

HCB 2 EMPLOYEE CHECKLIST

- ☐ LRI ATTESTATION/CRITERIA QUESTIONS
- ☐ EMPLOYEE APPLICATION
- ☐ EMPLOYEE CONTRACT
- ☐ AFFIRMATION OF IRS NOTICE 2014-7
- ☐ DIRECT DEPOSIT
- ☐ W4
- ☐ K4
- ☐ I-9 (2 IDS FROM LIST)
- ☐ DRIVER'S LICENSE
- ☐ CAR INSURANCE (IF TRANSPORTING PARTICIPANT)
- ☐ TB TEST
- ☐ DAILY ATTENDANT CARE TEST (COMPLETED ONLINE)
- ☐ EMPLOYEE TRAINING VERIFICATION
- ☐ CPR-FIRST AID ACKNOWLEDGEMENT FORM
- ☐ KIPDA PDS PROGRAM EVV GUIDELINES
- ☐ KARES BACKGROUND FORMS
- ☐ ABUSE NEGLECT EXPLOITATION
- ☐ FRAUD WASTE AND ABUSE
- ☐ EMPLOYEE EMAIL FORM

Legally Responsible Individual Process

Definitions of Legally Responsible Individual

Minor Child (Under 18 years of age)	Adult (18 years and older)
<ul style="list-style-type: none"> • Parent • Stepparent • Adoptive parent • Guardian as defined by KRS 387.010(3) – <i>an individual, agency or corporation appointed by the District Court to have care, custody, and control of a minor and to manage the minors' finance resources.</i> 	<ul style="list-style-type: none"> • Spouse • Gaurdian as defined by KRS 387.812(3) – <i>a person appointed by the court to make decisions regarding the persona of an adult.</i>

**Foster parents cannot be paid PDS Employees due to receiving payment from the state for the provision of foster care.*

Extraordinary Care

- Through an HCBS wavier, **a state may elect to make payment for personal care or similar services that are rendered by legally responsible individuals when such services are deemed extraordinary care** so long as the state specifics satisfactory criteria for authorizing such payments.
- CMS defines extraordinary care as:
 - ✓ **Care exceeding the range of activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age.**
 - ✓ Care is necessary to assure the health and welfare of the participant and needed to avoid institutionalization.

Extraordinary Care is a qualifying waiver service, Ordinary Care is not.

Process

- Services Advisor and Participant/PDS Representative work together to answer the criteria questions, based on the age of the participant.
- Participant/PDS Representative will sign LRI Attestation form, giving service advisor permission to submit LRI request in MWMA.
- Participant/PDS Representative can provide, but is not required to, submit supporting documentation such as doctors letter, test results, behavior support plan, documentation of attempts to hire other employees or employment record for LRI. *No additional documents are required, only the LRI Attestation Letter is required.*

Minor Child (Under 18 years of age)

Minimum of One Criteria in Category A and Category B to be approved LRI.		
Category A		Category B
1) The child's care needs have reduced or eliminated the LRI's ability to maintain paid employment in the past 12 months or longer, and there is not an alternative caregiver who is functionally able to provide care.		1) The child's dependency in performing activities of daily living (ADL's) must be directly related to his/her disability and exceeds that of his/her age matched peers.
2) The LRI can demonstrate attempts within the first 30 days to recruit a qualified provider (Traditional or PDS) but cannot secure one.		2) The child demonstrates destructive or injurious behaviors exceeding that of his/her age matched peers, and such behaviors represent a risk of serious injury of death to self and others.
3) The minor child has communication barrier exceeding that of his/her age matched peers that impacts his/her ability to effectively communicate needs and wishes.		

Adult (18 years or older)

Meet One Criteria to be approved LRI.
1) The participants care needs have reduced or eliminated the LRI's ability to maintain paid employment in the past 12 months or longer, and there is not a alternative caregiver who is functionally able to provide care.
2) The LRI can demonstrate attempts within the first 30 days to recruit a qualified provider (Traditional or PDS) but cannot secure one.
3) The participant has communication barrier exceeding that of his/her age matched peers that impacts his/her ability to effectively communicate needs and wishes.

Potential Outcomes

Approval	Lack of Information	Denial
Participant/ PDS Representative will receive a letter. The hiring process will continue.	Services Advisor will receive notification. They will follow up with Participant/ PDS Representative on next steps and submit requested information.	The request is denied. Participant/ PDS Representative will receive a certified letter. Letter will include instruction on how to request reconsideration and Appeal Rights.

Minor Child (Under 18 years of age)

Complete a minimum of One box in Criteria Category A **and**
a minimum of one box in Category B

Category A

- 1) The child's care needs have reduced or eliminated the legally responsible individual's ability to maintain paid employment in the past 12 months or longer, and there is not an alternative caregiver who is functionally able to provide care.

- 2) The legally responsible individual can demonstrate attempts within the first 30 days to recruit a qualified provider (Traditional or PDS) but cannot secure one.

- 3) The minor child has communication barrier exceeding that of his/her age matched peers that impacts his/her ability to effectively communicate needs and wishes.

Category B

- 1) The child's dependency in performing activities of daily living (ADL's) must be directly related to his/her disability and exceeds that of his/her age matched peers.

- 2) The child demonstrates destructive or injurious behaviors exceeding that of his/her age matched peers, and such behaviors represent a risk of serious injury or death to self and others.

Adult (18 years or older)

Complete a minimum of one box.

- 1) The participant's care needs have reduced or eliminated the legally responsible individual's ability to maintain paid employment in the past 12 months or longer, and there is not an alternative caregiver who is functionally able to provide care.

- 2) The legally responsible individual can demonstrate attempts within the first 30 days to recruit a qualified provider (Traditional or PDS) but cannot secure one.

- 3) The participant has communication barrier exceeding that of his/her age matched peers that impacts his/her ability to effectively communicate needs and wishes.

Participant Name: _____

Medicaid ID Number: _____

Legally Responsible Individual (LRI) Review Request Attestation

The case manager obtained and recorded verbal responses during this LRI review request process based on answers received from the participant and others present. After this process, the case manager verbally reviewed all responses with the participant and all other individuals present for the application process. The case manager did not receive any objections, questions, or requests to revise any of the responses. This attestation should be considered a true and accurate reflection as of the date and time completed as indicated by the signatures below.

Participant Signature Date

Print Participant Name

PDS Representative Signature Date

Print PDS Representative Name

Guardian Signature Date

Print Guardian Name

APPLICATION

1. Applicant to complete (3 pages)
2. Completed and return to KIPDA in packet
3. Important Definitions:
 - a. Participant/Employee: person receiving service
 - b. Family Member Name: applicant



Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Aging and Independent Living

PARTICIPANT DIRECTED SERVICES
EMPLOYMENT APPLICATION

Participant/Employer Name: _____

Applicant Instructions

1. Please print answers to all questions;
2. A resume will not be accepted in lieu of this application;
3. Proof of eligibility to work in the United States must be submitted prior to employment;
4. Registry and/or background checks must be completed prior to employment; and
5. Any false statements and/or omissions may result in a rejection of this application and/or removal from employment after hire.

Personal Information

Last Name First Name Middle Name

Date of Birth SSN # Telephone #

Street Address (Including Apt. # or P.O. Box #) City State Zip Code

If you have not lived in Kentucky within the past year, please provide a previous address:

Street Address (Including Apt. # or P.O. Box #) City State Zip Code

Street Address (Including Apt. # or P.O. Box #) City State Zip Code

If required to transport, can you provide proof of valid Liability Vehicle insurance? ☐ Yes ☐ No
Can you lift more than 50lbs while standing? ☐ Yes ☐ No
Are you legally eligible for employment in the United States? ☐ Yes ☐ No
Have you ever been arrested or convicted of a criminal offense? ☐ Yes ☐ No

If yes, please describe. Please note that an affirmative answer will not automatically disqualify you from being considered as a candidate for employment.

What is your relationship to the participant/employer? _____

Certification/Education

Are you currently certified in CPR/ First Aid? ☐ Yes ☐ No
If yes, please provide case management agency with documentation.

Please list any other certifications relevant to the position: _____

Please list highest level of education completed: _____

Work Experience

Do you have experience as a caregiver? ☐ Yes ☐ No

If yes, please describe _____

Are you currently employed? ☐ Yes ☐ No

Company Name	Supervisor Name	Telephone #
--------------	-----------------	-------------

Street Address (Including Apt. # or P.O. Box #)	City	State	Zip Code
---	------	-------	----------

Start Date	Schedule (Days & Hours Working)
------------	---------------------------------

Please list any job history relative to the position, beginning with the most recent.

1) _____

Company Name	Supervisor Name	Telephone #
--------------	-----------------	-------------

Street Address (Including Apt. # or P.O. Box #)	City	State	Zip Code
---	------	-------	----------

Start Date (Month/Year)	End Date (Month/Year)	Reason(s) for Leaving
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2) _____

Company Name	Supervisor Name	Telephone #
--------------	-----------------	-------------

Street Address (Including Apt. # or P.O. Box #)	City	State	Zip Code
---	------	-------	----------

Start Date (Month/Year)	End Date (Month/Year)	Reason(s) for Leaving
-------------------------	-----------------------	-----------------------

3) _____

Company Name	Supervisor Name	Telephone #
--------------	-----------------	-------------

Street Address (Including Apt. # or P.O. Box #)	City	State	Zip Code
---	------	-------	----------

Start Date (Month/Year)	End Date (Month/Year)	Reason(s) for Leaving
-------------------------	-----------------------	-----------------------

References

1)

Full Name Occupation Telephone #

Street Address (Including Apt. # or P.O. Box #) City State Zip Code

2)

Full Name Occupation Telephone #

Street Address (Including Apt. # or P.O. Box #) City State Zip Code

3)

Full Name Occupation Telephone #

Street Address (Including Apt. # or P.O. Box #) City State Zip Code

Emergency Contacts

1)

Full Name Relationship Telephone #

Street Address (Including Apt. # or P.O. Box #) City State Zip Code

2)

Full Name Relationship Telephone #

Street Address (Including Apt. # or P.O. Box #) City State Zip Code

I certify that the information provided within this employment application is true and correct to the best of my knowledge.

Signature

Date

CONTRACT

1. Applicant to complete (2 pages)
2. Important Definitions:
 - a. Employer: person receiving service
 - b. Employee name: applicant
 - c. Employer/Participant: representative signature
 - d. Employee/Provider: applicant signature
 - e. Service Provided:
 - i. Examples AC-HCB2 and Respite
 - f. Rate per hour:
 - i. Agreed upon rate per house for each service

**Kentucky Participant Directed Services (PDS)
Employee/Provider Contract**

I (employee name) _____, last four of Social Security Number _____
have agreed to work under the employment of (employer name/waiver participant name)
_____ Medicaid ID _____.

I understand that, as a waiver participant, I can choose a PDS representative to help me with my responsibilities as an employer.

Participant Directed Services Representative Name (if applicable) _____.

Financial Management Agency Name _____.

Case Manager Agency Name _____.

Services delivered under this contract will consist of the following:

Service Provided	Service Code	Rate Per Hour	Hours Per Week	Anticipated Start Date*	End Date**

*Anticipated start date should reflect the date services are anticipated to begin.

** Only complete end date if the employee stops providing the service.

Please see the attached list for a list of services available via PDS. For a full waiver service listing and max rates, please see the Home and Community Based Services Waiver Rates document on <https://www.chfs.ky.gov/agencies/dms/Pages/feesrates.aspx>.

**Kentucky Participant Directed Services (PDS)
Employee/Provider Contract**

As the employee:

- ☐ I agree to provide the services as specified by my employer (the waiver participant) as defined in the table above.
- ☐ I understand civil or criminal penalties can be pursued and termination from employment can occur if allegations of fraud against the Department for Medicaid Services are substantiated.
- ☐ I understand that I shall not be allowed to provide services based on the results of my background check, all applicable screenings and/or failing to complete trainings/certifications required by my employer (the waiver participant).
- ☐ I understand that under KRS 205.5607 (Kentucky Independence Plus Through Consumer Directed Services Program) Workers Compensation (KRS Chapter 342) shall not apply to my employment as a PDS employee. This means that neither the state, nor any state agency, nor political subdivision, nor any fiscal intermediary, nor representative, nor case manager can be held liable for any injuries or losses I may incur while providing services.
- ☐ I understand that I must maintain employee/employer confidentiality.
- ☐ I understand this is an at-will contract and either party may terminate this agreement at any time.
- ☐ I understand that I must notify my employer (the waiver participant) of the contraction of any infectious disease(s) and I shall abstain from work until the infectious disease can no longer be transmitted as documented by a medical professional.
- ☐ I agree to follow all relevant state and federal statutes and regulations, including the use of Electronic Visit Verification.
- ☐ I have received and fully understand the list of employment guidelines and will follow them to the best of my ability. I further understand that any or all items of this contract may be subject to renewal or change upon agreement by my employer (the waiver participant) and myself.

**Kentucky Participant Directed Services (PDS)
Employee/Provider Contract**

As the employer (waiver participant):

- ☐ I understand that I may be responsible for wages for my employee should my employee or I not provide employee qualifications by the respective deadlines.
- ☐ I understand that I can only require my employee to assist with duties that are relevant to my needs and outcomes that are specified on the Person-Centered Service Plan for Medicaid payment.
- ☐ I understand that I may be responsible for payment for any hours I may require my employee to work beyond any prior authorization limits or waiver regulation guidelines.

Employee Signature Date

Employer/Participant Date

PDS Representative (if applicable) Date

**Kentucky Participant Directed Services (PDS)
Employee/Provider Contract**

Waiver Services Available via PDS		
Waiver Program	Service	Code
ABI Acute	Companion	S5135 HI
ABI Acute	Personal Care	97535 HI
ABI Acute	Respite	T1005 HI
ABI Acute	Supported Employment	H0039 HI
ABI LTC	Community Living Supports	97535 HI
ABI LTC	Respite	T1005 HI
ABI LTC	Supported Employment	H0039 HI
HCB	Attendant Care	S5108 HI
HCB	Non-specialized Respite	T1005 HI
MP	Attendant Care	S5125 HI
MP	Community Living Supports	97535 HI
MP	Homemaker	S5130 HI
MP	Personal Care	T1019 HI
MP	Respite	T1005 HI
MP	Supported Employment	H0039
SCL	Community Access	97535 HI
SCL	Community Access Group	97537 HI
SCL	Community Guide	H2015 HI
SCL	Personal Assistance	T1019 HI
SCL	Respite	T1005 HI
SCL	Supported Employment	T2019 HI

AFIRMATION OF IRS NOTICE 2014-7

1. If applicant lives in the same home with participant, and would like to be exempt of withholding, complete and return in packet.
2. If applicant does not live in the same home with participant, he/she does not qualify for this, disregard.
3. Important Definitions:
 - a. Participant: person receiving service
 - b. Family Member name: applicant
 - c. Participant/Rep: Representative



Area Agency on Aging and Independent Living
Area Development District
Metropolitan Planning Organization



May 4, 2023

RE: IRS Notice 2014-7 and February 2015 Q &A's

If you have a paid caregiver living full-time with you in the home, this information should be provided to them.

On January 3, 2014, the Internal Revenue Service issued Notice 2014-7, 2014-4 I.R.B. 445. Notice 2014-7 provides guidance on the federal income tax treatment of certain payments to individual care providers for the care of eligible individuals under a state Medicaid Home and Community-Based Services waiver program described in section 1915(c) of the Social Security Act (Medicaid Waiver payments). Section 1915(c) enables individuals who otherwise would require care in a hospital, nursing facility, or intermediate care facility to receive care in the individual care provider's home. The notice provides that the IRS will treat these Medicaid waiver payments as difficulty of care payments excludable from gross income under § 131 of the Internal Revenue Code. The original notice is available at <http://www.irs.gov/pub/irs-drop/n-14-07.pdf>.

On February 27, 2015 the IRS followed up with NEW Q&A's with more details that may apply to one or more of your employees. The Q&A's may be read in full at <http://www.irs.gov/Individuals/Certain-Medicaid-Waiver-Payments-May-Be-Excludable-From-Income>. In essence, the notice states that Medicaid difficulty of care payments paid to a caregiver are not subject to federal income tax if the caregiver and care recipient live in the same home full time. This is not restricted to certain family members but extends to anyone fitting the IRS definition of providing care in "the provider's home" for purposes of Notice 2014-7.

If you believe this applies to your situation, please consult your tax professional if you have questions, and have each eligible employee complete the attached "Affirmation of IRS Notice 2014-7 Qualification of Federal Withholding Exemption". If new to the program, include this with your Employment Contract. KEEP THIS LETTER AS REFERENCE FOR FEDERAL AND STATE TAX RETURNS.

You may also wish to contact your tax professional regarding filing an amended return for a refund of prior year taxes on wages fitting this definition. The normal deadline for filing amended returns is the later of 3 years after filing the original return or 2 years after paying the tax. Kentucky State and Local Occupational Tax jurisdictions are now following this same guidance.

We are prohibited from providing any tax advice, so please consult a tax professional if you have any questions regarding eligibility.

