CONSUMER DIRECTED SERVICES
EMPLOYMENT APPLICATION INSTRUCTIONS

Please read these instructions before proceeding to the application.

- Do not use white out, erasable ink, red ink, or pencil on the application or other documents.
- Complete the employment application in its entirety. Incomplete applications cannot be processed.
- Disclose all misdemeanor or felony convictions. You do not need to report minor traffic violations.
- Complete, sign and return the Family Care Safety Worker Registration form.
- Include a one-time fee of $14.53, this amount includes a $.43 processing fee. Fee is not required if already registered. Pay via money order or check made payable to Services for Independent Living.
- Complete and sign the Chamber Background Form – If you have not lived in Missouri for the past 5 consecutive years. Include a one-time fee of $10.75 if this needs to be ran.
- Initial each section of the Attendant Contract.
- Complete the I-9 form – this form CANNOT contain errors or marked-through corrections.
- Bring with you/provide proper and current identification listed on the I-9 List of Acceptable Forms page. Most people bring a driver's license and social security card. **Please make sure that both forms of identification have the same name on them.**

I consent and acknowledge that Services for Independent Living (SIL) will perform a background screening via the Family Care Safety Registry and Office of Inspector General. Any subsequent screening may result in termination, depending on the results.

I verify that I have fully read and understand the conditions described in this letter. I also understand that I am required to complete all employment documentation ***before*** I am authorized to work.

_____ _____

Applicant Signature Date

Medicaid	Attendant Care Contract
Non-Public Entity OHCDS	Services to be subcontracted by
Organized Health Care Delivery System	Services for Independent Living
Home and Community Based Services	
Request for Proposal	

For Office Use Only: Do not write in this box, please.

A. Consumer/Employer's Name: _____

B. Attendant/Employee's Name: _____

ATTENDANT CARE CONTRACT

This Attendant Care Contract ("**Contract**") is made by Services for Independent Living and the Attendant/Employee identified in line B. above who will be employed by the Consumer/Employer identified in line A. above. ***Read thoroughly and initial after each section.***

1. Definitions. In order to make this Contract more easily understood, certain terms are defined and various responsibilities are described as follows:
a.) The term **"Consumer/Employer"** means the individual identified in line A. above, who, requires Attendant care services in his/her home. Hereafter, the Consumer/Employer will be referred to as "**Consumer.**" Consumer is the employer of Attendant/Employee and as such is responsible for directing, managing, scheduling (within the parameters of authorized service hours), and supervising Attendant/Employee. Consumer, through the fiscal intermediary, will pay the Attendant/Employee at a rate chosen by Consumer (Employee/Attendant Wage Selection form) for services authorized in Consumer's Plan of Care and by this Contract. ____

b.) The term "**Attendant/Employee**" means the individual identified in line B. above, who, as a party to this contract, agrees to provide Attendant care services to Consumer. Hereafter, the Attendant/Employee will be referred to as "**Attendant.**" ____

c.) The term "**consumer-directed services**" (CDS) or "**self-directed services**" means those services that Consumer needs to have provided to him/her within his/her home in order to achieve independent living within the community. Consumer-directed services may include helping Consumer with eating, dressing, meal preparation, toileting, bathing, grooming, transferring, housekeeping and specific health maintenance tasks, as well as some other tasks that ensure Consumer's health and safety, like grocery shopping and laundry. The consumer-directed services that Attendant will perform pursuant to the CDS program will be described and authorized in the Consumer's Plan of Care. Your employer will let you know about services authorized on their care plan. ____

d.) The term "**Services for Independent Living**" means the agency signing this Contract. Hereafter, Services for Independent Living will be referred to as "**SIL**." SIL is recognized as a vendor of Consumer Directed Services and enrolled as an Organized Health Care Delivery System with the Department of Health and Senior Services, Division of Senior and Disability Services. SIL is authorized to provide administrative support to Consumer and is authorized to enter into payroll service contracts with payroll service companies to provide fiscal intermediary services as set forth below. ____

e.) The term "**fiscal intermediary**" means a payroll service company, under contract with SIL, retained to perform "**fiscal intermediary services**". These include calculating the amount that an attendant is to be paid by Consumer, writing payroll checks (or making direct deposits), withholding and paying state and federal income taxes to the appropriate authorities, withholding and paying Social Security (FICA) and Medicare payments and/or Consumer's portions as is required by law or regulations and paying them to the appropriate authorities, and making unemployment/workers compensation insurance payments, as well as withholding/paying those amounts as may be required by law or regulations from time-to-time. The fiscal intermediary will provide Attendant internet account information so that attendant may access payroll documents in a secure way. The fiscal intermediary will prepare and provide Consumer and Attendant with end-of-year tax information and forms within the time prescribed by law, such as W-2's, so that Consumer and Attendant may comply with all tax filing requirements. The fiscal intermediary will maintain copies of all records required by law or regulations for tax and other purposes, and these shall be the official records documenting the employer/employee (Consumer/Attendant) relationship. ____

2. Purpose and background information. The purpose of this Contract is to allow the Consumer to interview, hire, direct, manage, schedule, supervise, and discharge his/her Attendant. SIL is a vendor of consumer directed services and as such it is authorized by the Missouri Department of Health and Senior Services to provide administrative support and case management for consumer-directed services. SIL may contract with payroll service companies to act as a fiscal intermediary. The fiscal intermediary will act as an agent for and provide payroll services for Consumer, as explained herein. ____

