working in Michigan: Illinois, Indiana, Kentucky, Minnesota, Ohio, or Wisconsin.
- You are a member of a Native American tribe that has a tax agreement with the State of Michigan and whose principal place of residence is within the designated agreement area.
- You are an enrolled member of a federally-recognized tribe that does not have a tax agreement with the State of Michigan, you reside within that tribe's Indian Country (as defined in 18 USC 1151), and compensation from this job will be earned within that Indian Country.

Line 8c: For questions about Renaissance Zones, contact your local assessor's office.

Direct Deposit Authorization Agreement

Request Type (check one):

☐ New Account Setup

☐ Change in Existing Account

☐ Cancellation

Please allow up to five (5) business days for your request to be processed. The change will be effective on the on the next scheduled service period following the date the request is processed.

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

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.

Worker Pay Rate Information

Select the appropriate reason for this form:

☐ New Client Setup

☐ Change Existing Rate

REQUIRED INFORMATION	
Participant/Employer Name	ID
Worker Name	ID or Last 4 of SSN
Authorized Representative Name (if applicable)	ID (if applicable)

Below, please indicate the Pay Rate you agree to. The Pay Rate is the amount that the Worker will receive per hour worked. **Please provide a Pay Rate for ONLY services approved in your Individual Plan of Service (IPOS).**

Rate Name	Hourly Rate
CLS Rate	
Respite Rate	
Overnight Health and Safety Rate	

By signing below, the Participant/Employer and Worker certify that the information in this form is correct and was agreed to by both parties. For changes to existing rates, please allow five (5) days for processing. Once processed, the change will take effect the next pay period. Changes will not be applied retroactively to payments already made.

Worker Signature

Date

Participant/Employer Signature

Date

Please return this form to Palco via email: enrollment@palcofirst.com or via fax to Toll free: 877.859.8757 local: 501.821.0045 1.877.859.8757.

Palco Michigan
Self-Directed Services Training Requirements Grid
(Updated February 2025)

Summit Pointe workers all certificates must be submitted to enrollment@palcofirst.com

Van Buren workers all certificates must be submitted to both enrollment@palcofirst.com and sdservices@vbcmh.com

Required Training	Frequency	Delivery Method	Notes	Paid Training Time
Training in IPOS	Prior to delivery of any service and then when IPOS is updated or amended	Provided in person by either the Case Manager, the individual/lead, or staff/family member/guardian who has been trained by the Case Manager	Document training on IPOS Training Document form provided by the Case Manager Send completed training document to your CSM	30 mins
Blood Borne Pathogens	Within 30 days of hire and then annually thereafter	https://www.improvingmipractices.org/focus-areas/courses/healthcare-workplace-essentials/infection-control-standard-precautions/course Select: Infection Control & Standard Precautions	Must set up an account with: www.improvingmypractices.org	1 hour
Recipient Rights	Within 30 days of hire and then annually thereafter	https://www.improvingmipractices.org/focus-areas/courses/healthcare-workplace-essentials/recipient-rights-direct-care-professionals	Preferred: Summit Pointe Recipient Rights Training – Biweekly Tuesday Mornings Register Here Van Buren: Must set up an account with: www.improvingmypractices.org	Initial: 2 hours Renewal: 3.5 hours
General Emergency Procedures (fire, tornado, etc.)	Within 30 days of hire and then annually thereafter	https://www.improvingmipractices.org/focus-areas/courses/healthcare-workplace-essentials/emergency-preparedness Select: Emergency Preparedness	Must set up an account with: www.improvingmypractices.org	1 hour

First Aid (CPR is optional but often scheduled together)	Within 60 days of hire and every 2 years thereafter	https://www.michigan.gov/mde/services/ed-serv/ed-cert/cert-guidance/becoming-a-teacher/cpr-first-aid In-Person Skills demonstration is required as part of the First Aid certification.	Send certificate of completion to: Enrollment@palcofirst.com	Up to 7 hours
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OPTIONAL TRAININGS – NOT REQUIRED UNLESS YOU HAVE BEEN INFORMED THAT IT IS NEEDED

Medication Administration <i>*Only required if necessary to implement IPOS or the employer requires but is unable to take medicine independently*</i>	One time - Within 90 days of hire or prior to working independently with employer.	https://iskzoo.org/providers/isk-training/ Online Refresher (if needed) can be done completed at: https://www.improvingmipractices.org/focus-areas/courses/healthcare-workplace-essentials/medication-administration-refresher/course#	Contact FMS with preferred date/time/location of training and they will schedule and purchase the training.	Initial Training: Up to 7 hours Refresher: 30 mins
MANDT or CPI Non-aversive techniques for prevention and treatment of challenging behavior	Within 60 days of hire and then annually thereafter	https://iskzoo.org/providers/isk-training/ <i>*Only required if necessary to implement IPOS or the employer requires but is unable to take medicine independently*</i>	Contact FMS with preferred date/time/location of training and they will schedule and purchase the training.	Initial Training: Up to 14 hours Annual Refresher: Up to 7 hours