Sincerely,

Freida Winkfield Shaw
Director of Finance

11520 Commonwealth Drive
Louisville, KY 40299
www.kipda.org

Phone: 502.266.6084
Fax: 502.266.5047
TDD: 800.648.6056



Affirmation of IRS Notice 2014-7

Qualification of Federal Withholding Exemption

(Also applies to Kentucky State Withholding and Local Occupational Tax)

Under penalties of perjury, I declare that I am an individual care provider receiving payments under a state Medicaid Home and Community-Based Services waiver program for care I provide to

_____ (**print client name**), who lives in the same home under the care recipient's plan of care as of _____ (move-in date).

I also understand it is **my responsibility** to notify KIPDA if the living arrangements change, and I am no longer eligible for this exemption status.

Full-time living address of Care Recipient and Employee:

Employee Signed: _____ Date: _____

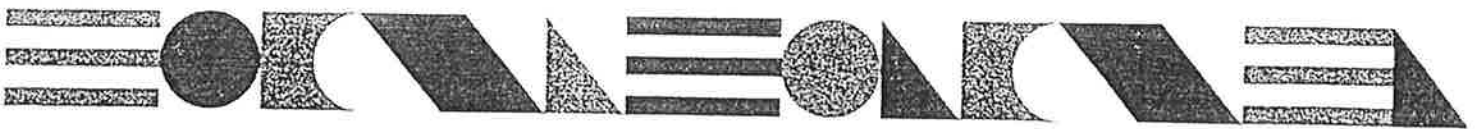
Printed Name: _____ SS: _____

A Caregiver (Employee) may qualify for this exemption **IF** they reside in the **SAME** home as the Participant (Employer) they are caring for. **This is no relevance to relationship status**

If completed a Caregivers (Employee) wages will not be taxed by Federal, State, and Local Taxes. This will then be the responsibility of the Caregiver (Employee) if issues arise during tax time.

DIRECT DEPOSIT

1. Applicant to complete
2. Attach voided check
3. Return to KIPDA



Area Agency on Aging and Independent Living
Area Development District
Metropolitan Planning Organization



May 4, 2023

ATTN: PDS/CDO Participants and their Employees

RE: Direct Deposit Requirement effective December 30, 2016

The Department of Labor states that we may require Direct Deposit of *ALL* payroll as long as 'you (employee) have the ability to withdraw the entire net pay without having to pay a fee to the financial institution.'

As a result of this information, KIPDA will be requiring a Direct Deposit method of pay for all PDS/CDO Client employees prior to their hire date. No checks will be issued or mailed.

Please note that there are many banking options available for Direct Deposit that will meet the Department of Labor's standard. KIPDA has attached a letter detailing how this option works with one available banking institution in our communities, the Fifth Third Bank.

Remember, the Fifth Third Bank is just one option. You are free to choose your own personal banking institution or other methods of Direct Deposit, but you must complete the Direct Deposit form and submit it to KIPDA prior to your hire date.

Again, Direct Deposit is a KIPDA requirement prior to your hire date.

Sincerely,

Freida Winkfield Shaw
Director of Finance

11520 Commonwealth Drive
Louisville, KY 40299
www.kipda.org

Phone: 502.266.6084
Fax: 502.266.5047
TDD: 800.648.6056



Fifth Third Membership Advantage

Additional Benefits Available:

- **Free Financial Empowerment Seminars**, such as:
 - Home Buying and Borrowing
 - Saving and Budgeting
 - Protecting Your Identity
 - Your Credit Today
 - Strategies to Slash Debt
 - Health Savings Accounts
- Access to over 50,000 fee-free ATMs nationwide.⁸
- Dedicated service and advice from a **team of personal bankers**.
- **Fifth Third Identity Alert**⁵
- **0.25 rate discount** for new installment loans and lines of credit.⁶
- **0.50 discount point** on mortgage loans.⁷
- **Credit cards** that offer a variety of first-rate benefits suited to your lifestyle, including competitive rates, special savings and valuable rewards.⁹

Two Easy Ways to Enroll:

- 1 Visit a Fifth Third Banking Center
- 2 Contact your Fifth Third Representative:

Jill Kennedy
Jill.Kennedy@53.com
502-909-3401

1. Employee ID badge, membership card, business card, pay stub, customized program flyer or direct deposit must be provided before Membership Advantage code is applied to account. Periodic proof of employment or membership may be required to retain Membership Advantage benefits.
2. A \$5 discount will be applied to the monthly service charge for Fifth Third Enhanced and Preferred checking account types. This account earns interest. Please request a Rate Sheet for the interest rates and annual percentage yields. At the Bank's discretion, the Bank may change the interest rate and annual percentage yield at any time on your account. Your interest begins to accrue no later than the business day we receive credit for the deposit of non-cash items (for example, checks). Interest on your account will be compounded continuously and credited monthly. The Bank uses the daily balance method to calculate interest on your account. This method applies a daily periodic rate to the balance in your account each day. When your account is closed you will forfeit any accrued interest. Please call us toll free at 1-866-671-5353, or visit a Fifth Third Branch near you for additional details.
3. Subject to transaction fee based upon deposit amount. Terms and Conditions apply. Transactions subject to applicable cutoff times. Please see Digital Services User Agreement for details regarding cutoff times. All checks subject to approval by a third party vendor.
4. Qualifying transactions to earn discounts include direct deposit/ACH credits, debit card purchases, check saving, money orders, cashier's checks, mobile immediate deposits and Zelle transactions (effective 4/14/18). Discounts apply to check cashing, money orders, cashier's checks, mobile immediate deposits, ID Alert, and savings accounts.
5. The benefits in Fifth Third Identity Alert® and Fifth Third Identity Alert Premium® are provided by Fifth Third's vendor, Affinion Benefits Group. To find out more information on our identity theft protection solutions, please visit your local Fifth Third Banking Center or visit 53.com/IdentityAlert.
6. Lending subject to credit review and approval. 0.25% rate discount on new installment loans and lines of credit available when payments are automatically deducted from your Fifth Third checking account using Auto BillPayer®. Terms and conditions are subject to change without notice.
7. Receive one-half (0.50) discount point if you participate in the Fifth Third Auto BillPayer® which can be used to buy down your interest rate. This adds up to a savings of \$800 based on a \$160,000 loan. This discount will be shown at the time of your loan application and will be applied at closing based on final mortgage amount. This offer requires participation in our automatic payment program and requires automatic payment deduction from your qualifying Fifth Third account. No minimum deposit required to open a checking or savings account. Account must be funded within 45 days of opening. Loans subject to credit review and approval. Fifth Third Bank, 38 Fountain Square Plaza, Cincinnati, OH 45263, NMLS# 403245, Equal Housing Lender. Fifth Third Bank, Member FDIC, Fifth Third and Fifth Third Bank are registered service marks of Fifth Third Bancorp.
8. Fifth Third Bank is part of the Allpoint®, Presto!, and 7-Eleven® network of ATMs, which features more than 50,000 fee-free ATMs nationwide. Customers of Fifth Third Bank can use their Fifth Third debit or prepaid card to withdraw cash fee-free from any domestic Allpoint® ATM in addition to Presto! ATMs located in Publix stores, and 7-Eleven® ATMs listed on our ATM locator on 53.com
9. Credit Cards subject to credit review and approval. Rates determined by credit worthiness of applicant.

No minimum deposit required to open a checking or savings account. Account must be funded within 45 days of opening.

Fifth Third Bank, Member FDIC. Equal Housing Lender.



FIFTH THIRD BANK

Fifth Third Membership Advantage



You are eligible for Membership Advantage because of the relationship your company has with Fifth Third Bank. **With Membership Advantage, you have the opportunity to select a personalized checking package and receive exclusive banking benefits designed to save you time and money.**

Proof of employment with enrolled employers or associations required.¹

Great choices to fit your financial needs: Traditional checking accounts and Fifth Third Express BankingSM

TRADITIONAL CHECKING ACCOUNTS

Fifth Third Preferred CheckingTM

Join this exclusive program to earn higher interest on your checking account and get preferred discounts, benefits, and services.

Fifth Third Enhanced CheckingTM

Earn interest on your checking account and get enhanced discounts and benefits.

Fifth Third Free CheckingSM

Get all the advantages of a checking account and no monthly service charge.

Benefits for all Traditional Checking Accounts:

- Online and mobile banking
- Debit card
- Direct deposit
- Overdraft Protection (enrollment required)

FIFTH THIRD EXPRESS BANKINGSM

Fifth Third Express BankingSM

A new simple way to manage your funds. It's designed for those who want immediate access to their money and the convenience and security of a banking relationship.

Express Banking Features:

- Check cashing and direct deposit
- Mobile Deposit with immediate funds availability³
- Money orders and cashier's checks
- Online and mobile banking
- Discounted fees of up to 50% on select services based on account usage⁴
- No credit score requirement
- No check writing or ability to deposit checks at ATMs
- No monthly service charge, balance requirement OR overdraft fees.

AUTHORIZATION AGREEMENT FOR DIRECT DEPOSITS
(ACH CREDITS)

KIPDA CDO Payroll Operations

FEIN: 20-5967432

I hereby authorize KIPDA CDO Payroll Operations to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries made in error to my [] Checking [] Savings account (select one) indicated below and the depository named below, hereinafter called DEPOSITORY, to credit and/or debit the same such account. *(This may also be a Pre-paid Card, but TRANSIT and ACCOUNT # must be obtained from the bank/customer service center listed on the back of the card.)*

DEPOSITORY (Bank) NAME _____

BRANCH _____ PHONE _____

CITY _____ STATE _____ ZIP CODE _____

TRANSIT/ABA# _____ ACCOUNT # _____

Attach VOIDED Check or Bank Printout HERE

This authority is to remain in full force and effect until KIPDA CDO Payroll Operations has received *written notification* from me of its termination in such time and in such manner as to afford KIPDA CDO Payroll Operations and DEPOSITORY a reasonable opportunity in which to act.

EMPLOYEE NAME PRINTED _____

EMPLOYEE SIGNATURE _____

SS # _____

DATE _____

W-4

1. Applicant to complete for federal withholding
2. Return to KIPDA in packet

Employee's Withholding Certificate

OMB No. 1545-0074

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.

2026

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.)		
Caution: To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.			

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 Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(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):			
	(a) Multiply the number of qualifying children under age 17 by \$2,200	3(a) \$		
	(b) Multiply the number of other dependents by \$500	3(b) \$		
	Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here		3	\$
Step 4: 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. Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) Enter the result here		4(b)	\$
	(c) Extra withholding. Enter any additional tax you want withheld each pay period		4(c)	\$

Exempt from withholding	I claim exemption from withholding for 2026, and I certify that I meet both of the conditions for exemption for 2026. See <i>Exemption from withholding</i> on page 2. I understand I will need to submit a new Form W-4 for 2027 ☐
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Step 5: Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Sign Here	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 2026 if you meet both of the following conditions: you had no federal income tax liability in 2025 and you expect to have no federal income tax liability in 2026. You had no federal income tax liability in 2025 if (1) your total tax on line 24 on your 2025 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2026 tax return. To claim exemption from withholding, certify that you meet both of the conditions by checking the box in the *Exempt from withholding* section. 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 16, 2027.

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 of tax withheld 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 (and/or your spouse if married filing jointly) must have the required social security number to claim certain credits. 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.

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 15, if you expect to claim deductions other than the basic standard deduction on your 2026 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for qualified tips, overtime compensation, and passenger vehicle loan interest; student loan interest; IRAs; and seniors. You (and/or your spouse if married filing jointly) must have the required social security number to claim certain deductions. For additional eligibility requirements, see Pub. 501.

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 when you file your tax return.

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

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

Note: If more than one job has annual wages of more than \$120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at www.irs.gov/W4App.

- 1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 5. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 1 \$ _____

- 2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.
 - a Find the amount from the appropriate table on page 5 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a 2a \$ _____
 - b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 5 and enter this amount on line 2b 2b \$ _____
 - c Add the amounts from lines 2a and 2b and enter the result on line 2c 2c \$ _____

- 3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. 3 _____

- 4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (plus any other additional amount you want withheld) 4 \$ _____

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

See the Instructions for Schedule 1-A (Form 1040) for more information about whether you qualify for the deductions on lines 1a, 1b, 1c, 3a, and 3b.

1	Deductions for qualified tips, overtime compensation, and passenger vehicle loan interest.	
a	Qualified tips. If your total income is less than \$150,000 (\$300,000 if married filing jointly), enter an estimate of your qualified tips up to \$25,000	1a \$ _____
b	Qualified overtime compensation. If your total income is less than \$150,000 (\$300,000 if married filing jointly), enter an estimate of your qualified overtime compensation up to \$12,500 (\$25,000 if married filing jointly) of the "and-a-half" portion of time-and-a-half compensation	1b \$ _____
c	Qualified passenger vehicle loan interest. If your total income is less than \$100,000 (\$200,000 if married filing jointly), enter an estimate of your qualified passenger vehicle loan interest up to \$10,000	1c \$ _____
2	Add lines 1a, 1b, and 1c. Enter the result here	2 \$ _____
3	Seniors age 65 or older. If your total income is less than \$75,000 (\$150,000 if married filing jointly):	
a	Enter \$6,000 if you are age 65 or older before the end of the year	3a \$ _____
b	Enter \$6,000 if your spouse is age 65 or older before the end of the year and has a social security number valid for employment	3b \$ _____
4	Add lines 3a and 3b. Enter the result here	4 \$ _____
5	Enter an estimate of your student loan interest, deductible IRA contributions, educator expenses, alimony paid, and certain other adjustments from Schedule 1 (Form 1040), Part II. See Pub. 505 for more information	5 \$ _____
6	Itemized deductions. Enter an estimate of your 2026 itemized deductions from Schedule A (Form 1040). Such deductions may include qualifying:	
a	Medical and dental expenses. Enter expenses in excess of 7.5% (0.075) of your total income	6a \$ _____
b	State and local taxes. If your total income is less than \$505,000 (\$252,500 if married filing separately), enter state and local taxes paid up to \$40,400 (\$20,200 if married filing separately)	6b \$ _____
c	Home mortgage interest. If your home acquisition debt is less than \$750,000 (\$375,000 if married filing separately), enter your home mortgage interest expense (including mortgage insurance premiums)	6c \$ _____
d	Gifts to charities. Enter contributions in excess of 0.5% (0.005) of your total income	6d \$ _____
e	Other itemized deductions. Enter the amount for other itemized deductions	6e \$ _____
7	Add lines 6a, 6b, 6c, 6d, and 6e. Enter the result here	7 \$ _____
8	Limitation on itemized deductions.	
a	Enter your total income	8a \$ _____
b	Subtract line 4 from line 8a. If line 4 is greater than line 8a, enter -0- here and on line 10. Skip line 9	8b \$ _____
9	Enter: $\left\{ \begin{array}{l} \bullet \$768,700 \text{ if you're married filing jointly or a qualifying surviving spouse} \\ \bullet \$640,600 \text{ if you're single or head of household} \\ \bullet \$384,350 \text{ if you're married filing separately} \end{array} \right\}$	9 \$ _____
10	If line 9 is greater than line 8b, enter the amount from line 7. Otherwise, multiply line 7 by 94% (0.94) and enter the result here	10 \$ _____
11	Standard deduction.	
	Enter: $\left\{ \begin{array}{l} \bullet \$32,200 \text{ if you're married filing jointly or a qualifying surviving spouse} \\ \bullet \$24,150 \text{ if you're head of household} \\ \bullet \$16,100 \text{ if you're single or married filing separately} \end{array} \right\}$	11 \$ _____
12	Cash gifts to charities. If you take the standard deduction, enter cash contributions up to \$1,000 (\$2,000 if married filing jointly)	12 \$ _____
13	Add lines 11 and 12. Enter the result here	13 \$ _____
14	If line 10 is greater than line 13, subtract line 11 from line 10 and enter the result here. If line 13 is greater than line 10, enter the amount from line 12	14 \$ _____
15	Add lines 2, 4, 5, and 14. Enter the result here and in Step 4(b) of Form W-4	15 \$ _____

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$0	\$480	\$850	\$850	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020
\$10,000 - 19,999	0	480	1,480	1,850	2,050	2,220	2,220	2,220	2,220	2,220	2,220	2,620
\$20,000 - 29,999	480	1,480	2,480	3,050	3,250	3,420	3,420	3,420	3,420	3,420	3,820	4,820
\$30,000 - 39,999	850	1,850	3,050	3,620	3,820	3,990	3,990	3,990	3,990	4,390	5,390	6,390
\$40,000 - 49,999	850	2,050	3,250	3,820	4,020	4,190	4,190	4,190	4,590	5,590	6,590	7,590
\$50,000 - 59,999	1,020	2,220	3,420	3,990	4,190	4,360	4,360	4,760	5,760	6,760	7,760	8,760
\$60,000 - 69,999	1,020	2,220	3,420	3,990	4,190	4,360	4,760	5,760	6,760	7,760	8,760	9,760
\$70,000 - 79,999	1,020	2,220	3,420	3,990	4,190	4,760	5,760	6,760	7,760	8,760	9,760	10,760
\$80,000 - 99,999	1,020	2,220	3,420	4,240	5,440	6,610	7,610	8,610	9,610	10,610	11,610	12,610
\$100,000 - 149,999	1,870	4,070	6,270	7,840	9,040	10,210	11,210	12,210	13,210	14,210	15,360	16,560
\$150,000 - 239,999	1,870	4,100	6,500	8,270	9,670	11,040	12,240	13,440	14,640	15,840	17,040	18,240
\$240,000 - 319,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,780	14,980	16,180	17,380	18,580
\$320,000 - 364,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,860	15,860	17,860	19,860	21,860
\$365,000 - 524,999	2,720	5,920	9,390	12,260	14,760	17,230	19,530	21,830	24,130	26,430	28,730	31,030
\$525,000 and over	3,140	6,840	10,540	13,610	16,310	18,980	21,480	23,980	26,480	28,980	31,480	33,990