Consumer will employ Attendant to work in Consumer's home, at the direction and under the supervision of Consumer, to provide the attendant care services described and authorized in Consumer's Plan of Care. Telephony calls to clock-in and clock-out must occur in the Consumer's home and attendant can only be clocked-in for one person at a time. Because of the work arrangement contemplated in this contract, Attendant is an employee of Consumer, and not an independent contractor. It is, therefore, necessary that Consumer, through the fiscal intermediary, withhold and pay all income taxes required by law, as well as all other withholdings or payments that employers generally make in connection with employees in order to comply with applicable laws and regulations. ____

The fiscal intermediary will perform intermediary services as described above and prepare payment for hours worked to Attendant on behalf of Consumer. ____

3. Basis for payment. Attendant agrees to perform the consumer-directed services described and authorized in Consumer's Plan of Care at an hourly rage chosen by Consumer of $8.60 to $9.15/hour, which rate may be increased from time-to-time. Attendant will be paid through a fiscal intermediary only for those consumer-directed services described and authorized in Consumer's Plan of Care for the particular month at issue. Medicaid will provide funds to the fiscal intermediary to pay Attendant on behalf of Consumer for authorized attendant care services actually performed for Consumer. ____

4. Method of payment. SIL will provide Consumer with documents authorizing payment on behalf of the Consumer for the consumer-directed services described and authorized in Consumer's Plan of Care. The documents will set forth the maximum number of hours to be worked for purposes of the CDS program during a specific time period; and the applicable time period for performance of the consumer directed services. SIL will also provide details to both consumer and attendant on using the Clock In-Clock Out (CICO) telephony system for timekeeping. ____

Attendants will be paid on the 1st and 16th of each month according to the CICO telephony records. ____

It is imperative that Consumer and Attendant accurately record and report services and hours. Falsification or misrepresentation on any telephony call constitutes fraud. Payments made on behalf of Consumer as a result of inaccurate/false call records will be recouped from Attendant and/or Consumer to the extent permitted under applicable law. Any incidents of apparent fraud will be reported to Medicaid and/or other appropriate authorities. ____

5. Conditions and understandings of Contract. Attendant understands an investigation to determine if fraud has occurred with respect to false reports related to the CDS program may be performed and agrees to provide any requested assistance with respect to any such investigation. Additionally, as Medicaid funds are used, in whole or in part, to pay Attendant, the Missouri Department of Social Services and the U.S. Department of Health and Human Services, and/or its/their designee(s), have the right to evaluate, through inspection or other means, the consumer-directed services rendered and reimbursed hereunder. ____

Attendant understands and agrees that he/she is not an employee of SIL. Attendant will not represent that he/she is an employee of SIL. Attendant understands and agrees that pursuant to this Contract, he/she is employed solely by Consumer. ____
Attendant understands that, depending on the results of a background check or information revealed on an application, Attendant may not be eligible to provide services and receive payment under the CDS program unless and until Attendant obtains a Good Cause Waiver. Attendant shall not receive any wages through SIL or a fiscal intermediary on behalf of Consumer for services rendered unless and until they are eligible for employment for purposes of the CDS program. The Attendant shall not hold SIL or a fiscal intermediary responsible for failing to process or pay any wages on behalf of Consumer for services provided to Consumer prior to fulfilling CDS program pre-employment responsibilities. ____

6. Liability for work related injury/illness. Attendant understands and agrees that Attendant and/or Consumer is/are solely responsible for any injuries or illness Attendant sustains while providing consumer-directed services and/or acting within the scope of his/her employment, and that neither SIL nor the State of Missouri has any liability for such injuries or illness. ____

7. Mandated Reporter. Attendant agrees and understands that he/she is required by law to report suspected abuse, neglect, and/or exploitation as determined under Sections *660.00*, *565.188, 208.912, 208.915* and *198.070* RSMo to **Missouri Senior and Disabilities Hotline** at **1-800-392-0210.** ____

8. Direction and supervision of Consumer. Attendant understands and agrees that he/she will perform the consumer-directed services specified in Consumer's Plan of Care under the direction and supervision of Consumer on such dates and at such times as agreed upon by Attendant and Consumer; however, for purposes of reimbursement through the CDS program, the service time shall not exceed the number of hours authorized for service. ____

9. Termination. Attendant understands and agrees that he/she is an at-will employee of Consumer and that he/she can resign at any time and Consumer can discharge him/her at any time for no reason or any lawful reason unless Consumer and Attendant separately agree to more limited circumstances and notice requirements under which the employment relationship and this Contract can be terminated. This Contract shall terminate upon the ending of the employment relationship between Consumer and Attendant. Consumer or Attendant shall inform SIL when Consumer's employment relationship with Attendant has ended. _____

10. Confidentiality. Attendant understands that Consumer is entitled to have his/her personal and health care information treated with confidentiality. Attendant agrees to protect and maintain Consumer's confidentiality in accordance with HIPPA any other applicable laws. Under no circumstances will Attendant discuss or disclose any Consumer's personal or health care information without legal authorization. Consumer's right to confidential treatment of personal and health care information survives the termination of this Contract. ___