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$90	\$850	\$1,020	\$1,020	\$1,020	\$1,070	\$1,870	\$1,870	\$1,870	\$1,870	\$1,870	\$1,970
\$10,000 - 19,999	850	1,780	1,980	1,980	2,030	3,030	3,830	3,830	3,830	3,830	3,930	4,130
\$20,000 - 29,999	1,020	1,980	2,180	2,230	3,230	4,230	5,030	5,030	5,030	5,130	5,330	5,530
\$30,000 - 39,999	1,020	1,980	2,230	3,230	4,230	5,230	6,030	6,030	6,130	6,330	6,530	6,730
\$40,000 - 59,999	1,020	2,880	4,080	5,080	6,080	7,080	7,950	8,150	8,350	8,550	8,750	8,950
\$60,000 - 79,999	1,870	3,830	5,030	6,030	7,100	8,300	9,300	9,500	9,700	9,900	10,100	10,300
\$80,000 - 99,999	1,870	3,830	5,100	6,300	7,500	8,700	9,700	9,900	10,100	10,300	10,500	10,700
\$100,000 - 124,999	2,030	4,190	5,590	6,790	7,990	9,190	10,190	10,390	10,590	10,940	11,940	12,940
\$125,000 - 149,999	2,040	4,200	5,600	6,800	8,000	9,200	10,200	10,950	11,950	12,950	13,950	14,950
\$150,000 - 174,999	2,040	4,200	5,600	6,800	8,150	10,150	11,950	12,950	13,950	14,950	16,170	17,470
\$175,000 - 199,999	2,040	4,200	6,150	8,150	10,150	12,150	13,950	15,020	16,320	17,620	18,920	20,220
\$200,000 - 249,999	2,720	5,680	7,880	10,140	12,440	14,740	16,840	18,140	19,440	20,740	22,040	23,340
\$250,000 - 449,999	2,970	6,230	8,730	11,030	13,330	15,630	17,730	19,030	20,330	21,630	22,930	24,240
\$450,000 and over	3,140	6,600	9,300	11,800	14,300	16,800	19,100	20,600	22,100	23,600	25,100	26,610

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$280	\$850	\$950	\$1,020	\$1,020	\$1,020	\$1,020	\$1,560	\$1,870	\$1,870	\$1,870
\$10,000 - 19,999	280	1,280	1,950	2,150	2,220	2,220	2,220	2,760	3,760	4,070	4,070	4,210
\$20,000 - 29,999	850	1,950	2,720	2,920	2,980	2,980	3,520	4,520	5,520	5,830	5,980	6,180
\$30,000 - 39,999	950	2,150	2,920	3,120	3,180	3,720	4,720	5,720	6,720	7,180	7,380	7,580
\$40,000 - 59,999	1,020	2,220	2,980	3,570	4,640	5,640	6,640	7,750	8,950	9,460	9,660	9,860
\$60,000 - 79,999	1,020	2,610	4,370	5,570	6,640	7,750	8,950	10,150	11,350	11,860	12,060	12,260
\$80,000 - 99,999	1,870	4,070	5,830	7,150	8,410	9,610	10,810	12,010	13,210	13,720	13,920	14,120
\$100,000 - 124,999	1,870	4,270	6,230	7,630	8,900	10,100	11,300	12,500	13,700	14,210	14,720	15,720
\$125,000 - 149,999	2,040	4,440	6,400	7,800	9,070	10,270	11,470	12,670	14,580	15,890	16,890	17,890
\$150,000 - 174,999	2,040	4,440	6,400	7,800	9,070	10,580	12,580	14,580	16,580	17,890	18,890	20,170
\$175,000 - 199,999	2,040	4,440	6,400	8,510	10,580	12,580	14,580	16,580	18,710	20,320	21,620	22,920
\$200,000 - 249,999	2,720	5,920	8,680	10,900	13,270	15,570	17,870	20,170	22,470	24,080	25,380	26,680
\$250,000 - 449,999	2,970	6,470	9,540	12,040	14,410	16,710	19,010	21,310	23,610	25,220	26,520	27,820
\$450,000 and over	3,140	6,840	10,110	12,810	15,380	17,880	20,380	22,880	25,380	27,190	28,690	30,190

K-4

1. Applicant to complete for Kentucky state withholding
2. This is for Kentucky, if applicant lives out of state, please contact CM for other state specific requirements
3. Return to KIPDA in packet

KENTUCKY'S WITHHOLDING
CERTIFICATE

2026

Social Security Number		
Name—Last, First, Middle Initial		
Mailing Address (Number and Street including Apartment Number or P.O. Box)		
City, Town or Post Office	State	ZIP Code

All Kentucky wage earners are taxed at a flat 3.5% rate with a standard deduction allowance of \$3,360. The Department of Revenue annually adjust the standard deduction in accordance with KRS 141.081(2)(a).

Check if exempt:

- ☐ 1. Kentucky income tax liability is not expected this year (see instructions)
- ☐ 2. You qualify for the Fort Campbell Exemption Certificate. I am a resident of _____ State
- ☐ 3. You qualify for the nonresident military spouse exemption
- ☐ 4. You work in Kentucky and reside in a reciprocal state

Additional withholding per pay period under agreement with employer \$ _____

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

Signature	Date
-----------	------

Instructions to Employees

All Kentucky wage earners are taxed at a flat 3.5% tax rate with an allowance for the standard deduction.

You may be exempt from withholding if any of the four conditions below are met:

- You may be exempt from withholding for 2026 if both the following apply:
 - For 2025, you had a right to a refund of all Kentucky income tax withheld because you had no Kentucky income tax liability, and
 - For 2026, you expect a refund of all your Kentucky income tax withheld.

Income Tax Liability Thresholds—The 2025 filing threshold amount based upon federal poverty level is expected to be \$15,650 for a family size of one (single, or married living apart from your spouse for the entire year), \$21,150 for a family of two (single with one dependent child or a married couple), \$26,650 for a family of three (single with two dependent children or a married couple with one dependent child) and \$32,150 for a family of four or more (single with three dependent children or a married couple with two or more dependent children). Modified gross income is equal to your federal adjusted gross income plus any interest income from other states municipal bonds and pension income from a qualifying lump-sum distribution. If your combined modified gross income is expected to be less than the threshold amount for your family size, then you (and your spouse, if applicable) may not have an income tax liability.

If both the above statements apply, you are exempt and may check box 1. Your exemption for 2026 expires February 15, 2027.

- Under the provisions of Public Law 105-261, pay and compensation earned at the Fort Campbell, Kentucky, military base is exempt from Kentucky income tax if you are not a resident of Kentucky. KRS 141.010(32) defines "resident" as an individual domiciled within this state or an individual who is not domiciled in this state, but maintains a place of abode in this state and spends in the aggregate more than one hundred eighty-three (183) days of the taxable year in this state.

Check box 2 if you certify that you are not a resident of Kentucky and only earn wages as an employee at Fort Campbell, Kentucky. This exemption must be revoked within 10 days of a move or change of address to Kentucky.

3. You may be exempt from withholding, if you meet the conditions set for under the Servicemember Civil Relief Act as amended by the Military Spouses Residence Relief Act. You must complete the worksheet below to determine if you are eligible.

In order to qualify you must complete this form in full, certify that the you are not subject to Kentucky withholding tax because you met the conditions set forth below, and provide a copy of your spouse's military picture ID issued to the employee by the U.S. Department of Defense.

-
1. My spouse is a military servicemember.....(check one) ☐ YES ☐ NO
2. I am NOT a military servicemember.....(check one) ☐ YES ☐ NO
3. My military servicemember spouse has a current military order assigning him or her to a military location in Kentucky.....(check one) ☐ YES ☐ NO
4. I and my military servicemember spouse live at the same address.....(check one) ☐ YES ☐ NO
5. My military servicemember's state of domicile is a state other than Kentucky and I am electing to use that state of domicile.....(check one) ☐ YES ☐ NO
If yes, enter the 2-letter state code of the servicemember's state of domicile _____
6. I am present in Kentucky solely to be with my military servicemember spouse.....(check one) ☐ YES ☐ NO

If you checked "YES" to all the statements above, your earned income is exempt from Kentucky withholding tax.

Check box 3 if you checked "YES" to all the statements listed in the worksheet. You are exempt from Kentucky income tax withholding. This exemption will terminate if any of the answers to the questions changes to "NO". In general, the exemption termination date will be the earlier of:

- The day the military servicemember is no longer in the military;
- The day the employee enlists in the military;
- The day the employee and the military servicemember no longer live at the same address; or
- The day the military servicemember's permanent duty station changes to a location outside of Kentucky.

4. You may be exempt from withholding if you work in Kentucky but reside in one of the following reciprocal states: Illinois, Indiana, Michigan, West Virginia, Wisconsin, Virginia and you commute daily to Ohio and you are not a shareholder-employee who is a "twenty (20) percent or greater" direct or indirect equity investor in a S corporation.

In order to qualify you must complete the worksheet below:

I have not been a resident of Kentucky during the year. (Check block in front of applicable statement.) I work in Kentucky and reside in:

- ☐ Illinois, ☐ Indiana, ☐ Michigan, ☐ West Virginia, ☐ Wisconsin
☐ Virginia and commute daily to my place of employment in Kentucky. (*Must commute daily to apply.*)
☐ Ohio and I am not a shareholder-employee who is a "twenty (20) percent or greater" direct or indirect equity investor in an S corporation.
-

Check box 4 if you certify you work in Kentucky and reside in a reciprocal state.

If you meet any of the four exemptions you are exempted from Kentucky withholding. However, you must complete this form and file it with your employer before withholding can be stopped. You will need to maintain a copy of the K-4 for your permanent records.

Instructions to Employers

Form K-4 is only required to document that an employee has requested an exemption from withholding OR to document that an employee has requested additional withholding in excess of the amounts calculated using the formula or tables. If neither situation applies, then an employer is not required to maintain Form K-4.

Upon receipt of this form, properly completed, you are authorized to discontinue withholding for an employee who qualifies for one of the four exemptions. Retain a copy of all K-4's received from employees.

I-9 FORM

1. Applicant to complete for identity verification
2. Provide copies of supporting documentation
3. Return to KIPDA in packet



Instructions for Form I-9, Employment Eligibility Verification

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

USCIS
Form I-9

OMB No. 1615-0047
Expires 05/31/2027

Anti-Discrimination Notice: Employers must allow all employees to choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information entered in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or **Supplement B, Reverification and Rehire**. Employees do NOT need to prove their citizenship, immigration status, or national origin when establishing their employment authorization for Form I-9 or E-Verify. Requesting such proof or any specific document from employees based on their citizenship, immigration status, or national origin, may be illegal. Similarly, discriminating against employees in hiring, firing, recruitment, or referral for a fee, based on citizenship, immigration status, or national origin may be illegal. Employers should not reject acceptable documentation due to a future expiration date. For more information on how to avoid discrimination or how to report it, contact the Immigrant and Employee Rights Section in the Department of Justice's Civil Rights Division at www.justice.gov/ier.

Purpose of Form I-9

Employers and employees must complete their respective sections of Form I-9. The form is used to document verification of the identity and employment authorization of each new employee (both U.S. citizen and noncitizen) hired after November 6, 1986, to work in the United States. In the Commonwealth of the Northern Mariana Islands (CNMI), employers must complete Form I-9 to document the verification of the identity and employment authorization of each new employee (both U.S. citizen and noncitizen) hired after November 27, 2011.

Definitions

Employee: A person who performs labor or services in the United States for an employer in return for wages or other remuneration. The term "employee" does not include individuals who do not receive any form of remuneration (e.g., volunteers), independent contractors, or those engaged in certain casual domestic employment.

Employer: A person or entity, including an agent or anyone acting directly or indirectly in the interest thereof, who engages the services or labor of an employee to be performed in the United States for wages or other remuneration. This includes recruiters and referrers for a fee who are agricultural associations, agricultural employers, or farm labor contractors.

Authorized Representative: Any person an employer designates to complete and sign Form I-9 on the employer's behalf. Employers are liable for any statutory and regulatory violations made in connection with the form or the verification process, including any violations committed by any individual designated to act on the employer's behalf.

Preparer and/or Translator: Any individual who helps the employee complete or translates **Section 1** for the employee.

General Instructions

Filing Fee. See Form G-1055, available at www.uscis.gov/forms, for specific information about the fees applicable to this form.

Form I-9 consists of:

- **Section 1:** Employee Information and Attestation
- **Section 2:** Employer Review and Verification
- Lists of Acceptable Documents
- Supplement A, Preparer and/or Translator Certification for Section 1
- Supplement B, Reverification and Rehire (formerly Section 3)

EMPLOYEES

Employees must complete and sign **Section 1** of Form I-9 no later than the first day of employment (i.e., the date the employee begins performing labor or services in the United States in return for wages or other remuneration). Employees may complete **Section 1** before the first day of employment, but cannot complete the form before acceptance of an offer of employment.

EMPLOYERS

Employers in the United States, except Puerto Rico, must complete the English-language version of Form I-9. Only employers located in Puerto Rico may complete the Spanish-language version of Form I-9 instead of the English-language version. Any employer may use the Spanish-language form and instructions as a translation tool.

All employers must:

- Make the instructions for Form I-9 and Lists of Acceptable Documents available to the employee when completing the Form I-9 and when requesting that the employee present documentation to complete Supplement B, Reverification and Rehire. See page 5 for more information.
- Ensure that the employee completes **Section 1**.
- Complete **Section 2** within three business days after the employee's first day of employment. If you hire an individual for less than three business days, complete **Section 2** no later than the first day of employment.
- Complete Supplement B, Reverification and Rehire when applicable.
- Leave a field blank if it does not apply and allow employees to leave fields blank in **Section 1**, where appropriate.
- Retain completed forms. You are not required to retain or store the page(s) containing the Lists of Acceptable Documents or the instructions for Form I-9. Do not mail completed forms to U.S. Citizenship and Immigration Services (USCIS) or Immigration and Customs Enforcement (ICE).

Additional guidance about how to complete Form I-9 may be found in the **Handbook for Employers: Guidance for Completing Form I-9 (M-274)** and on **I-9 Central**.

Section 1: Employee Information and Attestation

Step 1: Employee completes Section 1 no later than the first day of employment.

- All employees must provide their current legal name, complete address, and date of birth. If other fields do not apply, leave them blank.
- When completing the name fields, enter your current legal name and any last names you previously used, including any hyphens or punctuation. If you only have one name, enter it in the Last Name field and then enter "Unknown" in the First Name field.
- Providing your 9-digit Social Security number in the Social Security number field is voluntary, unless your employer participates in E-Verify. See page 5 for instructions related to E-Verify. Do not enter an Individual Taxpayer Identification Number (ITIN) as your Social Security number.

Step 2: Attest to your citizenship or immigration status.

You must select one box to attest to your citizenship or immigration status.

1. **A citizen of the United States.**
2. **A noncitizen national of the United States:** An individual born in American Samoa, certain former citizens of the former Trust Territory of the Pacific Islands, and certain children of noncitizen nationals born abroad.
3. **A lawful permanent resident:** An individual who is not a U.S. citizen and who resides in the United States under legally recognized and lawfully recorded permanent residence as an immigrant.

Conditional residents should select this status. Asylees and refugees should NOT select this status; they should instead select "A noncitizen authorized to work." If you select "lawful permanent resident," enter your 7- to 9-digit USCIS Number (A-Number) in the space provided.

4. **A noncitizen (other than Item Numbers 2. and 3. above) authorized to work:** An individual who has authorization to work but is not a U.S. citizen, noncitizen national, or lawful permanent resident.

If you select this box, enter the date that your employment authorization expires, if any, in the space provided. In most cases, your employment authorization expiration date is found on the documentation evidencing your employment authorization. If your employment authorization documentation has been automatically extended by the issuing authority, enter the expiration date of the automatic extension in this space.

- Refugees, asylees, and certain citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or Palau, and other noncitizens authorized to work whose employment authorization does not have an expiration date, should enter N/A in the Expiration Date field.

Employees who select "a noncitizen authorized to work" must enter **one** of the following to complete **Section 1**:

- (1) **USCIS Number/A-Number** (7 to 9 digits);
- (2) **Form I-94 Admission Number** (11 digits); or
- (3) **Foreign Passport Number and the Country of Issuance**

Your employer may not ask for documentation to verify the information you entered in **Section 1**.

Step 3: Sign and enter the date you signed Section 1. Do NOT back-date this field.

Step 4: Preparer and/or translator completes a Preparer and/or Translator Certification, if applicable.

If a preparer and/or translator assists an employee in completing Section 1, that person must complete a Certification area on Supplement A, Preparer and/or Translator Certification for Section 1, located on Page 3 of Form I-9. There is no limit to the number of preparers and/or translators an employee may use. Each preparer and/or translator must complete and sign a separate Certification area. Employers must ensure that they retain any additional pages with the employee's completed Form I-9. If the employee does not use a preparer or translator, employers are not required to provide or retain Supplement A.

Step 5: Present Form I-9 Documentation

Within three business days after your first day of employment, you, the employee, must present to your employer original, acceptable, and unexpired documentation that establishes your identity and employment authorization. For example, if you begin employment on Monday, you must present documentation on or before the Thursday of that week. However, if you were hired to work for less than three business days, you must present documentation no later than the first day of employment.

Choose which documentation to present to your employer from the Lists of Acceptable Documents. An employer cannot specify which documentation you may present from the Lists of Acceptable Documents. You may present either: 1.) one selection from List A or 2.) a combination of one selection from List B and one selection from List C. In certain cases, you may also present an acceptable receipt for List A, B, or C documents. For more information on receipts, refer to the M-274.

- List A documentations show both identity and employment authorization. Some documentation must be presented together to be considered acceptable List A documentation. If you present acceptable List A documentation, you should not be asked to present List B and List C documentation.
- List B documentation shows identity only and List C documentation shows employment authorization only. If you present acceptable List B and List C documentation, you should not be asked to present List A documentation. Guidance is available in the M-274 if you are under the age of 18 or have a disability (special placement) and cannot provide List B documentation.

Your employer must physically examine the documentation you present to complete Form I-9, or examine them consistent with an alternative procedure authorized by the Secretary of DHS. If your documentation reasonably appears to be genuine and to relate to you, your employer must accept the documentation. If your documentation does not reasonably appear to be genuine or to relate to you, your employer must reject it and provide you with an opportunity to present other documentation. Your employer may choose to make copies of your documentation, but must return the original(s) to you. Your employer may not ask for documentation to verify the information you entered in **Section 1**.

Section 2: Employer Review and Verification

Before completing **Section 2**, you, the employer, should review **Section 1**. If you find any errors or missing information in **Section 1**, the employee must correct the error, and then initial and date the correction.

You may designate an authorized representative to act on your behalf to complete **Section 2**.

You or your authorized representative must complete **Section 2** by physically examining evidence of the employee's identity and employment authorization within three business days after the employee's first day of employment. For example, if an employee begins employment on Monday, you must review the employee's documentation and complete **Section 2** on or before the Thursday of that week. However, if the individual will work for less than three business days, **Section 2** must be completed no later than the first day of employment.

Step 1: Enter information from the documentation the employee presents.

You, the employer or authorized representative, must either physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, the original, acceptable, and unexpired documentation the employee presents from the Lists of Acceptable Documents to complete the applicable document fields in **Section 2**. You cannot specify which documentation an employee may present from these Lists of Acceptable Documents. A document is acceptable if it reasonably appears to be genuine and to relate to the person presenting it. Photocopies, except for certified copies of birth certificates, are not acceptable for Form I-9. Employees must present one selection from List A or a combination of one selection from List B and one selection from List C.

You may use common abbreviations for states, document titles, or issuing authorities, such as: "DL" for driver's license, and "SSA" for Social Security Administration. Refer to the M-274 for abbreviation suggestions.

List A documentation shows both identity and employment authorization.

- Enter the required information from the List A documentation in the first set of document entry fields in the List A column. Some List A documentation consists of a combination of documents that must be presented together to be considered acceptable List A documentation. If the employee presents a combination of documents for List A, use the second and third sets of document entry fields in the List A column. Use the Additional Information space, as necessary, for additional documents. When entering document information in this space, ensure you record all available document information, such as the document title, issuing authority, document number and expiration date.
- If an employee presents acceptable List A documentation, do not ask the employee to present List B and List C documentation.

List B documentation shows identity only, and List C documentation shows employment authorization only.

- If an employee presents acceptable List B and List C documentation, enter the required information from the documentation under each corresponding column and do not ask the employee to present List A documentation.
- If an employee under the age of 18 or with disabilities (special placement) cannot provide List B documentation, see the M-274 for guidance.

In certain cases, the employee may present an acceptable receipt for List A, B, or C documentation. For more information on receipts, refer to the Lists of Acceptable Documents and the M-274.

Photocopies

- You may make photocopies of the documentation examined but must return the original documentation to the employee.
- You must retain any photocopies you make with Form I-9 in case of an inspection by DHS, the Department of Labor, or the Department of Justice, Civil Rights Division, Immigrant and Employee Rights Section.

Step 2: Enter additional information, if necessary.

Use the Additional Information field to record any additional information required to complete **Section 2**, or any updates that are necessary once **Section 2** is complete. Initial and date each additional notation. See the M-274 for more information. Such notations include, but are not limited to:

- Those required by DHS, such as extensions of employment authorization or a document's expiration date.
- Replacement document information if a receipt was previously presented.
- Additional documentation that may be presented by certain nonimmigrant employees.

You may also enter optional information, such as termination dates, form retention dates, and E-Verify case numbers, if applicable.

Step 3: Select the box in the Additional Information area if you used an alternate procedure for document examination authorized by the Secretary of DHS.

You must select this box if you used an alternative procedure authorized by DHS to examine the documents. You may refer to the M-274 for guidance on implementing alternative procedures for document examination approved by the Secretary of DHS.

Step 4: Complete the employer certification.

Employers or their authorized representatives, if applicable, must complete all applicable fields in this area, and sign and date where indicated.

Reverification and Rehire

To reverify an employee's work authorization or document an employee's rehire, use Supplement B, Reverification and Rehire (formerly Section 3). Employers need only complete and retain the supplement page when employment authorization reverification is required. Employers may choose to document a rehire on the supplement as well. Enter the employee's name at the top of each supplement page you use. In the New Name field, record any change the employee reports at the time of reverification or rehire. Use a new section of the supplement for each instance of a reverification or rehire, sign and date that section when completed, and attach it to the employee's completed Form I-9. Use additional supplement pages as necessary. Use the Additional Information fields if the employee's documentation presented for reverification requires future updates.

Reverifications

When reverification is required, you must reverify the employee by the earlier of the employment authorization expiration date stated in Section 1 (if any), or the expiration date of the List A or List C employment authorization documentation recorded in Section 2. Employers should complete any subsequent reverifications, if required, by the expiration date of the List A or List C documentation entered during the employee's most recent reverification.

For reverification, employees must present acceptable documentation from either List A or List C showing their continuing authorization to work in the United States. You must allow employees to choose which acceptable documentation to present for reverification. Employees are not required to show the same type of document they presented previously. Enter the documentation information in the appropriate fields provided.

You should not reverify the employment authorization of U.S. citizens and noncitizen nationals, or lawful permanent residents (including conditional residents) who presented a Permanent Resident Card (Form I-551) or other employment authorization documentation that is not subject to reverification (such as an unrestricted Social Security card). Reverification does not apply to List B documentation. Reverification may not apply to certain noncitizens. See the M-274 for more information about when reverification may not be required.

Rehires

If you rehire an employee within three years from the date the employee's Form I-9 was first completed, you may complete the supplement and attach it to the employee's previously completed Form I-9. If the employee remains employment-authorized, as indicated on the previously completed Form I-9, record the date of rehire and any name changes. If the employee's employment authorization or List A or C documents have expired, you must reverify the employee as described above.

Alternatively, you may complete a new Form I-9 for rehired employees. You must complete a new Form I-9 for any employee you rehired more than three years after you originally completed a Form I-9 for that employee.

Employee and Employer Instructions Related E-Verify

E-Verify uses Form I-9 information to confirm employees' employment eligibility. For more information, go to www.e-verify.gov or contact us at www.e-verify.gov/contact-us.

For employees of employers who participate in E-Verify:

- You must provide your Social Security number in the Social Security number field in **Section 1**.
 - If you have applied for, but have not yet received, your Social Security number, you should leave the field blank until you receive the number. Update this field once you receive it, and initial and date the notation.
 - If you can present acceptable identity and employment authorization documentation to complete Form I-9, you may begin working while waiting to receive your Social Security number.
- Providing your email address and telephone number in **Section 1** will allow you to receive notifications associated with your E-Verify case.
- If you present a List B document to your employer, it must contain a photograph.

For E-Verify employers:

- Ensure employees enter their Social Security number in **Section 1**.
- You must only accept List B documentation that contains a photograph. This applies to individuals under the age of 18 and individuals with disabilities.
- You must retain photocopies of certain documentation.

USCIS Forms and Information

Employers may photocopy or print blank Forms I-9. To ensure you are using the latest version of this form and corresponding instructions, visit the USCIS website at www.uscis.gov/i-9. You may order paper forms at www.uscis.gov/forms/forms-by-mail or by contacting the USCIS Contact Center at 1-800-375-5283 or 1-800-767-1833 (TTY).

For additional guidance about Form I-9, employers and employees should refer to the **Handbook for Employers: Guidance for Completing Form I-9 (M-274)** or USCIS' Form I-9 website at www.uscis.gov/i-9-central.

You can obtain information about Form I-9 by e-mailing USCIS at I9Central@uscis.dhs.gov. Employers may call 1-888-464-4218 or 1-877-875-6028 (TTY). Employees may call the USCIS employee hotline at 1-888-897-7781 or 1-877-875-6028 (TTY).

Retaining Completed Forms I-9

An employer must retain Form I-9, including any supplement pages, on which the employee and employer (or authorized representative) entered data, as well as any photocopies made of the documentation the employee presented, for as long as the employee works for the employer. When employment ends, the employer must retain the individual's Form I-9 and all attachments for one year from the date employment ends, or three years after the first day of employment, whichever is later. In the case of recruiters or referrers for a fee (only applicable to those that are agricultural associations, agricultural employers, or farm labor contractors), the retention period is three years after the first day of employment.

Completed Forms I-9 and all accompanying documents should be stored in a safe and secure location. Employers should ensure that the information employees provide on Form I-9 is used only as stated in the DHS Privacy Notice below.

Form I-9 may be generated, signed, and retained electronically, in compliance with Department of Homeland Security regulations at 8 CFR section 274a.2. Employers creating, modifying, or storing Form I-9 electronically are encouraged to review these and any other relevant standards for electronic signature, and the indexing, security, and documentation of electronic Form I-9 data.

Penalties

Employers may be subject to penalties if Form I-9 is not properly completed or for employment discrimination occurring during the employment eligibility verification process. See 8 U.S.C. section 1324a and section 1324b, 8 CFR section 274a.10 and 28 CFR Part 44. Individuals may also be prosecuted for knowingly and willfully entering false information, or for presenting fraudulent documentation, to complete Form I-9.

Employees: By signing **Section 1** of this form, employees attest under penalty of perjury (28 U.S.C. section 1746) that the information they provided, along with the citizenship or immigration status they select, and all information and documentation they provide to their employer, is true and correct, and they are aware that they may face penalties provided by law and may be subject to criminal prosecution for knowingly and willfully making false statements or using false documentation when completing this form. Further, falsely attesting to U.S. citizenship may subject employees to penalties or removal proceedings, and may adversely affect an employee's ability to seek future immigration benefits.

Employers: By signing **Sections 2 and 3**, as applicable, employers attest under penalty of perjury (28 U.S.C. section 1746) that they have physically examined the documentation presented by the employee, that the documentation reasonably appears to be genuine and to relate to the employee named, that to the best of their knowledge the employee is authorized to work in the United States, that the information they enter in **Section 2** is complete, true, and correct to the best of their knowledge, and that they are aware that they may face civil or criminal penalties provided by law and may be subject to criminal prosecution for knowingly and willfully making false statements or knowingly accepting false documentation when completing Form I-9.

DHS Privacy Notice

AUTHORITIES: The information requested on this form, and the associated documents, are collected under the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 U.S.C. 1324a).

PURPOSE: The primary purpose for providing the requested information on this form is for employers to verify the identity and employment authorization of their employees. Consistent with the requirements of the Immigration Reform and Control Act of 1986, employers use the Form I-9 to document the verification of the identity and employment authorization for new employees to prevent the unlawful hiring, or recruiting or referring for a fee, of individuals who are not authorized to work in the United States. This form is completed by both the employer and the employee and is ultimately retained by the employer.

DISCLOSURE: The information employees provide is voluntary. However, failure to provide the requested information, and acceptable documentation evidencing identity and authorization to work in the United States, may result in termination of employment. Failure of the employer to ensure proper completion of this form may result in the imposition of civil or criminal penalties against the employer. In addition, knowingly employing individuals who are not authorized to work in the United States may subject the employer to civil and/or criminal penalties.

ROUTINE USES: This information will be used by employers as a record of their basis for determining eligibility of an individual to work in the United States. The employer must retain this completed form and make it available for inspection by authorized officials of the Department of Homeland Security, Department of Labor, and Department of Justice, Civil Rights Division, Immigrant and Employee Rights Section. DHS may also share this information, as appropriate, for law enforcement purposes or in the interest of national security.

Paperwork Reduction Act

An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The public reporting burden for this collection of information is estimated at 34 minutes per response, when completing the form manually, and 25 minutes per response when using a computer to aid in completion of the form, including the time for reviewing instructions and completing and retaining the form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: U.S. Citizenship and Immigration Services, Office of Policy and Strategy, Regulatory Coordination Division, 5900 Capital Gateway Drive, Mail Stop Number 2140, Camp Springs, MD 20588-0009; OMB No. 1615-0047. **Do not mail your completed Form I-9 to this address.**



Employment Eligibility Verification

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

USCIS
Form I-9

OMB No 1615-0047
Expires 05/31/2027

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

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

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

Last Name (Family Name)		First Name (Given Name)		Middle Initial (if any)	Other Last Names Used (if any)		
Address (Street Number and Name)			Apt. Number (if any)	City or Town		State ZIP Code	
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number		Employee's Email Address			Employee's Telephone Number	
I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.		Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):					
		☐ 1. A citizen of the United States					
		☐ 2. A noncitizen national of the United States (See Instructions.)					
		☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)					
		☐ 4. A noncitizen (other than Item Numbers 2. and 3. above) authorized to work until (exp. date, if any)					
Signature of Employee		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
		Today's Date (mm/dd/yyyy)					

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

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

List A		OR	List B	AND	List C				
Document Title 1									
Issuing Authority									
Document Number (if any)									
Expiration Date (if any)									
Document Title 2 (if any)		Additional Information							
Issuing Authority									
Document Number (if any)									
Expiration Date (if any)									
Document Title 3 (if any)									
Issuing Authority									
Document Number (if any)									
Expiration Date (if any)									
						☐ Check here if you used an alternative procedure authorized by DHS to examine documents.			
Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.						First Day of Employment (mm/dd/yyyy):			
Last Name, First Name and Title of Employer or Authorized Representative			Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)				
Employer's Business or Organization Name			Employer's Business or Organization Address, City or Town, State, ZIP Code						

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

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.

* Documents extended by the issuing authority are considered unexpired.

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

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

LIST A		LIST B		LIST C
Documents that Establish Both Identity and Employment Authorization	OR	Documents that Establish Identity	AND	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			
Acceptable Receipts May be presented in lieu of a document listed above for a temporary period. For receipt validity dates, see the M-274.				
<ul style="list-style-type: none">Receipt for a replacement of a lost, stolen, or damaged List A document.Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual.Form I-94 with "RE" notation or refugee stamp issued to a refugee.	OR	Receipt for a replacement of a lost, stolen, or damaged List B document.		Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on [I-9 Central](#) for more information.



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

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

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

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

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

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

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

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

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

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

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

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

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



**Supplement B,
Reverification and Rehire (formerly Section 3)**

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

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

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

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

HCB2 Regulations require that any employee that may transport a participant must submit:

1. A VALID LEGIBLE COPY OF DRIVERS LICENSE

2. A LEGIBLE COPY OF CURRENT LIABILITY INSURANCE

THE DOCUMENTS LISTED ABOVE MUST BE SUBMITTED WITH THIS EMPLOYEE PACKET IN ORDER FOR THE PACKET TO BE COMPLETE.

****KEEP IN MIND THAT WHEN THESE DOCUMENTS EXPIRE KIPDA MUST RECEIVE AN UPDATED COPY FROM YOUR EMPLOYER OR YOU WILL BE INELIGIBLE TO WORK.****

Tuberculosis Screening:

ALL EMPLOYEES MUST COMPLETE A TUBERCULOSIS SCREENING
WITHIN 30 DAYS OF THE DATE OF HIRE.

THE EMPLOYEE MUST PROVIDE A COPY OF THE RESULTS TO THEIR
EMPLOYER, WHO MUST THEN PROVIDE THEM TO KIPDA.

YOU MAY OBTAIN THE SCREENING AT THE PROVIDER OF YOUR CHOICE
(HEALTH DEPARTMENT, YOUR DOCTOR, LITTLE CLINIC, ETC) .