11. Hospital stays. Should services be provided by Attendant to Consumer during Consumer's hospital stay, Consumer is solely responsible for paying the Attendant and those services shall not be reimbursable on behalf of Consumer through SIL or a fiscal intermediary. Should an Attendant receive wages during the Consumer's hospital stay through SIL or a fiscal intermediary on behalf of Consumer, SIL ***shall exercise*** the legal right to recoup the entire amount to the extent allowed by law as identified by the Department of Health and Senior Services and/or Missouri HealthNet. Additionally, Attendant and Consumer will be referred to the Missouri Depart of Senior and Disability Services Hotline and/or Office of Attorney General for an investigation of record falsification. ____

12. Miscellaneous provisions. This Contract shall be interpreted in accordance with and governed by the laws of the State of Missouri. The place of contract is the county where SIL has its principle office. ____

13. Subsequent background screenings. State law mandates an initial background screening for every potential attendant. Additionally, a subsequent background screening is performed upon the attendant's request to work for additional consumers. Depending on the results of a background check or information revealed on an application, Attendant may be ineligible to provide services and receive payment under the CDS program unless and until Attendant obtains a Good Cause Waiver. The invalidity or unenforceability of any portion or provision of this Contract shall not effect, impair, or render unenforceable any other portion or provision. It is intended that each provision herein that is invalid or unenforceable as written be valid and enforceable to the fullest extent possible. ____

The captions in this Contract are for convenience only and are not to be construed as substantive parts of this contract. ____

This contract shall not be modified except in writing signed and dated by all parties. ____

14. Signatures. BY SIGNING BELOW, YOU ACKNOWLEDGE YOU HAVE READ THIS CONTRACT, YOU ACCEPT IT, UNDERSTAND IT, AND AGREE TO ITS TERMS.

_____	_____
Signature: Employee/Personal Care Attendant	**Printed Name**
_____	_____
Signature: SIL Representative/Title	**Printed Name**
_____	_____
Signature: Employer/Consumer	**Printed Name**

Employee/Personal Care Attendant (PCA) Hourly Rate Selection

I, _____, the Employer/Consumer for my Employee/Personal Care Attendant _____, choose to pay my employee at the designated regular hourly rate as I have set forth below.

I understand I can pay my Employee/Personal Care Attendant any regular hourly rate within the range of $13.75 to $14.00. I choose to pay my Employee/Personal Care Attendant at the rate of $_____ per hour. I understand I can later increase my Employee/Personal Care Attendant's regular hourly rate during their employment for me up to the maximum rate of $14.00 per hour.

I understand Services for Independent Living will assume I want to continue to pay my Employee/Personal Care Attendant at their current regular hourly rate if I do not return this form completed and signed to Services for Independent Living before the date my Employee/Personal Care Attendant starts performing work for me pursuant to the CDS program that is authorized by my state plan of care.

_____ _____

Employer/Consumer Signature Date

Consumer Directed Services
EMPLOYMENT APPLICATION FOR HEALTH CARE SERVICE

IS YOUR APPLICATION COMPLETE, ACCURATE, DATED AND SIGNED?
IF IT IS NOT, WE WILL NOT PROCESS THE PAPERWORK. PLEASE LET US KNOW IF YOU HAVE QUESTIONS OR NEED HELP

Consumer/Employer: _____

Name_____; Aliases_____

Social Security #_____; All Social Security #s Used_____

Complete Address_____
Street Address City State Zip

Email Address_____

Telephone Number: (____) _____ Cell ☐ Alternate Number: (____) _____ Cell ☐

Are You 18 Years Of Age Or Older? _____ Yes _____ No ***(State Requirement: Must be able to show proof you are at least 18 years of age or older)***

Have you lived in Missouri for the last consecutive five years? _____ Yes _____ No

If NO, Have you worked for an in-home agency since your return? _____ Yes _____ No

If NO, you must complete the Chamber Background Check

Do you meet the physical and mental demands required to perform specific tasks of the consumer; agree to maintain confidentiality of personal and medical information; are emotionally mature and dependable; are able to handle emergency situations; and are not related by blood, adoption, or marriage? _____Yes _____ No How are you related to the consumer? _____

Do you smoke: _____ Yes _____ No Are you willing to work for people who do smoke? _____ Yes _____ No

BACKGROUND

Have you ever been convicted of, pled guilty to, or pled nolo contendere (no contest) to an offense other than a minor traffic violation? _____ Yes _____ No

**Examples of minor traffic violations include speeding tickets, illegal parking, running a red light, failure to yield, illegal turns, etc.*

If you answered yes, disclose below all criminal convictions, findings of guilt, pleas of guilty, and/or pleas of nolo contendere (no contest), except for minor traffic violations.

_____

_____

Have you ever been listed on the Employee Disqualification List? _____ Yes _____ No Reason_____

Have you ever applied for a Good Cause Waiver? _____Yes _____No When? _____ Why? _____

Please ask how to complete a Good Cause Waiver when criminal history is disclosed.

Are you registered with the Family Care Safety Registry? _____Yes _____No (If no, payment of $14.00 required)

Do you have a **valid MO** Driver's License? _____Yes _____No

Do you have regular access to reliable transportation? _____Yes _____ No

Can you read, write and follow directions? _____ Yes _____ No

Do you prefer working with males, females, or either? _____

Have you identified a consumer to work for? ____ Yes ____No If yes, whom: _____

Has someone asked you to work for them? ____ Yes ____No If yes, whom: _____

Consumer Directed Services
EMPLOYMENT APPLICATION FOR HEALTH CARE SERVICE

What experience do you have caring for children, individuals with chronic illness, or individuals with disabilities? _____

_____

Please list any certifications, professional designations and/or licenses you have:_____

_____

EMPLOYMENT HISTORY – List the last 5 years of employment with most recent first. If you were previously an attendant employed by an individual receiving Consumer Directed Services, list them as the Company.

1) Company Name: _____; Supervisor: _____

Mo/Yr Employed: From _____ To_____ Position Held: _____

Complete Address _____
Street Address City State Zip Code

Phone: _____ Duties: _____

Reason for leaving: _____ May we contact the employer? Yes___ No___

2) Company Name: _____; Supervisor: _____

Mo/Yr Employed: From _____ To_____ Position Held: _____

Complete Address _____
Street Address City State Zip Code

Phone: _____ Duties: _____

Reason for leaving: _____ May we contact the employer? Yes___ No___

3) Company Name: _____; Supervisor: _____

Mo/Yr Employed: From _____ To_____ Position Held: _____

Complete Address _____
Street Address City State Zip Code

Phone: _____ Duties: _____

Reason for leaving: _____ May we contact the employer? Yes___ No___

REFERENCES: List three credible references *not related to you.*

1) Name: _____Relationship _____ Phone #_____

Complete Address _____
Street Address City State Zip Code

2) Name: _____Relationship _____ Phone #_____

Complete Address _____
Street Address City State Zip Code

3) Name: _____Relationship _____ Phone #_____

Complete Address _____
Street Address City State Zip Code

Acknowledgement:

I certify the answers herein are true and accurate to the best of my knowledge and I hereby authorize performance of pre-employment criminal record checks for employment purposes only. I hereby give consent to performance of a closed records check pursuant to

Section 610.120 RSMO. I understand any employment with Consumer is conditioned on my consent to such checks as well as the findings/results of such checks. I hereby release any person or organization conducting such background checks and/or furnishing such criminal record information and Consumer from any and all liability arising out of the conducting of a check or the furnishing or receipt of criminal record information. Any such person or organization may rely on a copy of this release. In the event of employment with Consumer, I understand that false or misleading information given on this application or in interview(s) may result in refusal to hire or, if employed, may result in discharge after its discovery.

Signature of Applicant: _____ Date: _____

All qualified applicants will be considered without regard to race, color, gender (sex), religion, veteran status, disability, age, sexual orientation, national origin, ancestry, or any other classification protected by law.

Authorization to Release Information

To assist Services for Independent Living with reducing fraud, waste, and abuse, I hereby give permission to them to access specific employment records from my current employer. Records to be disclosed by my employer shall only include those containing my name, hours worked, and time in/time out. All other records are not to be released unless I provide additional written consent prior to the release of requested records.

I have listed my current employers below; I assure Services for Independent Living that I will update my employment record upon changing employers.

Company Name: _____

Address: _____

Phone: _____

Supervisor: _____

Company Name: _____

Address: _____

Phone: _____

Supervisor: _____

Company Name: _____

Address: _____

Phone: _____

Supervisor: _____

The above Release of Information shall remain in effect until revoked in writing. All records obtained shall be open to inspection by the State of Missouri and/or its agents or designees.

_____ _____

Employee Signature and Title Date

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
FAMILY CARE SAFETY REGISTRY

WORKER REGISTRATION

FCSR USE ONLY

Register online at www.health.mo.gov/safety/fcsr OR mail this form, copy of Social Security card, and payment to **Missouri Dept. of Health and Senior Services, Fee Receipts, PO Box 570, Jefferson City, MO 65102.**

REGISTRATION TYPE (Check all that apply. Complete column on right only if Long Term Care/Personal Care selected from left.)

- ☐ Adoptive Parent
  Agency Name: _____
- ☐ Child Care
- ☐ Foster Parent/Family Member of Foster Parent
  County Office: _____
- ☐ Hospital
- ☐ Long Term Care/Personal Care (Please choose subcategory at right ▸.)
- ☐ Mental Health/Psychiatric Hospital
- ☐ Voluntary *(Select voluntary if no other registration type applies.)*

A one-time registration fee of **$14.00** applies to all categories except Foster Parents. Foster Parents must list the Children's Division county office.

Register only once. If you believe you have already registered, check our website at www.health.mo.gov/safety/fcsr or call, toll free, 866-422-6872.

Long Term Care / Personal Care Subcategories
(Complete if LTC/PC selected at left.)

- ☐ Adult Day Care
- ☐ Assisted Living Facility
- ☐ Hospice
- ☐ Hospital LTAC/Swing Bed
- ☐ Mental Health – Residential Facility/ICF
- ☐ Nursing Facility/Skilled Nursing
- ☐ Personal Care – Home Health
- ☐ Personal Care – In-Home Services
- ☐ Personal Care – Consumer Directed Services/Center for Independent Living
- ☐ Personal Care – HCY/PDW/DDD/Other

SOCIAL SECURITY NUMBER (Mail copy of card with form.)

— —

PERSONAL INFORMATION (Provide all names you have used, starting with most recent. Include legal names and nicknames.)

LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX (JR., SR., II, III)

BIRTH NAME (LIST FULL NAME)	PRIOR NAMES USED (IF APPLICABLE, LIST FIRST AND LAST NAMES.)	DATE OF BIRTH (MM-DD-YYYY)	GENDER
			☐ M ☐ F

CONTACT INFORMATION

MAILING ADDRESS (ENTER YOUR STREET ADDRESS OR POST OFFICE BOX. THIS ADDRESS MUST BE DIFFERENT FROM EMPLOYER ADDRESS.)