YOU ARE RESPONSIBLE FOR PAYMENT.

Patient name (L,F,M): _____ DOB: _____ Race: _____ Sex: _____ SSN: _____
 Address: _____ City, State, Zip: _____
 Home/Work #: _____ Cell#: _____ Patient Pregnant: _____ No _____ Yes; If Yes, LMP _____
 Language: _____ Country of Origin: _____ Year arrived in US: _____ Interpreter needed: _____ No _____ Yes
 Allergies: _____ Current Medications: _____

I. Screen for Active TB Symptoms (Check all that apply)

- ☐ None (Skip to Section II, "Screen for TB Infection Risk")
☐ Cough for ≥ 3 weeks $\rightarrow$ Productive: ☐ YES ☐ NO
☐ Hemoptysis
☐ Fever, unexplained
☐ Unexplained weight loss
☐ Poor appetite
☐ Night sweats
☐ Fatigue

Evaluate these symptoms
in context

Pediatric Patients (≤ 5 years of age):

- ☐ Wheezing
☐ Failure to thrive
☐ Decreased activity,
playfulness and/or energy
☐ Lymph node swelling
☐ Personality changes

II. Screen for TB Infection Risk (Check all that apply)

Individuals with an increased risk for acquiring latent TB infection (LTBI) or for progression to active disease once infected should have a TST. Screening for persons with a history of LTBI should be individualized.

A. Assess Risk for Acquiring LTBI. The Patient:

- ☐ is a current high risk contact of a person known or suspected to have TB disease.
☐ has been in another country for - 3 or more months where TB is common, and has been in the US for ≤ 5 years
☐ is a resident or an employee of a high TB risk congregate setting
☐ is a healthcare worker who serves high-risk patients
☐ is medically underserved
☐ has been homeless within the past two years
☐ is an infant, a child or an adolescent exposed to an adult(s) in high-risk categories
☐ injects illicit drugs or uses crack cocaine
☐ is a member of a group identified by the health department to be at an increased risk for TB infection
☐ needs baseline/annual screening approved by the health department

B. Assess Risk for Developing TB Disease if Infected The Patient...

- ☐ is HIV positive
☐ has risk for HIV infection, but HIV status is unknown
☐ was recently infected with *Mycobacterium tuberculosis*
☐ has certain clinical conditions, placing them at higher risk for TB disease:
☐ injects illicit drugs (determine HIV status): _____
☐ has a history of inadequately treated TB
☐ is $>10\%$ below ideal body weight
☐ is on immunosuppressive therapy (this includes treatment for rheumatoid arthritis with drugs such as REMICADE, HUMIRA, etc.)

History of BCG / TB Skin Test / BAMT / TB Treatment:

History of prior BCG: ☐ NO ☐ YES $\rightarrow$ Year: _____
 History of prior (+) TST or (+) BAMT: ☐ NO ☐ YES
 Date (+) TST / (+) BAMT _____ TST: _____ mm
 CXR Date: _____ CXR result: ☐ ABN ☐ WNL
 Dx: ☐ LTBI ☐ Disease
 Tx Start: _____ Tx End: _____
 Rx: _____
 Completed: ☐ NO ☐ YES
 Location of Tx: _____

III. Finding(s) (Check all that apply)

- ☐ Previous Treatment for LTBI and/or TB disease
☐ No risk factors for TB infection
☐ Risk(s) for infection and/or progression to disease
☐ Possible TB suspect
☐ Previous (+) TST or (+) BAMT, no prior treatment

IV. Action(s) (Check all that apply)

- ☐ Issued screening letter ☐ Issued sputum containers
☐ Referred for CXR ☐ Referred for medical evaluation
☐ Administered the Mantoux TB Skin Test
☐ Draw BAMT / Interferon-gamma Release Assay ((IGRA)
☐ Other: _____

TST Brand/Lot

TST Brand/Lot#

Arm: ☐ Left ☐ Right

Arm: ☐ Left ☐ Right

Date/Time _____

Date/Time _____

Induration _____ mm

Induration _____ mm

☐ BAMT ☐ T-SPOT.TB ☐ QFT-TB-G-IT

Date/Time drawn: _____

Result: ☐ Pos ☐ Neg ☐ Borderline/Indeterminate

Screener's signature: _____

Screener's name (print): _____

Screener's title: _____

Date: _____ Phone #: _____

Comments: _____

- I hereby authorize the doctors, nurses, or nurse practitioners of the _____ Department for Public Health to administer a Tuberculin Skin Test (TST) or draw blood from me or my child named above for a Blood Assay for *Mycobacterium tuberculosis* (BAMT) test.
- I agree that the results of this test may be shared with other health care providers.
- I understand that:
 - this information will be used by health care providers for care and for surveillance /statistical purposes only.
 - this information will be kept confidential

X _____ Date: _____

IMPORTANT: A decision to test is a decision to treat. Given the high rates of false positive TB skin test results, the Kentucky TB Prevention and Control Program discourages administration of the Mantoux TST to persons who are at a low risk for TB infection.



Patient name (Patient Label)

Kentucky Department for Public Health
Tuberculosis Control Program

REPORT OF TUBERCULOSIS SCREENING

Date _____

TO WHOM IT MAY CONCERN:

The above named individual has been evaluated by _____
(Name of Health Department/ Facility)

_____ A tuberculosis health risk assessment was completed. No noted signs or symptoms suggestive of active disease.

_____ A tuberculin skin test was given on _____ (read within 48–72 hours after administration) and was read on _____ – results _____ mm.

_____ A tuberculin skin test (TST) is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis, risk factors for developing active TB or known recent contact exposure.

_____ The individual has a history of a positive tuberculin skin test (latent TB infection). Follow-up chest x-ray is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis.

_____ The individual either is currently receiving or has completed adequate medication for a positive tuberculin skin test (latent TB infection) and a chest x-ray is not indicated at this time. The individual has no symptoms suggestive of active tuberculosis disease.

_____ The individual had a chest x-ray on _____ that showed no evidence of active tuberculosis. As a result of this chest x-ray and the absence of symptoms suggestive of active TB disease, a repeat film is not indicated at this time.

Based on the available information, the individual can be considered free of tuberculosis in a communicable form.

Signature _____ Date _____
(MD, ARNP, PA, RN)

Address _____ Phone _____

Copy to Patient
Copy to Record

TB-3 (7/20)

EMPLOYEE DAIL ATTENDANT CARE TRAINING TEST AND CERTIFICATION

1. Test can be completed online or on paper.
 - a. If completed online we need a copy of the test
2. PDS employee name goes on the certification
3. PDS Representative signs and dates the certification.

<https://forms.office.com/pages/responsepage.aspx?id=TX9812fXH0a2JQYoeS6eKrtjUuMswgVKgzEtLcmvRWdUNzJEN1FMUk1DWVlaRUJLVENDTjhHOFVMRi4u&route=shorturl>

TEAM KENTUCKY

CABINET FOR HEALTH
AND FAMILY SERVICES

Department for Aging and Independent Living

ATTENDANT CARE TRAINING

Module 1

July 2023

Training Objectives

Provide basic understanding of:

Home and Community
Based Services (HCBS)
Waiver Programs

Provision of Attendant Care
Services under HCBS

Role of the Attendant Care
Aide

Person Centered Principles



Home and Community Based Services Waiver Programs (Introduction)

Section I

What is an HCBS Waiver?

Home and Community Based Services (HCBS) Waivers are Medicaid programs that provide opportunities for individuals who are aged, disabled, and/or have intellectual and developmental disabilities to receive services in their home or community.

HCBS Waivers

- When supported by the assessment, provides supportive services in home or community settings rather than in a long-term care facility setting.
- Address the needs of people with functional limitations, who need assistance with everyday activities, like homemaking and personal care.

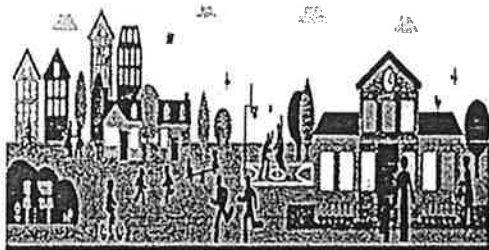
HCBS Waivers

Benefit Participants, Families, and Communities

- ✓ Empowers: Allows participant to choose their providers and services
- ✓ Familiarity: Supports and services are provided in the comfort of homes or small residential settings in the community
- ✓ Culturally responsive: Spiritual and cultural activities and support available
- ✓ ALL waivers, except Model 2, allow the participant to choose their paid caregivers.

HCBS Waivers

- HCBS Programs Promote Choice
- Intended to Safely Keep Individuals In Their Homes & Community
- Deliver Person-Centered Care supported by an assessment
- Kentucky Operates Six HCBS Programs



1915(c) HCB Services Medicaid Waiver Programs *In accordance with 42 USC 1396n(c)*

ACQUIRED BRAIN
INJURY ACUTE

ACQUIRED BRAIN
INJURY WAIVER -
LONG TERM CARE

SUPPORTS FOR
COMMUNITY
LIVING 2 WAIVER

MODEL II WAIVER
(ventilator
dependent)

MICHELLE P
WAIVER

HOME AND
COMMUNITY
BASED 2 WAIVER



HOME AND COMMUNITY BASED 2 WAIVER

Section II

HCB2 Waiver Program

Funded by Department for
Medicaid Services (DMS)

Operated by Department for Aging
and Independent Living (DAIL)

Offered Statewide

Serves About 17,000 Participants

Who is eligible for HCB2 Waiver Services?

- ❖ Age 65 or older and/or have a physical disability
- ❖ Meet the requirements to reside in a nursing facility
- ❖ Meet the financial qualifications
- ❖ Can have care needs met safely in the home

HCB2 Waiver Service Delivery Options

Traditional Services

Participants use agencies to provide *all* waiver services

Participant Directed Services (PDS)

Participants hire their own employees to provide waiver services

Blended Services

Participants use agencies to provide some of their services but hire their own employees for others

TRADITIONAL SERVICES

Adult Day Health Care (ADHC)

Attendant Care (AC)

Home Delivered Meals (HDM)

Goods and Services (G&S)

Minor Home Adaptation (MHA)

Participant Directed Services (PDS)

Support Coordination (PDS Case Management)

Attendant Care (AC)

Home Delivered Meals

Goods and Services

Environmental/Minor Home Adaptation

Blended

PDS Care Coordination

Any combination of Traditional and PDS

Person Centered Service Plan (PCSP)

ARE ALWAYS SUPPORTED BY THE ASSESSMENT

- An individualized plan that identifies:
 - Service needs of the participant (Goals)
 - Services to be provided participant (Objectives)
- Developed by the participant, authorized representative and the person-centered team
- Also referred to as the Plan of Care (POC)

PARTICIPANT SHOULD ALWAYS BE INVOLVED

HCB2 Waiver Definitions

Case Manager

- Serves as the participant's advocate to support, guide and assist with coordinating care
- Participates in the planning and development of the PCSP
- Links the participant to available services and resources
- Works as a facilitator, rather than a provider, of participant services

HCB2 Waiver Definitions

Service Advisor/Support Broker (PDS Care Coordination)

- Serves as the case manager when a participant is enrolled in PDS
- Serves as the participant's advocate to support, guide and assist with coordinating care
- Participates in the planning and development of the PCSP
- Links the participant to available services and resources
- Facilitates the delivery of direct services
- Helps the participant with personnel functions

HC2 Waiver Definitions

Attendant Care Aide

ARE ALWAYS SUPPORTED BY THE ASSESSMENT

- Employed by an agency or participant to assist the participant in completing tasks of daily living
- Provides direct **NON-SKILLED** services that enable a participant to remain in their home and community rather than an institution
- Referred to as a caregiver or direct support staff

HC2 Waiver Definitions

Natural Supports

- Non-paid person(s), primary caregiver, or community resource who can provide care or has historically helped the participant
- Includes family, friends, neighbors, room-mates, church members, and social/civic groups

HC2 Waiver Definitions

Emergency Backup Plan

- Ensures support is maintained for participant in the event of an unexpected staffing emergency
- Required for all HC2 waiver participants
- Should be communicated to all parties providing care for a participant
- Backup planning before an emergency helps to ensure participant's health, safety and welfare

Attendant Care Services Section III



What is Attendant Care (AC)?

Services provided are supported by the assessment and include non-medical hands-on assistance for a participant who has limitations performing:

- Activities of Daily Living (ADLs); or
- Instrumental Activities of Daily Living (IADLs)

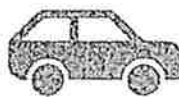
Activities of Daily Living (ADLs)

- ✓ Daily activities essential to a person's well-being and that healthy individuals can do for themselves
- ✓ Self-care tasks which include:
 - ❖ Bathing or showering
 - ❖ Dressing
 - ❖ Getting in and out of bed or a chair
 - ❖ Walking
 - ❖ Using the toilet
 - ❖ Eating

Instrumental Activities of Daily Living (IADLs)

- ✓ Activities **required** to support daily life and **enhance** the participant's interactions with others and/or environment
- ✓ **Important** for home and community life and may include:
 - ❖ Preparing meals
 - ❖ Light housekeeping
 - ❖ Money Management (e.g., paying bills)
 - ❖ Medication management
 - ❖ Shopping for groceries or personal items
 - ❖ Using a telephone
 - ❖ Transportation to appointments

Transporting Participants



- Must be specified on PCSP
- Valid driver's license
- Current liability insurance on vehicle used for transport of participant
- Obey all traffic laws
- Practice defensive driving
- Report all accidents in accordance the agency's policies
- Ensure vehicle doors are locked when unoccupied

Activities not included in Attendant Care (AC)

Direct medical care

Duplicated State Plan or other waiver services

Personal care/homemaking/ADHC occurring at the SAME TIME

Any activity or service not considered to be an ADL or IADL

Who can provide AC Services?

- In a Traditional HCB setting, AC services are provided by caregivers employed with an agency
- In a PDS setting, AC services are provided by anyone selected by the participant or PDS representative and who meets the requirements to provide AC services

AC Service Documentation

- Clear and concise service documentation is critical to providing participants with quality care
- Required for direct service employees to receive accurate and timely payment
- To maintain accurate service documentation, document while the service is happening or as soon as possible following the service
- If it is not documented, it has not been completed
- Required data elements of Electronic Visit Verification: <https://www.chfs.ky.gov/agencies/dms/dca/Pages/evv.aspx>

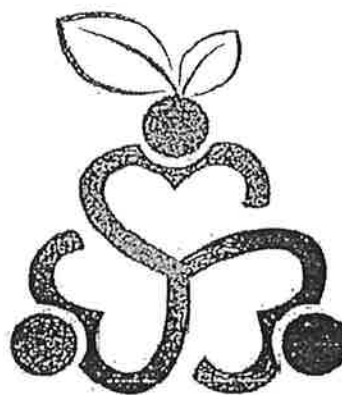
AC Service Documentation

Includes:

- ✓ Date, duration, description and location of service provided
- ✓ The arrival and departure time of the caregiver
- ✓ The name, title and signature of caregiver who provided the service
- ✓ The signature of participant when possible.
- ✓ If the participant is unable to sign, a note as to why is required if it is unsupported by the assessment.

Things to Remember

- ✓ The participant's assessment and PCSP identifies ADL and IADL assistance which is to be provided
- ✓ Allow and encourage the participant to be as independent as possible
- ✓ Follow the instruction or guidance of the participant, when appropriate and protects the participant's health, safety, and welfare
- ✓ Supporting ADL and IADL can be a tough job but incredibly rewarding



ROLE OF THE ATTENDANT CARE AIDE

SECTION IV

Maintain Confidentiality

Personal information and records regarding the participant, as well as personal conversations, and/or professional discussions between the participant and others is strictly confidential.

Confidential information, while documented in case notes and critical incident reports, is not to be shared with anyone (e.g., family, friends, or those in the community).

Confidentiality with respect to participant information is mandatory and should not be shared without the participant's written authorization.

Maintain Confidentiality

HIPAA Confidentiality

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal regulation relating to the confidentiality of patient data

HIPAA Privacy

Protects all "individually identifiable health information" held or transmitted by a covered entity in any form and calls this information "protected health information (PHI)"

Maintain Confidentiality

PHI Information Includes:

- ❖ Demographic data that relates to the individual's past, present or future physical or mental health or condition
- ❖ The provision of health care to the individual
- ❖ Payment for the provision of health care to the individual
- ❖ Information that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual
- ❖ PHI includes many common identifiers such as name, address, birthdate, and Social Security Number

Identify and Report Abuse, Neglect & Exploitation (ANE)

- AC aides play an important part in identifying Abuse, Neglect, and Exploitation which includes:
 - ❖ Knowing about different types of abuse and neglect
 - ❖ Recognizing the signs
 - ❖ Identifying risk factors
 - ❖ Knowing who to tell about suspected ANE
 - ❖ Supporting participant's safety
- Anyone can abuse or neglect a participant, including a spouse or partner, other family member, friend, neighbor, stranger, paid staff, or volunteer
- ANE can occur in any setting inside or outside of the place where the participant lives

Types of Abuse

➤ Physical Abuse

Infliction of injury, unreasonable confinement, intimidation, or punishment that results in physical pain or injury

➤ Emotional Abuse

Inflicting mental pain, anguish, or distress on a vulnerable person through verbal or nonverbal acts

➤ Sexual Abuse

Non-consensual sexual contact of any kind, coercing a vulnerable person to witness sexual behaviors

Physical: Assault, slapping, hitting, pushing, misuse of medication, restraint, inappropriate physical sanctions

Emotional: Threats of harm or abandonment, humiliation, blaming, intimidation, coercion, harassment, isolation, unreasonable withdrawal of services or support networks

Sexual: Rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography, witnessing sexual acts

Examples of Abuse

What is Neglect?