CITY	STATE	ZIP CODE	COUNTY

TELEPHONE	EMAIL ADDRESS (REQUIRED)	COUNTRY (COMPLETE ONLY IF OUTSIDE U.S.)

EMPLOYER ASSOCIATED WITH THIS REGISTRATION (Complete either left or right column, not both.)

☐ My current/potential child care, long term care or mental health care employer is:

EMPLOYER NAME

EMPLOYER ADDRESS

EMPLOYER CITY	STATE	ZIP

EMPLOYER TELEPHONE	EMPLOYER CONTACT NAME	EMPLOYER CONTACT TITLE

☐ No Employer, because I am a(n):

- ☐ Adoptive Parent
- ☐ Foster Parent/Family Member
- ☐ Home Child Care Provider
- ☐ Private Pay/Private Duty
- ☐ Student
- ☐ Volunteer
- ☐ Other (Explain:_____)

REGISTRATION AGREEMENT

The information provided is complete and accurate to the best of my knowledge. I understand it is unlawful to withhold or falsify information required on this form. I grant my permission for the Missouri Department of Health and Senior Services (DHSS) to obtain any and all background information authorized by law to process this request. Furthermore, I authorize the DHSS to release the fact that I am a registrant in the Family Care Safety Registry (FCSR) and any related background information to the requester of the FCSR for employment purposes only, as provided in §210.921, subsection 1, subdivisions (1) and (2), RSMo. For purposes of the FCSR, "employment purposes" includes direct employer/employee relationships, prospective employer/employee relationships, and screening and interviewing of persons or facilities by those persons contemplating the placement of an individual in a child care, elder care or personal care setting. I understand that if I dispute the information contained in the FCSR I have the right to appeal the accuracy of the transfer of information to the FCSR within thirty (30) days of receiving the results of the background screening.

NOTICE: The FCSR may choose to deposit the check enclosed electronically as an ACH debit entry to my designated bank account. I understand that my signature below authorizes my financial institution to deduct this payment from my account. In the event that DHSS or its subcontractor is unable to secure funds from my account or I provide insufficient or inaccurate information regarding my account, my obligation to the DHSS will remain unpaid and further collection action may be taken by the DHSS or its subcontractor, including, but not limited to, returned check fees.

SIGNATURE OF APPLICANT	DATE OF SIGNATURE (MUST BE WITHIN SIX MONTHS OF SUBMISSION.)

WHAT IS THE FAMILY CARE SAFETY REGISTRY?
The Family Care Safety Registry (FCSR), administered by the Missouri Department of Health and Senior Services (DHSS), provides families and employers with a method to obtain background screening information. The Registry, through various state agencies, offers several resources to screen child care, long term care and mental health workers:

- State criminal history and sex offender registry records maintained by the Missouri State Highway Patrol
- Child abuse/neglect records maintained by the Missouri Department of Social Services
- The Employee Disqualification List maintained by the Missouri Department of Health and Senior Services
- The Employee Disqualification Registry maintained by the Missouri Department of Mental Health
- Child care facility licensing records maintained by the Missouri Department of Health and Senior Services
- Foster parent records maintained by the Missouri Department of Social Services

WHO HAS TO REGISTER?
Any person hired on or after January 1, 2001, as a child care worker or elder care worker, hired on or after January 1, 2002, as a personal care worker, or hired on or after January 1, 2009, as a mental health worker, as provided in §210.906, RSMo, is required to make application for registration in the Family Care Safety Registry within fifteen (15) days of the beginning of employment. **Such person who fails to submit a completed registration form to the DHSS without good cause, as determined by the department, is guilty of a class B misdemeanor**. Employees and volunteers from non-state and/or federally regulated entities are NOT REQUIRED to register with the FCSR.

HOW DO I COMPLETE THE REGISTRATION FORM?
Registration Type – Check at least one box from the left column for type of registration that best describes your worker category. If no other type applies, select "Voluntary." (A "voluntary registrant" is a person who is not mandated to register with the Family Care Safety Registry pursuant to §210.900 et seq., RSMo.) If you checked Long Term Care / Personal Care, please also make one or more selections from the column on the right for subcategory.

Social Security Number – You must provide your Social Security number pursuant to 19CSR 30-80.030(1). This identifying information, including Social Security number, will be used for internal identification purposes and to conduct background screenings for the resource information listed in paragraph one above.

Personal Information – List your current Last Name, First Name, Middle Name, and any suffix associated with your last name. List any other names by which you may have been known, including maiden names, past married names, and nicknames (attach additional sheets if needed). For identification purposes, list your gender and date of birth.

Contact Information – List your address, city, state, ZIP code, and county. Include your telephone number and email address. We will use this information to notify you of registration results and any background screenings conducted. Email notifications will be encrypted for improved security. To reduce postage costs, the Registry may contact you to request a personal email address if one is not provided.

Employer Associated with this Registration - If you are currently employed by or are seeking employment with a child care or long term care provider, please list the facility name, address, telephone number, and contact person. If registration is not for employment purposes, make a selection from column on right. The employer entered in this section will not receive a copy of the registration notification. Employers eligible to use the Registry for caregiver screenings must make a separate request for your background information.