A situation in which an adult is unable to perform or obtain the goods or services that are necessary to maintain their health or welfare, or the deprivation of services or goods by a caregiver that are necessary for the well-being of the adult

Examples of Neglect

Deprivation of food, shelter, clothes or medical care

Lack of personal hygiene

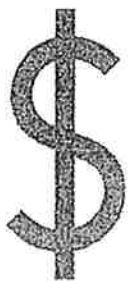
Unsafe living conditions

Unsanitary living conditions

Untreated physical and/or mental health problems

Includes self-neglect or when a participant can no longer meet their own basic daily needs

What is Exploitation?



Obtaining or using another person's resources such as money, assets, or property, by deception, intimidation, or similar means, with the intent to deprive the person of those resources

Extensive withdrawal from monetary accounts

Increased or changed spending habits of participant

Someone added to the participant's financial account(s)

Unpaid health care costs

Using the participant's ATM/credit card without permission

Identity theft

Examples of Exploitation

Warning Signs of Abuse, Neglect and Exploitation



• Changes in behavior

Example: participant is refusing to go places or see people they typically like to see

• Changes in emotional states

Example: the participant is more withdrawn, nervous, fearful, sad or anxious

Warning Signs of Abuse Include:

- Unexplained cuts, bruises, or bleeding
- Broken bones
- Burns
- Overmedication
- Isolation

Warning Signs of Neglect Include:

- Dehydrated or malnourished
- Poor hygiene
Example: dirty hair, skin, clothing
Example: strong body odor
- Isolation
- Lack of food and other amenities in the home
- Unexplained weight loss
- Pressure sores
- Lack of proper medical care or treatment
- Insect infestation in the home

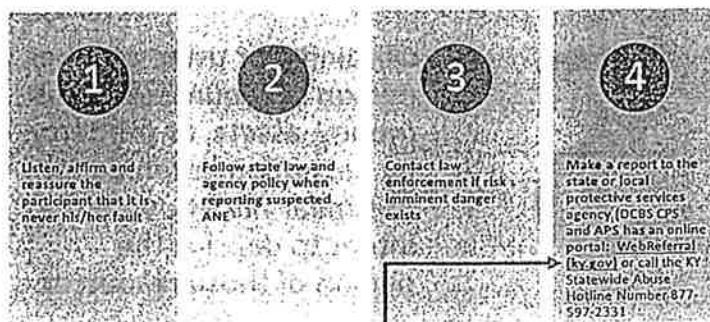
Warning Signs of Exploitation Include:

- Withdrawals of significant amounts of cash from bank accounts
- Missing money or medication
- Forged checks
- Unexplained/unknown credit card(s), creditor(s), or other charges
- Unpaid bills or limited/no access to information about finances
- Reliance/dependency on caregivers who have history of substance abuse or other mental health issues or do not have much prior history with participant (example: person's new best friend or neighbor, not previously involved with participant)

Preventing Abuse, Neglect & Exploitation

Know	Know the warning signs
Ask	Ask a lot of questions
Develop & Increase	Develop and increase the participant's circle of support
Refer	Refer participant to community resources, health care and social work professionals for more assistance

Addressing/Reporting Abuse, Neglect & Exploitation (ANE)



Identify and Report Program Fraud, Waste and Abuse (FWA)



AC aides play an important role in identifying and reporting suspected program FWA by:

- ✓ Knowing how FWA is defined
- ✓ Recognizing their role in fighting FWA
- ✓ Identifying prevention measures for FWA

Defining Fraud, Waste and Abuse (FWA)



- Fraud** is the intentional misrepresentation of information to gain undeserved payment for a claim
- Waste** involves spending federal or state health care dollars on services that are unnecessary
- Abuse** involves a questionable practice, which is inconsistent with accepted medical or business policies

Recognizing Fraud, Waste and Abuse (FWA)



- Using a participant's member ID card that does not belong to that person
- Failing to remove someone as a beneficiary when that person is no longer eligible
- Adding someone to a policy that is not eligible for coverage (example: grandchild)
- Visiting several doctors or doctor shopping to obtain multiple prescriptions

Preventing Program Fraud, Waste and Abuse

- 1 Always protect Medicaid and insurance card(s) and personal information of participants
- 2 Document services/activities correctly
- 3 Report suspected fraud, waste, and abuse as soon as possible through OIG's complaint email: chfs.fraud@ky.gov or by calling (800) 372-2970



CTRL+ Click to the OIG complaint email

Reporting Incidents



- AC aides are responsible for reporting *all* Incidents and Critical Incidents and should be familiar with agency and state requirements for reporting
- DMS reporting instructions dated June 4, 2021, located here: <https://www.chfs.ky.gov/agencies/dms/dca/Documents/irinstructionalguide.pdf>
- An incident may or may not involve abuse, neglect or exploitation

Incident Reporting

An incident is any occurrence that impacts the health, safety, welfare, or lifestyle choice of a participant and includes, but is not limited to :

- A minor injury
- A medication error without a serious outcome
- A behavior or situation that is not a critical incident



Incident Reporting

A Critical Incident is an alleged, suspected, or actual occurrence of an incident that can reasonably be expected to result in harm to an individual and includes but is not limited to:

- Abuse, neglect, or exploitation (ANE)
- A serious medication error
- Death / Unexpected Death
- A homicidal or suicidal ideation
- A missing person
- Other action or event that the provider determines may result in harm to the participant

Maintain a Safe Environment

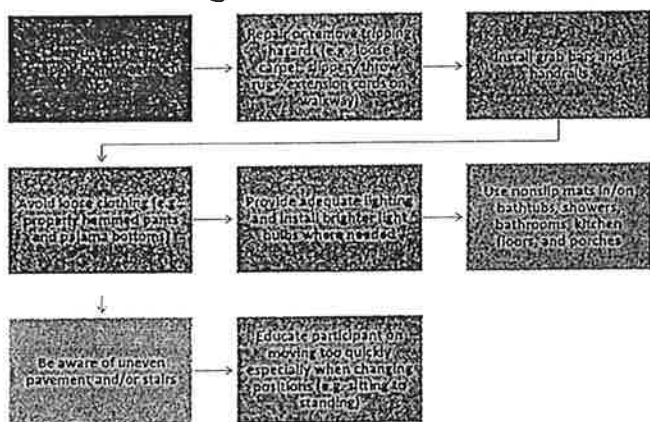
AC aides are responsible for maintaining a safe environment for participants both in the home and community, when possible



Maintaining a safe environment includes:

- Preventing falls and accidents
- Keeping area tidy, sanitary and free from hazards
- Responding to emergency situations
- Controlling the spread of infection or communicable disease

Preventing Falls and Accidents



Keeping Area Tidy, Sanitary & Free From Hazards

- Keeping participant's home clean and sanitary by:
- Report infestations of bedbugs, roaches or rodents
- Eliminate foul odors by removing trash and light debris
- Report home conditions which are unsanitary (e.g., too many pets) or are in disrepair (e.g., clutter in home) to Direct Service Supervisor and Case Manager or Service Advisor
- Assist participant with a plan for a path of exit in case of emergency

Responding to Emergency Situations

Preventing fires and practicing fire safety by:

- Never leaving food cooking unattended on stove
- Inspecting appliances to ensure they are in safe working order
- Using appliance for their intended use only
- Ensuring home has working smoke detectors
- Having an evacuation plan in the event of a fire
- Knowing how to call for help when necessary



Responding to Emergency Situations

Cardiopulmonary Resuscitation (CPR) and First Aid training can be lifesaving

A large percentage of cardiac arrests occur in the home

CPR and First Aid training is empowering and provides techniques needed to respond to emergency situations

Anyone providing services to participants must obtain a CPR and First Aid certification per regulation requirements within 6 months of hire and maintain a certification thereafter

If participant is PD9 and has a signed OMR, CPR is not required per 907 KAR 7:010 Section 6.11(2)



Preventing and Controlling the Spread of Infection



Practicing good hand hygiene is important because hands are the primary pathway of germ transmission

Hand hygiene or hand washing reduces potential pathogens on the hands and is considered a primary measure for reducing the risk of transmitting infection

Hand Hygiene means cleaning your hands by handwashing, which is washing your hands with soap and water, or by using alcohol-based hand sanitizer which is at least 60% alcohol

Preventing and Controlling the Spread of Infection

Hand Washing Guidelines

- Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap.
- Lather your hands by rubbing them together with the soap. Lather the backs of your hands, between your fingers, and under your nails.
- Scrub your hands for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song from beginning to end **twice**.
- Rinse your hands well under clean, running water.
- Dry your hands using a clean towel or air dry them.

(Handwashing Guidelines [Video](#))



Preventing and Controlling the Spread of Infection

- Wearing personal protective equipment (PPE) minimizes exposure to hazards when caring for those with an infectious illness or with a compromised immune system.
- PPE protects the caregiver, the participant, and anyone with whom they may have contact
- PPE includes items such as gloves, safety glasses and masks

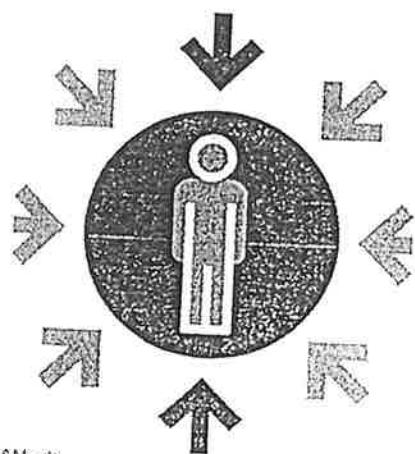


Preventing and Controlling the Spread of Infection



Clean your hands the right way and at the right times

- ✓ When your hands are visibly soiled - use soap and water to remove debris
- ✓ After touching potentially infectious material such as blood, body fluids or contaminated surfaces
- ✓ Before putting on and after taking off PPE, including gloves
- ✓ After using the restroom



PERSON CENTERED CARE SECTION V

Person Centered Care

- Driven by the Participant
- Includes People Chosen by the Participant
- Reflects Personal Preferences & Choices
- Respects Cultural & Spiritual Values
- Offers Choices Regarding Services
- Respects the Participant's Right to Privacy
- Follows Person-Centered Principles

Person Centered Principles

Respecting	Respecting the participant's preferences and goals
Treating	Treating the participant with dignity
Understanding	Understanding the experiences and goals of the participant
Maintaining	Maintaining confidentiality of participant's situation and information
Giving	Giving responsibility and empowering the participant

Delivering Person Centered Care

Requires:

- Taking **time** to understand what is important to the participant
- Building **trust** with the participant and working together
- Being **familiar** with the PCSP of the participant
- **Respecting** the participant's choice
- **Empowering** the participant



End of Module 1 Attendant Care Training

Thank you for attending DAIL's Attendant
Care Module 1 – training

Next step is to complete the Attendant
Care Module 1 – acknowledgement form
and knowledge-check assessment (quiz)

EMPLOYEE TRAINING VERIFICATION

Training form indicating that the PDS employee has received training from the PDS Representative on items listed. If you need additional information on any indicated topic, please inform CM.

- PDS Representative to sign on indicated line.
- Employee to sign top line
- Dates need to match

**PARTICIPANT DIRECTED SERVICES
EMPLOYEE TRAINING VERIFICATION**

As a chosen employee, I certify that prior to direct services being initiated, I received training from my employer or in the presence of my employer on:

- Principles of Self-Determination;
- Employee Contracts;
- Employee Background Checks;
- Timesheets;
- Person-Centered Planning;
- Fraud, Abuse, Neglect, and Exploitation; and
- Any additional topics required by my support brokerage agency, DAIL, DMS or employer.

Employee Signature

Date

Participant/Representative/Employer Signature

Date

Support Broker Signature (if applicable)

Date

Fraud, Abuse, Neglect, and Exploitation

KIPDA - Kentuckiana Regional Planning and Development Agency
11520 Commonwealth Dr
Louisville KY 40299

502-266-5571

1

What is Fraud?

Fraud is defined as:

- "an intentional deception or intentional misrepresentation made by a person with the knowledge that the deception could result in some unauthorized personal benefit or unauthorized benefit to some other person."
- "dependent upon evidence that must prove misrepresentation with intent to illegally obtain services, payment or other gains."

Source: <http://chfs.ky.gov/dms/fraud.htm>

2

Examples of Recipient Fraud / Abuse Include:

- Forging or altering prescriptions
- Forging or altering timesheets
- Recording time on timesheets for hours that were not worked
- Allowing others to use a Medicaid card to get services
- Failure to keep the Medicaid Card safe.
- Intentionally seeking and receiving excessive drugs, services or supplies.
- Collusion with providers in order to get services or supplies.
- Providing false information in order to qualify for Medicaid
- Drug diversion

3

Reporting Fraud

- The Division of Audits and Investigations is responsible for investigating and auditing for possible fraud, waste or abuse of the programs administered by the Cabinet as mandated by KRS 194A.030. **Public Assistance Fraud is a Crime**
- Because public assistance fraud is a crime, substantiated investigations are referred for criminal prosecution or administrative sanctions

4

Reporting Medicaid Fraud

- You Can Help: If you know or suspect that someone is defrauding or abusing one or more of the programs that we investigate, please tell us. While many cases are the result of routine computer matches, many others could not have been detected without the help of conscientious and concerned citizens and taxpayers.

- To report Medicaid and welfare fraud, please call:
800-372-2970

- You may also report suspected public assistance fraud by email: chfs.fraud@ky.gov, or by sending your complaint to us by mail at the following address:

Office of Inspector General
Division of Audits and Investigations
275 E. Main St., 5E-D
Frankfort, KY 40621

5

What Is Abuse? (Adults)

KRS 209.020 (8)

The infliction of injury, sexual abuse, unreasonable confinement, intimidation, or punishment that results in physical pain or injury, including mental injury.

6

What Is Abuse? (Children)

KRS 620.010 –

"...children have certain fundamental rights which must be protected and preserved. These include but are not limited to:

- the rights to adequate food, clothing and shelter;
- the right to be free from physical sexual or emotional injury or exploitation;
- the right to develop physically, mentally, and emotionally to their potential; and
- the right to educational instruction and the right to a secure, stable family..."

7

Indicators of Physical Abuse

- Multiple or patterned bruising or lacerations
- Injuries of unknown origins or a questionable history of injuries or falls
- Injuries in various stages of healing
- Bone fractures, broken bones, bite marks, rope marks
- Broken glasses
- Laboratory finding of medication overdose
- Sudden change in behavior
- Caregiver's refusal to allow visitors to see adult alone

8

Indicators of Sexual Abuse

- Bruises around the breasts or genitals
- Unexplained venereal disease or genital infections
- Unexplained vaginal or anal bleeding
- Torn, stained or bloody underclothing

9

Indicators of Mental Abuse

- Being upset or agitated
- Apathy, withdrawal, depression
- Sucking, biting, rocking (behaviors usually attributed to dementia)
- Caregiver behaviors such as belittling, threats, or other controlling behaviors.

10

Examples of Mental Abuse

- Attacks on a person's self esteem
- Treating an adult as a child, disrupting rights of privacy or self-determination
- Shaming, constant criticism, berating, ignoring, ridiculing, cursing, screaming, yelling
- Threats of violence or other harmful consequences
- Forced isolation or imprisonment
- Controlling victim's activities such as sleeping, eating or social interaction.

11

What is Neglect?

KRS 209.020 (16) –

- A situation in which an adult is unable to perform or obtain for himself the goods and services which are necessary to maintain his/her welfare and health; or
- The deprivation of services by a caregiver which are necessary to maintain the health and welfare of the adult.

12

What is Neglect?

- Self neglect
 - Environment unclean
 - Person is unclean
 - Spoiled food
 - Animals
- Caregiver neglect
 - Requested services not provided
 - Natural supports change

13

Passive vs. Active Neglect

- **Passive Neglect:** Failure to provide adequate food, water and health related services or supervision due to a lack of ability, skills or knowledge (includes self neglect)
- **Active Neglect:** Deliberate withholding of services, medical care or necessary supplies with the intention of causing pain or suffering or to inflict punishment.

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Indicators of Neglect

- Dehydration, malnutrition, extreme hunger
- Untreated health problems, bedsores
- Unsafe or unsanitary living conditions
- Being dirty or un bathed
- Unusual weight loss
- Desertion of the elder at the hospital, doctor's office or shopping center, etc,

15

What is Exploitation?

Financial Exploitation:

Obtaining or using another persons resources, including but not limited to funds, assets, or property by deception, intimidation, or similar means with the intent to deprive the person with these resources.

16

Indicators of Exploitation

- Unusual bank account activity;
- Large cash withdrawals from the elder's bank account
- Large checks written to unusual recipients
- Sudden changes in an individuals financial situation
- Abrupt changes in wills, trusts, contracts
- Accompanied by new friends when going to the bank
- Withdrawal of large amounts of cash
- Missing items of value

17

Other Possible Signs of Exploitation

- Failure by a Power of Attorney or Payee to adequately account for how money is spent.
- Disconnected utilities, lack of food, supplies or spending money when money should be available to cover these expenses
- Outcomes or goals are not being met;
- Little to no conversations based on the needs of the consumer
- Reluctance or denial by supports to allow professional opinion or intervention.

18

Reporting Requirements

- You Must Report!!
- KRS 209 requires any person having reasonable cause to suspect that an adult has suffered abuse, neglect or exploitation to report or cause a report to be made immediately to the Department for Community Based Services.
- Kentucky Abuse Hotline 1-877-597-2331

19

Department for Community Based Services Investigations

- Department for Social Services is required to notify the appropriate law enforcement agency, conduct an investigation of the allegation and offer protective services to the victim.
- Department personnel may enter any health facility or health services licensed by the cabinet at any reason time to carry out the investigation

Kentucky Statute 209.030(4) Protection of Adults

20

Reporting

- You do not have to prove the allegation. You only have to have reasonable suspicion.
- Privileged relationships such as doctor- patient relationships do not relieve one of the responsibility for reporting
- You can make ANONYMOUS report if you do not want to disclose your name.
- Failure to report is a Class B misdemeanor punishable by law.

21

When to Report

- Immediately upon knowledge of or reasonable suspicions of abuse, neglect or exploitation a report should be made.
- The death of the adult or child does not relive one of the responsibility of reporting.

22

What You Should Report

- The name and age of the victim
- Where the victim lives
- The name and address of the person responsible for their care.
- Identity of the perpetrator
- Names of witnesses
- Date and time of the incident
- Any other helpful information.

23

Questions?

24

Participant Directed Services (PDS) Employment
CPR / First Aid Acknowledgement Form

I, _____ (Participant, or Designated PDS Representative), am providing
this acknowledgment as part of the employment documentation for
_____ (Prospective PDS Employee Name) to be a PDS employee.

ACKNOWLEDGEMENT	
<p>I, as the PDS employer and/or my PDS representative, have the right to determine any training requirements my PDS employee must meet above and beyond what is required by the Department for Medicaid Services. I choose to waive the recommended CPR/First Aid certification for the prospective PDS employee named above.</p> <p>In doing so, I acknowledge that:</p> <ul style="list-style-type: none">☒ The Department for Medicaid Services recommends CPR/First Aid certification as a component of PDS employee requirements within six (6) months of hire.☒ There are potential health, safety, and welfare risks of employing a PDS employee without requiring the recommended CPR/First Aid certification. I am fully informed of my rights and responsibilities as a PDS employer and accept the risk and potential adverse outcomes associated with waiving the recommended CPR/First Aid certification for this prospective PDS employee.	
Signature of Participant or PDS Representative	Date of Signature (month, day, year)
Printed or Typed Name of Participant or PDS Representative	
Participant Name	Medicaid ID Number

KIPDA PDS Program EVV Guidelines

1. EVV must electronically verify six aspects of service delivery:
 - a. the date,
 - b. location,
 - c. type of service,
 - d. the individual providing the service,
 - e. the individual receiving the service,
 - f. start and end times of the service.
 2. Manually entering timesheets does not capture the location of services provided, which is not in accordance with the Federally Mandated 21st Century Cures Act. This is considered an unverified visit. Manual entries will not be approved for Medicaid payment.
 - a. It is then you as the Employer (the participant/representatives) who is responsible for paying for any unverified visits.
 - b. Also,
 - i. **1st offense**, a verbal warning will be issued to the participant/representative and employee. EVV training for proper usage will be reissued.
 - ii. **2nd offense**, a Corrective Action Plan will be issued, and the employee will have 30 days to get within compliance.
 - iii. **3rd offense**, an involuntary termination of PDS waiver services will be submitted to DAIL. Participant has the option of transferring to a traditional agency.
 3. Always ensure that your employee submits time according to your prior approved plan of care. Employees are not allowed to exceed the prior approved amount of hours for services.
 4. Always ensure that your employee submits tasks according to your approved plan of care. Employees are prohibited from selecting tasks that are not prior approved.
 5. Ensure that your employees' time in and time out is correct before submission. Incorrect time will not be approved for payment. Corrections (when permitted) will first need to be made by the employee, then reviewed and approved by the you the Employer (participant/representative). Time entered at any time past the previous payroll period will not be processed for payment at a future date.
 6. It is strongly encouraged for the participant/representative to review and approve employee's time daily. It is mandatory for you, the Employer (participant/representative), to review and approve employees' time at least on the bi-weekly schedule in order for the employees to be paid appropriately.
 7. A Corrective Action Plan will be implemented if the same errors are consistently being made (Ex: forgetting to clock in and to clock out, clocking in and clocking out at an unauthorized address - also may be considered fraud and will be reported as such, selecting inappropriate tasks, selecting incorrect service codes. The participant will be at risk of termination of waiver services or will be transferred to a traditional agency, as described above.
 8. Your employee will not be eligible to render services through the PDS Waiver Program if you are an inpatient of a hospital, nursing facility, rehab facility, mental institution, or hospice care. It is your responsibility to negotiate services outside of waiver approved services. Medicaid does not currently reimburse for services outside of approved care plans.
 9. It is you, the Employer (participants/representative) responsibility to ensure that all employee eligibility paperwork is valid and kept up to date (Ex: TB Skin Test, CPR/FA, DAIL Attendant Care Training, PDS Participant/Provider Contract, Vehicle Insurance, Driver's License.) Both employee and participant/representative will receive weekly expiration notices in the Mains'I portal starting 6 weeks from the employee eligibility item expiration date. If any employee eligibility items lapse, payment will immediately be stopped until updated documentation is received. Your employee will not be eligible to render services through the PDS Waiver Program during the time of the lapse and there will not be payment issued for services during gap periods. All employee eligibility items are due in a timely manner.
 10. Time submitted should be factual, complete, and accurate. Submitting time for services not rendered is considered Medicaid FRAUD. This would result in immediate termination of the Waiver program and legal action against you from the Department for Medicaid services. Suspected fraud will be reported to the Office of Inspector General immediately by KIPDA.
 11. It is highly recommended that you as an employee have at least 2 weeks worth of payroll amounts to assure that employees are paid by you (outside of Medicaid) if lapses in your Medicaid, lapses in employee eligibility, and/or other instances occur that are not reimbursable by Medicaid.
- ❖ Examples of Medicaid fraud include, but are not limited to:

- Completing time or signing for someone else.
- Billing for unnecessary/unapproved services or items.
- Billing for services when the participant is in an alternative care setting.
- Billing for services while the participant is not present.
- Billing for services or items not rendered.
- Receiving "kickbacks" from your employee from Medicaid wages.
- Beneficiary fraud includes misrepresenting one's circumstances to obtain coverage, including PDS Services.

FRAUD is punishable by law and will result in legal action against you, the Employer.

Please remember participant confidentiality. Services are individualized; therefore, should not be discussed between other participants and/or employees. A breach of confidentiality dictates either loss of services and/or loss of employment.

Participant/Representative Signature

Date

Employee Signature

Date

KIPDA PDS Program EVV Guidelines

Copy

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Please remember participant confidentiality. Services are individualized; therefore, should not be discussed between other participants and/or employees. A breach of confidentiality dictates either loss of services and/or loss of employment.

Participant/Representative Signature

Date

Employee Signature

Date

DISCLOSURES TO BE PROVIDED TO AND SIGNED BY APPLICANT FOR EMPLOYMENT OR LICENSURE

Kentucky National Background Check Program (KY-NBCP)
Office of Inspector General, Cabinet for Health and Family Services

FOR THIS TYPE OF EMPLOYMENT OR LICENSURE, STATE AND FEDERAL LAW REQUIRE A STATE AND NATIONAL
CRIMINAL BACKGROUND CHECK AS A CONDITION OF EMPLOYMENT

By signing this notice of required disclosures, the applicant for employment, volunteer services, or professional
licensure, has the responsibility to be aware of the following:

- (1) A set of the applicant's fingerprints will be required to complete a background check under the Kentucky
National Background Check Program (KY-NBCP).
- (2) The applicant must complete and sign the Waiver Agreement and Statement (OIG 1:190-2), and provide a
government-issued form of identification containing the applicant's photograph (such as a valid driver's license).
- (3) A background check facilitated by the KY-NBCP shall include a:
 - (a) Check of required abuse registries;
 - (b) Check of licensing board data, if applicable, to validate licensure status; and
 - (c) Fingerprint-supported state and Federal Bureau of Investigation (FBI) criminal background check,
which includes a comparison of the applicant's fingerprints with any latent fingerprints that may be on
file with the Department of Kentucky State Police (KSP) or the FBI. The fingerprint images will be used for
all criminal justice purposes.
- (4) The applicant's fingerprint images and associated information will be retained by KSP and the FBI in their
databases and will be used to determine if the applicant has any criminal history information on file with the State
and Federal criminal history repositories. KSP or the FBI will process future searches, including latent fingerprint
searches, against the applicant's fingerprints and make full use of them in any criminal prosecution under state or
federal law, as well as notify the Cabinet for Health and Family Services of subsequent arrests and convictions
indicated in the criminal history repositories concerning the applicant.
- (5) Upon submission by the applicant to the fingerprint-supported State and FBI criminal background check, an
employer *may* choose to hire the applicant provisionally while the background check is processed. Upon
completion of the criminal background check, the Cabinet for Health and Family Services, Office of Inspector
General may release any record of State criminal history found in the files of the Kentucky centralized criminal
history record information system to the applicant's current or prospective employer as reported on the OIG
1:190-2, Waiver Agreement and Statement.
- (6) The applicant's Social Security Account Number is needed in order to keep records accurate pursuant to the
Federal Privacy Act Statement, which may be downloaded at: [http://www.fbi.gov/about-](http://www.fbi.gov/about-us/cjis/cc/library/privacy-act-statement-1)
[us/cjis/cc/library/privacy-act-statement-1](http://www.fbi.gov/about-us/cjis/cc/library/privacy-act-statement-1)
- (7) All information provided to the KY-NBCP, Office of Inspector General, Cabinet for Health and Family Services
shall be kept confidential in compliance with applicable state and federal laws and regulations.
- (8) The applicant has the right to request and inspect his or her criminal history record and to request correction
of any inaccurate information. If the applicant does not exercise his or her right to inspect criminal history
information, the Commonwealth shall not be responsible for the dissemination of inaccurate information, or liable
for damages resulting from its determination of the applicant's eligibility for employment.

I HAVE READ, AND UNDERSTAND, THE FOREGOING DISCLOSURES.

Printed Name of Applicant: _____

Date of Birth: _____ Last Four Digits of SSN: _____

Signature: _____ Date: _____

Kentucky National Background Check Program (KY-NBCP)
Office of Inspector General, Cabinet for Health and Family Services

WAIVER AGREEMENT AND STATEMENT

Pursuant to the 906 KAR 1:190, Kentucky National Background Check Program, this form must be completed and signed by every prospective or current employee, volunteer, licensee, and contractor/vendor for whom fingerprint-based criminal history records are requested by a qualified entity.

I, the undersigned applicant, hereby authorize KIPDA on behalf of (hereinafter "qualified entity") to request submission of a set of my fingerprints to the Department of Kentucky State Police (KSP) and Federal Bureau of Investigation (FBI) for the purpose of accessing and reviewing state and national criminal history records that may pertain to me. By signing this Waiver Agreement and Statement, it is my intent to authorize the dissemination of any Kentucky and national criminal history record that may pertain to me to the Kentucky Cabinet for Health and Family Services, Office of Inspector General (hereinafter "OIG") for the purpose of determining whether I am eligible for employment, licensing, serving as a volunteer, or working as a contractor/vendor under 906 KAR 1:190. I further authorize the OIG to release any record of State criminal history found in the files of the Kentucky centralized criminal history record information system to the above-named qualified entity. I understand that the OIG cannot disseminate any national criminal history record from the FBI to the above-named qualified entity pursuant to 28 C.F.R. 50.12.

I further understand that, until the criminal history background check is completed, the qualified entity may choose to hire me provisionally and deny me unsupervised access to children, the elderly, or individuals with disabilities. I understand that upon written request to the OIG, I will be provided with a copy, if any, of a KSP or FBI criminal history report received on me. I understand that the OIG will only provide my criminal history report by certified mail, restricted delivery service. To receive my criminal history report from the local post office, I understand that I must show proof of identity and provide my signature. I also understand that I am entitled to challenge the accuracy and completeness of any information contained in any such report. I may obtain a prompt determination as to the validity of my challenge before a final decision is made about my status as an employee, volunteer, or contractor/vendor. If I do not exercise my right to challenge the accuracy and completeness of any information contained in my criminal history report, I agree to hold harmless the KSP and its employees from any claim for damages arising from the dissemination of inaccurate information. I also release the Cabinet for Health and Family Services, its officers, agents, and employees, from any liability or damages as a result of actions taken in good faith to comply with 906 KAR 1:190, including the disqualification of an applicant or employee from employment on the basis of a disqualifying offense.

☐ **Yes, I have been convicted of, pled guilty to, entered an Alford plea or a plea of nolo contendere to, or am under indictment for, a crime. If yes, please describe the crime(s) and the particulars on an additional sheet of paper.**

☐ **No, I have not been convicted of, pled guilty to, entered an Alford plea or a plea of nolo contendere to, and am not under indictment for, a crime.**

I am a current or prospective (check one): ☐ Employee ☐ Licensee ☐ Volunteer ☐ Contractor/Vendor

Applicant Signature: _____ **Date:** _____

Applicant Printed Name: _____

Applicant Date of Birth: _____ **Applicant Social Security Number:** _____

Applicant Address: _____

TO BE COMPLETED BY THE QUALIFIED ENTITY:

ENTITY NAME:	
ADDRESS:	
ENTITY ASSIGNED OCA:	

KEEP FOR YOUR RECORDS

Applicant and Employee Rights under Kentucky's National Background Check Program

An applicant or employee may: (1) challenge the accuracy and completeness of any information contained in his or her criminal history report, (2) challenge the finding that he or she is the true subject on an abuse registry, or (3) appeal the finding that he or she is not eligible for hire as the result of a State and FBI criminal history check in accordance with the following instructions:

I. Challenge Requests

Pursuant to Kentucky's Criminal History Record Information User Agreement, Section 6.12, a copy of an applicant's KSP and/or FBI rap sheet may be provided to the applicant upon completion of the initial fitness determination. A written request for the rap sheet must be submitted to the OIG at the following address:

Attn: National Background Check Program
Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

Upon receipt of the request, the OIG will send a copy of the applicant's rap sheet by certified mail, restricted delivery service. Applicants must show proof of identity and sign for the certified mail to obtain his or her rap sheet from the local post office.

Request to Challenge a KSP rap sheet: If an applicant believes that the information contained in his or her KSP rap sheet is incomplete or inaccurate, the applicant may contact the Kentucky State Police, Criminal Records Dissemination Section, at (502) 227-8700.

Request to Challenge an FBI rap sheet: In accordance with 28 C.F.R. 16.34, if an applicant believes that any information contained in his or her FBI rap sheet is incomplete or inaccurate, the applicant may direct his/her challenge regarding the accuracy or completeness of any entry on his/her record to:

FBI, Criminal Justice Information Services (CJIS) Division
ATTN: SCU, Mod. D-2
1000 Custer Hollow Road
Clarksburg, WV 26306

Abuse Registries: If an applicant believes that his or her name is listed on one of the following abuse registries in error, the applicant may contact the agency responsible for the registry as follows:

- **List of Excluded Individuals/Entities (LEIE)** – Contact the federal DHHS Office of Inspector General
 - <http://oig.hhs.gov/contact-us/>
- **Kentucky Nurse Aide Abuse Registry** – Contact the Kentucky CHFS Office of Inspector General
 - (502) 564-7963
- **Kentucky Caregiver Misconduct Registry** - Contact the Kentucky CHFS Ombudsman Office
 - (800) 372-2973 or (502) 564-5497
- **Kentucky Child Abuse and Neglect Registry** - Contact the Kentucky CHFS Ombudsman Office
 - (800) 372-2973 or (502) 564-5497

Out-of-state abuse registry findings must be addressed with the agency responsible for maintaining the abuse record.

Professional Licensing: If an applicant believes that his or her professional license is incorrectly reported as “not in good standing” or otherwise inactive, the applicant may contact the appropriate professional licensing board.

II. Request for Informal Review

If an applicant wishes to challenge the accuracy of the OIG's determination that the applicant is "not eligible for hire" based on the results of the applicant's criminal history check, the applicant may request an informal review as follows:

Step One: The applicant must sign, date, and send a written request for an informal review no later than 10 calendar days from the date of notice of the disqualifying offense to the following address:

Attn: National Background Check Program
Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

Step Two: The applicant's written request must include a copy of official documentation verifying the disqualifying offense was dismissed or otherwise removed from the applicant's criminal history report.