Registration Agreement – Sign and date the registration form. Your signature will authorize the Family Care Safety Registry to conduct the background screening outlined in §210.903.2, RSMo and to provide the information to requesters for employment purposes, as provided in §210.921.1, RSMo.

WHERE DO I SEND MY REGISTRATION FORM?
Send your completed registration form and photocopy of Social Security card and required fee to the **Missouri Department of Health and Senior Services, ATTN: Fee Receipts, P.O. Box 570, Jefferson City, MO 65102.** If you have questions, please call the Registry using the toll-free telephone number, **866-422-6872**.

WHEN WILL I KNOW THE RESULTS OF MY BACKGROUND SCREENING?
After the background screening has been completed, you will be notified in writing of the results that will be recorded in the Family Care Safety Registry. You will also be notified in writing each time background screening information is provided. The notification will contain the name and address of the person who made the request and the background information disclosed. The person making the request will be informed that information will be released for employment purposes only, pursuant to §210.921.1, RSMo. Any person using Registry information for any other purpose is guilty of a class B misdemeanor. In addition, state agencies can request information for licensure or regulatory purposes. Prior to disclosing information, the Registry obtains the name and address of the requester, and determines that the request is for employment or regulatory purposes. To ensure you receive these notifications, it will be important for you to notify the Family Care Safety Registry when you have a change in your contact information. Notify the Family Care Safety Registry of changes in personal or contact information using the toll-free telephone number, 866-422-6872, by email to fcsr@health.mo.gov, or by mail to FCSR, PO Box 570, Jefferson City, MO 65102.

WHAT IF I DON'T AGREE WITH THE RESULTS OF MY BACKGROUND SCREENING?
As provided in §210.912, RSMo, you have the right to appeal the information transferred to the Family Care Safety Registry. Your right to appeal is limited to the accuracy of the transfer of information from the state agency that maintains the background information and does not include a right to appeal the accuracy of the substance of the information transferred. An appeal must be filed in writing to the Office of the Director, Missouri Department of Health and Senior Services, P.O. Box 570, Jefferson City, MO, 65102, within 30 days of receiving the results of the background screening determination. An administrative appeal shall be set within 30 days of the filing of the appeal and a decision shall be made within 60 days. This right to appeal is in addition to any other appeal rights granted by state law.

WHAT INFORMATION WILL BE DISCLOSED BY THE FAMILY CARE SAFETY REGISTRY?
Disclosure of background information on a person registered in the Family Care Safety Registry will be limited. If the person is registered, the Registry worker will disclose whether the person's name is listed in any of the background checks pursuant to §210.903, subsection 2, RSMo, and if so, which one(s). Specific information will be disclosed by the Registry pursuant to §210.921, subsection 1, subdivision (2).

Chamber Background Check

(Fill out if you have lived in Missouri 5 years or less)

AUTHORIZATION FOR CONSUMER REPORTS

Authorization

I hereby authorize procurement of consumer report(s) and investigative consumer report(s) by *Services for Independent Living* ("Company"). **If hired (or contracted), this authorization shall remain on file and shall serve as ongoing authorization for *Services for Independent Living* to procure such reports at any time during my employment, contract, or volunteer period. I authorize without reservation, any person, business or agency contacted by the consumer reporting agency to furnish the above-mentioned information.**

This authorization is conditioned upon the following representations of my rights:

I understand that I have the right to make a request to the consumer reporting agency: Datasource, Inc ("Agency"), 1200 South Outer Road, Blue Springs, MO 64015, telephone number (877) 577-3832, upon proper identification, to obtain copies of any reports furnished to Company by the Agency and to request the nature and substance of **all information** in its files on me at the time of my request, including the sources of information, and the Agency, on Company's behalf, will provide a complete and accurate disclosure of the nature and scope of the investigation covered by any investigative consumer report(s). The Agency will also disclose the recipients of any such reports on me which the Agency has previously furnished within the two-year period for employment requests, and one year for other purposes preceding my request (California three years). I hereby consent to Company obtaining the above information from the Agency. I understand that I can dispute, at any time, any information that is inaccurate in any type of report with the Agency. I may view the Agency's privacy policy at their website: www.datasourcecorp.com

I understand that if the Company is located in California, Minnesota, or Oklahoma, that I have the right to request a copy of any report Company receives on me at the time the report is provided to Company. By checking the following box, I request a copy of all such reports be sent to me. Check here: □

As a California applicant, I understand that I have the right under Section 1786.22 of the California Civil Code to contact the Agency during reasonable hours (9:00 a.m. to 5:00 p.m. (ETZ) Monday through Friday) to obtain all information in Agency's file for my review. I may obtain such information as follows: 1) In person at the Agency's offices, which address is listed above. I can have someone accompany me to the Agency's offices. Agency may require this third party to present reasonable identification. I may be required at the time of such visit to sign an authorization for the Agency to disclose to or discuss Agency's information with this third party; 2) By certified mail, if I have previously provided identification in a written request that my file be sent to me or to a third party identified by me; 3) By telephone, if I have previously provided proper identification in writing to Agency; and 4) Agency has trained personnel to explain any information in my file to me and if the file contains any information that is coded, such will be explained to me.

I understand that if I am applying for employment in New York, that I have the right to receive a copy of Article 23-A of the New York Correction Law _____(initial if this applies).

I understand that if the report is provided to an employer in the State of Washington, that I can contact the following office for more information regarding my rights under Washington state law in regard to these reports: State of Washington Attorney General, Consumer Protection Division, 800 5th Ave, Ste. 2000, Seattle, Washington 98104-3188, (206) 464-7744.

I understand that I have rights under the Fair Credit Reporting Act, and I acknowledge receipt of the Summary of Rights _____ (initials).

Chamber Background Check
(Fill out if you have lived in Missouri 5 years or less)

Printed Full Name: _____

Signature: _____

Date: _____

APPLICANT/EMPLOYEE:

Printed Full Name: _____
(First) (Middle) (Last)

Alias/Maiden Name(s): _____

Social Security Number: _____ Date of Birth: _____

Driver's License Number: _____ State of Issuance: _____

Email: _____ Phone: _____

(List all addresses during the past 7 years)

Current: _____
(Street) (City) (State) (Zip) (Dates)

Previous: _____
(Street) (City) (State) (Zip) (Dates)

Previous: _____
(Street) (City) (State) (Zip) (Dates)

Previous: _____
(Street) (City) (State) (Zip) (Dates)

Previous: _____
(Street) (City) (State) (Zip) (Dates)

Chamber Background Check
(Fill out if you have lived in Missouri 5 years or less)

DISCLOSURE FOR CONSUMER REPORTS

In connection with my application for employment (including contract or volunteer services), or application to rent a dwelling with **Services for Independent Living**, I understand consumer reports will be requested by you ("Services for Independent Living"). These reports may include, as allowed by law, the following types of information, as applicable: names and dates of previous employers, reason for termination of employment, work experience, reasons for termination of tenancy, former landlords, education, accidents, licensure, credit, etc. I further understand that such reports may contain public record information such as, but not limited to: my driving record, workers' compensation claims, judgments, bankruptcy proceedings, evictions, criminal records, etc., from federal, state, and other agencies that maintain such records.

In addition, investigative consumer reports (gathered from personal interviews, as applicable, with former employers or landlords, past or current neighbors and associates of mine, etc.) to gather information regarding my work or tenant performance, character, general reputation and personal characteristics, and mode of living (lifestyle) may be obtained.

If I am hired, I understand that my employer can use this disclosure and authorization to continue to obtain such consumer reports throughout my employment, contract period or volunteer service.

Signature: _____

Dated: _____

Services for Independent Living
1401 Hathman Place
Columbia, MO 65201
573-874-1646
www.silcolumbia.org

Eligible Attendant List

The Eligible Attendant List is a list of eligible attendants that is provided to Consumers within the Consumer Directed Services (CDS) program that are looking for an attendant.
Services for Independent Living (SIL) is required to maintain this list for CDS Consumers and update it monthly.

If you choose to be on the list, you will be contacted monthly by a SIL employee to verify if you wish to continue to be on the list or if your availability has changed. Being on the list does not guarantee more hours. Note, you are not required to be on this list.

If a CDS Consumer needs an attendant, your name and number will be provided to them.

Name: _____

Phone Number: _____ Email address: _____

We provide services in Audrain, Boone, Callaway, Cooper, Howard, Montgomery & Randolph Counties.

Please choose which county or town within those counties you can work in: _____

_____

Availability:

Monday:	_____ (AM before 12PM)	_____ (PM after 12PM)	_____ (Not Available)
Tuesday:	_____ (AM before 12PM)	_____ (PM after 12PM)	_____ (Not Available)
Wednesday:	_____ (AM before 12PM)	_____ (PM after 12PM)	_____ (Not Available)
Thursday:	_____ (AM before 12PM)	_____ (PM after 12PM)	_____ (Not Available)
Friday:	_____ (AM before 12PM)	_____ (PM after 12PM)	_____ (Not Available)
Saturday:	_____ (AM before 12PM)	_____ (PM after 12PM)	_____ (Not Available)
Sunday:	_____ (AM before 12PM)	_____ (PM after 12PM)	_____ (Not Available)

Signature: _____ Date: _____

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2023

Step 1: Enter Personal Information

(a) First name and middle initial | Last name | (b) **Social security number**

Address

City or town, state, and ZIP code

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.

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

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, other details, and privacy.

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Reserved for future use.

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

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

TIP: If you have self-employment income, see page 2.

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

Step 3: Claim Dependent and Other Credits

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

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

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

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

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2023 if you meet both of the following conditions: you had no federal income tax liability in 2022 **and** you expect to have no federal income tax liability in 2023. You had no federal income tax liability in 2022 if (1) your total tax on line 24 on your 2022 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2023 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2024.

Your privacy. If you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c).

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 income and self-employment taxes through withholding from your wages, you should enter the self-employment income on Step 4(a). Then compute your self-employment tax, divide that tax by the number of pay periods remaining in the year, and include that resulting amount per pay period on Step 4(c). You can also add half of the annual amount of self-employment tax to Step 4(b) as a deduction. To calculate self-employment tax, you generally multiply the self-employment income by 14.13% (this rate is a quick way to figure your self-employment tax and equals the sum of the 12.4% social security tax and the 2.9% Medicare tax multiplied by 0.9235). See Pub. 505 for more information, especially if the sum of self-employment income multiplied by 0.9235 and wages exceeds $160,200 for a given individual.

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.