*See Request for Administrative Hearing if dissatisfied with outcome of the informal review.

III. Request for Rehabilitation Review

Certain criminal offenses found upon completion of a State and FBI criminal background check are eligible for consideration under the rehabilitation review process. The rehabilitation review process allows an applicant the opportunity to demonstrate that he or she is rehabilitated and not likely to repeat the conduct that led to the disqualifying offense.

Offenses not eligible for consideration under the rehabilitation review process include the following:

1. A disqualifying felony offense that occurred less than seven (7) years prior to the date of the criminal background check;
2. Any disqualifying felony or misdemeanor offense related to abuse, neglect, or exploitation of an adult defined by KRS 209.020(4) or a child;
3. A felony or misdemeanor sexual offense;
4. Registration as a sex offender under federal law or under the law of any state; or
5. Any person who is a violent offender.

A request for rehabilitation review shall be made as follows:

1. A written request must be signed, dated, and mailed to the National Background Check Program at the following address:

Attn: National Background Check Program
Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

2. Be mailed no later than 14 calendar days from the date of notice of the disqualifying offense; and
3. Be accompanied by a written explanation of each disqualifying criminal offense, including:
 - A description of the events related to the disqualifying offense;

- The number of years since the occurrence of the disqualifying offense;
- The age of the offender at the time of the disqualifying offense;
- Any other circumstances surrounding the offense;
- Official documentation showing that all fines, including court-imposed fines or restitution, have been paid or documentation showing adherence to a payment schedule, if applicable;
- The date probation or parole was satisfactorily completed, if applicable; and
- Employment and character references, including any other evidence demonstrating the ability of the individual to perform the employment responsibilities and duties competently.

*See Request for Administrative Hearing if dissatisfied with outcome of the rehabilitation review.

IV. Request for Administrative Hearing

An applicant may appeal the results of an informal review or rehabilitation review by submitting a written request for an administrative hearing to the Office of Ombudsman at the address provided below. The request must be submitted within 30 calendar days of notice of the decision from the informal review or rehabilitation review.

The request for an administrative hearing must be signed, dated, and mailed to the following address:

Attn: Office of Ombudsman
Cabinet for Health and Family Services
275 East Main Street, 1E-B
Frankfort, Kentucky 40621

Applicant Pre-Screening Form

(Please Type or Print Clearly)

The Applicant must provide this information before an application can be processed in the Kentucky Applicant Registry and Employment Screening (KARES) System

Declarations: By signing this form I consent to registry screening and submission of my fingerprints to the Kentucky State Police (KSP) for forwarding to the Federal Bureau of Investigation for the purpose of conducting a state and national criminal history records check pursuant to The Affordable Care Act¹ (ACA) Subtitle C, Section 6201 and pursuant to 906 KAR 1:190E. I understand that the results will be shared with the Kentucky National Background Check Program (KYNBCP) operated by the Cabinet for Health and Family Services – Office of Inspector General (CHFS-OIG).

Authority: The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

Principal Purpose: Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

I understand that as part of my application for employment or licensing, my fingerprints will be used to check the criminal history records of the Department of Kentucky State Police. I hereby give authority and consent to the Department of Kentucky State Police to retain my fingerprints and process future searches (including latent fingerprint searches) against them and make full use of them in any criminal prosecution under state or federal law. I also authorize and consent to the Department of Kentucky State Police notifying the Cabinet for Health and Family Services of subsequent arrests or convictions indicated in the criminal history records concerning me for use in determining my eligibility for employment or licensure. This authorization is given freely and voluntarily by me without coercion, duress, or threats of any kind.

Social Security Account Number (SSAN). Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal agencies to use this number to help identify individuals in agency records.

My signature acknowledges that I have read, understand and accept the terms and conditions outlined in this form.

Kentucky National Background Check Documentation
KARES WEB PORTAL

Name of Facility or Employer:			
Address of Employer:			
Applicant's Last Name:		Applicants First and Middle Names:	
Maiden Name:	Social Security Number:	Date of Birth:	Gender:
Government Issued ID (Include No. & Type):		State or Agency of Issue:	
Race:	Eye Color:	Hair Color:	Height (feet & inches):
Weight (lbs):	U.S. Citizen (Yes/No):	Place of Birth:	
Phone Number:	Phone Number Type:	Email Address:	
Current Physical Address Line One:		Current Physical Address Line Two:	
City:	State:	Zip Code:	County:
Current Mailing Address (if different):		City:	State:
Zip Code:	County:	Alt Phone Number:	Alt Phone Number Type:

List all residences you have lived at during the past seven years; include the timeframe in year from and year to format: (Use additional sheets if needed)

Complete Address	Year From	Year To

List all cities and states where you have worked during the past seven years; include the timeframe in year from and year to format: (Use additional sheets if needed)

City	State	Year From	Year To

List any aliases and other names you have ever used; including any other dates of birth and social security numbers: (Use additional sheets if needed)

First Name	Middle Name	Last Name	Date of Birth	Social Security Number

Have you ever been convicted of a crime?

☐ Yes ☐ No

→ If you answered "YES" to the question above, please provide an explanation in this box for each conviction. Please provide the following: (1) offense(s) for which you were convicted; (2) the date of the conviction(s); (3) the state or territory where the conviction(s) occurred; (4) the court; and (5) any action(s) taken by the court against you, including any sentence, or probation imposed. (Use additional sheets if needed)

Do you have any charges (pending) against you for a crime?

☐ Yes ☐ No

→ If you answered "YES" to the question above, please provide an explanation in this box for each charge. Please provide the following: (1) offense(s) for which you were charged; (2) the date of the conviction(s); (3) the state or territory where the conviction(s) occurred; (4) the court; and (5) any action(s) taken by the court against you, including any sentence, or probation imposed. (Use additional sheets if needed)

Has any government or regulatory agency (other than the police) ever found that you abused or neglected any person or client?

☐ Yes ☐ No

→ If you answered "YES" to the question above, please provide an explanation in this box, including when and where it happened.

Has any government or regulatory agency (other than the police) ever found that you misappropriated (improperly took or used) the property of a person or client? ☐ Yes ☐ No
→ If you answered "YES" to the question above, please provide an explanation in this box, including when and where it happened.

Has any government agency (other than the police) ever found that you abused an elderly person? ☐ Yes ☐ No
→ If you answered "YES" to the question above, please provide an explanation in this box, including when and where it happened.

Do you have a government issued credential that is not current or is limited so as to restrict you from providing care to clients? ☐ Yes ☐ No
→ If yes, explain, including credential name, laminations or restrictions and time period.

Answering "NO" to all questions does not guarantee employment.

SIGNATURE, CERTIFICATION AND RELEASE OF INFORMATION

YOU MUST SIGN THIS FORM. Please read the following acknowledgements carefully before you sign.

I understand that information requested regarding gender, race, height, eye color, hair color, weight, place of birth, citizenship and date of birth is for the sole purpose of identification and the accurate gathering of the criminal history record information, and that it will not be used to discriminate against me in violation of the law.

I understand that a false statement on any part of this form is grounds for either not hiring me, or firing me after I begin work. I consent to the release of information regarding a criminal history on me by the Kentucky State Police, Federal Bureau of Investigation (FBI), and any of its authorized agents. I certify that, to the best of my knowledge and belief, all of my statements are true, correct and complete.

Applicant's Signature:	Signature of Parent or Guardian if Under Age 18:	
Signature of Authorized Personnel at Hiring Facility:	Title:	Today's Date:

Copy of ID Needed for KARES Background Check

Select document and enter additional information.

Document:

- 
- Driver's License or ID card
 - State Issued Driver's License
 - U.S. Passport or U.S. Passport Card
 - Permanent Resident/Alien Card
 - State Issued Identification Card
 - Foreign Passport with I-551 stamp
 - United States Armed Forces ID
 - Employment Authorization Document
 - Visa
 - Foreign Passport with Form I-94 or Form I-94A
 - Passport from the FSM or RMI

Abuse, Neglect and Exploitation

KIPDA has always had a suspected abuse, neglect, and exploitation policy to help protect vulnerable individuals. This policy has applied to all KIPDA employees who suspect abuse, neglect and exploitation of any KIPDA participant or vulnerable individual.

SUSPECTED ABUSE, NEGLECT AND EXPLOITATION OF VULNERABLE INDIVIDUALS

For Participants: Abuse of any type is not tolerated. Participants should report any suspected abuse (including concerns about themselves as victims) to their case manager, and to the Kentucky Abuse Reporting Hotline 1-877-597-2331 .

For KIPDA Staff:

Policy: KY State Law, KRS 209, requires all persons to report any suspected cases and/or situations of neglect or abuse of any vulnerable individuals including older adults.

Procedures:

- All KIPDA staff are to notify Adult Protective Services to report concerns of suspected neglect or abuse.
- All KIPDA staff are to indicate suspected neglect or abuse in a progress note indicating the nature of the situation and the date and time Adult Protective Services was contacted.
- Home care aides are to report concerns of suspected neglect or abuse to the KIPDA In-Home Services provider. Providers, either the aide or provider supervisor, shall notify Adult Protective Services. Providers are to contact the KIPDA case manager and note the concern/report in the participant database.
- KIPDA staff are to educate KIPDA participants on how they can self report their concerns about abuse, neglect and exploitation. They are encouraged to do so if they feel that they are in a potential situation. They should use the same numbers and websites listed here.

QUALITY ASSURANCE:

- The Director of Social Services and/or Quality Management Planner are to be made aware of the suspected neglect or abuse report.
- The Director of Social Services or designee, In-Home Services Coordinator, Waiver coordinator, Quality Management Planner, ICC/Case manager or Social Service Assistant will follow-up with Adult Protective Services case worker as to outcome of the possible investigation.
- Quality Management Planner is to review all documentation related to suspected neglect or abuse situations.

For Providers/Agencies/Contractors:

- All suspected cases of abuse and neglect should be reported to the Kentucky Abuse Hotline 1-877-597-2331 .
- All suspected cases of abuse and neglect should be reported to KIPDA management as well.
- Agencies should review other abuse, neglect and exploitation guidance in this section as well as in KIPDA's other policies, procedures and statements.
- Local authorities such as the police or 911 should also be contacted as appropriate.

KIPDA's Policy Statement on Suspected Abuse, Neglect and Exploitation of Participants, Participants, and Potential Participants

- KIPDA maintains a commitment to serving the most vulnerable people in the community. All too often, these are individuals who are at risk for being abused, neglected, or exploited. If any KIPDA staff member, volunteer, provider, or community partner suspects abuse, neglect, or exploitation of someone connected to a KIPDA service or program, they are advised to report their concern to their supervisor, to KIPDA, to the appropriate authorities, and to the Kentucky Abuse Hotline which can be reached either online or by phone:
- WebReferral (ky.gov)
- Kentucky Abuse Hotline 1-877-597-2331
- KIPDA staff and partners are advised to use the abuse hotline rather than the web referral for reports that appear to be of a more urgent nature. If there is an immediate danger, KIPDA's staff and partners are encouraged to call 911 as situationally appropriate. At times, KIPDA's staff and partners might opt to call the local police department's nonemergency number and request a health, safety, and welfare check. KIPDA's staff and partners are expected to use situational and professional judgement to determine the appropriate course of action. KIPDA's staff and partners are encouraged to consult with KIPDA management if the situation is unclear.

Date

Signature

Printed name and role

FRAUD, WASTE AND ABUSE FACT SHEET HOME AND COMMUNITY BASED (HCB) WAIVER

What is program fraud?

- Fraud is misrepresenting the truth or hiding information or facts.
- Fraud may occur if a Medicaid member, family member, representative, employee or agency gives false information or changes facts to benefit or get assistance from a state program.
- Fraud is defined by Kentucky law and can be found in KRS 205.8451. To read KRS 205.8451 you may visit <https://apps.legislature.ky.gov/law/statutes/statute.aspx?id=7851statute.aspx>

What is program waste?

- Waste is the careless expenditure or use of program resources.
- Waste may occur if inefficient or ineffective practices results in cost to the program.

What is program abuse?

- Abuse is activities or practices that are not consistent with sound business or program guidelines and results in unnecessary cost to the state program.
- Abuse may occur if actions that are improper, inappropriate, and outside acceptable standards of the program are taken.

What is the difference between Fraud, Waste, and Abuse?

- Fraud requires the person to have an intent and the knowledge that their actions are wrong.
- Waste and Abuse may involve obtaining an improper payment but does not require the same intent and knowledge.

Approved by: DMS
Issued by: DAIL

Date Approved: 11/2021
Date Issued: 01/2022
DAIL Reference Number: 01-2022-A



KENTUCKY CABINET FOR
HEALTH AND FAMILY SERVICES

FRAUD, WASTE AND ABUSE FACT SHEET HOME AND COMMUNITY BASED (HCB) WAIVER

- These differences are based upon intent and knowledge and depends on specific facts circumstances.

How is suspected Fraud, Waste and Abuse reported?

- Suspected Fraud, Waste and Abuse should be reported to the Office of Inspector General (OIG) by any person who knows or has reason to believe it is being committed.
- The OIG accepts tips and complaints from all sources on potential Fraud, Waste and Abuse
- The report may be made by:

Phone: (800) 372-2970

Email: chfs.fraud@ky.gov

Mail: Office of Inspector General
Division of Audits and Investigations
275 East Main Street, 5E-D
Frankfort, KY 40621

What information is needed to report suspected Fraud, Waste and Abuse?

- If known, the name and address of the person or agency suspected of committing the Fraud, Waste and Abuse and extent of the violation
- Any other information or details which may be helpful in investigation of the suspected Fraud, Waste and Abuse.

**I confirm that I read, understand, and have no questions related to the material above.
Further, I acknowledge it is my responsibility to report suspected fraud, waste, and abuse as outlined above.**

Name: _____ **Signature:** _____

Waiver Role: _____ **Date:** _____

Approved by: DMS

Issued by: DAIL

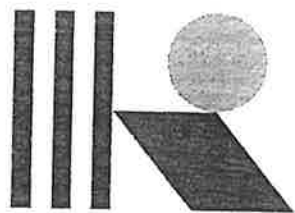
Date Approved: 11/2021

Date Issued: 01/2022

DAIL Reference Number: 01-2022-A



KENTUCKY CABINET FOR
HEALTH AND FAMILY SERVICES



**Kentuckiana
Regional Planning &
Development Agency**

**HCB WAIVER
EMPLOYEE E-MAIL ADDRESS**

Employee Name: _____

Employee E-Mail: _____

Re-type E-Mail: _____

KIPDA Financial Management
MEDICAID WAIVER
VENDOR AND EMPLOYEE PAYMENT SCHEDULE

Pay Period		Representative Approval Due	Direct Deposit Date
12/14/2025	12/27/2025	December 28, 2025	January 9, 2026
12/28/2025	1/10/2026	January 11, 2026	January 23, 2026
1/11/2026	1/24/2026	January 25, 2026	February 6, 2026
1/25/2026	2/7/2026	February 8, 2026	February 20, 2026
2/8/2026	2/21/2026	February 22, 2026	March 6, 2026
2/22/2026	3/7/2026	March 8, 2026	March 20, 2026
3/8/2026	3/21/2026	March 22, 2026	April 3, 2026
3/22/2026	4/4/2026	April 5, 2026	April 17, 2026
4/5/2026	4/18/2026	April 19, 2026	May 1, 2026
4/19/2026	5/2/2026	May 3, 2026	May 15, 2026
5/3/2026	5/16/2026	May 17, 2026	May 29, 2026
5/17/2026	5/30/2026	May 31, 2026	June 12, 2026
5/31/2026	6/13/2026	June 14, 2026	June 26, 2026
6/14/2026	6/27/2026	June 28, 2026	July 10, 2026
6/28/2026	7/11/2026	July 12, 2026	July 24, 2026
7/12/2026	7/25/2026	July 26, 2026	August 7, 2026
7/26/2026	8/8/2026	August 9, 2026	August 21, 2026
8/9/2026	8/22/2026	August 23, 2026	September 4, 2026
8/23/2026	9/5/2026	September 6, 2026	September 18, 2026
9/6/2026	9/19/2026	September 20, 2026	October 2, 2026
9/20/2026	10/3/2026	October 4, 2026	October 16, 2026
10/4/2026	10/17/2026	October 18, 2026	October 30, 2026
10/18/2026	10/31/2026	November 1, 2026	November 13, 2026
11/1/2026	11/14/2026	November 15, 2026	November 27, 2026
11/15/2026	11/28/2026	November 29, 2026	December 11, 2026
11/29/2026	12/12/2026	December 13, 2026	December 25, 2026
12/13/2026	12/26/2026	December 27, 2026	January 8, 2027



K I P D A
**Kentuckiana Regional Planning
& Development Agency**

(Employee)

Is Awarded This

Certificate of Completion of Training

To certify that upon satisfactorily completing the Mains' I
EVV Start to Finish with the Mobile App Training

Client/Representative

Date

By signature of the client/representative (if applicable), you are
confirming the Mains' I EVV Start to Finish with the Mobile App
training has been viewed in its entirety.