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 roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

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

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

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2023 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. 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.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . 1 $

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . 2a $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . 2b $

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . 2c $

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

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

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

1 Enter an estimate of your 2023 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . 1 $

2 Enter:
- $27,700 if you're married filing jointly or a qualifying surviving spouse
- $20,800 if you're head of household
- $13,850 if you're single or married filing separately

. . . . . 2 $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . 3 $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . 4 $

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . 5 $

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and 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	$850	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,870
$10,000 - 19,999	0	930	1,850	2,000	2,200	2,220	2,220	2,220	2,220	2,220	3,200	4,070
$20,000 - 29,999	850	1,850	2,920	3,120	3,320	3,340	3,340	3,340	3,340	4,320	5,320	6,190
$30,000 - 39,999	850	2,000	3,120	3,320	3,520	3,540	3,540	3,540	4,520	5,520	6,520	7,390
$40,000 - 49,999	1,000	2,200	3,320	3,520	3,720	3,740	3,740	4,720	5,720	6,720	7,720	8,590
$50,000 - 59,999	1,020	2,220	3,340	3,540	3,740	3,760	4,750	5,750	6,750	7,750	8,750	9,610
$60,000 - 69,999	1,020	2,220	3,340	3,540	3,740	4,750	5,750	6,750	7,750	8,750	9,750	10,610
$70,000 - 79,999	1,020	2,220	3,340	3,540	4,720	5,750	6,750	7,750	8,750	9,750	10,750	11,610
$80,000 - 99,999	1,020	2,220	4,170	5,370	6,570	7,600	8,600	9,600	10,600	11,600	12,600	13,460
$100,000 - 149,999	1,870	4,070	6,190	7,390	8,590	9,610	10,610	11,660	12,860	14,060	15,260	16,330
$150,000 - 239,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
$240,000 - 259,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
$260,000 - 279,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	18,140
$280,000 - 299,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,870	17,870	19,740
$300,000 - 319,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,470	15,470	17,470	19,470	21,340
$320,000 - 364,999	2,040	4,440	6,760	8,550	10,750	12,770	14,770	16,770	18,770	20,770	22,770	24,640
$365,000 - 524,999	2,970	6,470	9,890	12,390	14,890	17,220	19,520	21,820	24,120	26,420	28,720	30,880
$525,000 and over	3,140	6,840	10,460	13,160	15,860	18,390	20,890	23,390	25,890	28,390	30,890	33,250

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	$310	$890	$1,020	$1,020	$1,020	$1,860	$1,870	$1,870	$1,870	$1,870	$2,030	$2,040
$10,000 - 19,999	890	1,630	1,750	1,750	2,600	3,600	3,600	3,600	3,600	3,760	3,960	3,970
$20,000 - 29,999	1,020	1,750	1,880	2,720	3,720	4,720	4,730	4,730	4,890	5,090	5,290	5,300
$30,000 - 39,999	1,020	1,750	2,720	3,720	4,720	5,720	5,730	5,890	6,090	6,290	6,490	6,500
$40,000 - 59,999	1,710	3,450	4,570	5,570	6,570	7,700	7,910	8,110	8,310	8,510	8,710	8,720
$60,000 - 79,999	1,870	3,600	4,730	5,860	7,060	8,260	8,460	8,660	8,860	9,060	9,260	9,280
$80,000 - 99,999	1,870	3,730	5,060	6,260	7,460	8,660	8,860	9,060	9,260	9,460	10,430	11,240
$100,000 - 124,999	2,040	3,970	5,300	6,500	7,700	8,900	9,110	9,610	10,610	11,610	12,610	13,430
$125,000 - 149,999	2,040	3,970	5,300	6,500	7,700	9,610	10,610	11,610	12,610	13,610	14,900	16,020
$150,000 - 174,999	2,040	3,970	5,610	7,610	9,610	11,610	12,610	13,750	15,050	16,350	17,650	18,770
$175,000 - 199,999	2,720	5,450	7,580	9,580	11,580	13,870	15,180	16,480	17,780	19,080	20,380	21,490
$200,000 - 249,999	2,900	5,930	8,360	10,660	12,960	15,260	16,570	17,870	19,170	20,470	21,770	22,880
$250,000 - 399,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
$400,000 - 449,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
$450,000 and over	3,140	6,380	9,010	11,510	14,010	16,510	18,010	19,510	21,010	22,510	24,010	25,330

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	$620	$860	$1,020	$1,020	$1,020	$1,020	$1,650	$1,870	$1,870	$1,890	$2,040
$10,000 - 19,999	620	1,630	2,060	2,220	2,220	2,220	2,850	3,850	4,070	4,090	4,290	4,440
$20,000 - 29,999	860	2,060	2,490	2,650	2,650	3,280	4,280	5,280	5,520	5,720	5,920	6,070
$30,000 - 39,999	1,020	2,220	2,650	2,810	3,440	4,440	5,440	6,460	6,880	7,080	7,280	7,430
$40,000 - 59,999	1,020	2,220	3,130	4,290	5,290	6,290	7,480	8,680	9,100	9,300	9,500	9,650
$60,000 - 79,999	1,500	3,700	5,130	6,290	7,480	8,680	9,880	11,080	11,500	11,700	11,900	12,050
$80,000 - 99,999	1,870	4,070	5,690	7,050	8,250	9,450	10,650	11,850	12,260	12,460	12,870	13,820
$100,000 - 124,999	2,040	4,440	6,070	7,430	8,630	9,830	11,030	12,230	13,190	14,190	15,190	16,150
$125,000 - 149,999	2,040	4,440	6,070	7,430	8,630	9,980	11,980	13,980	15,190	16,190	17,270	18,530
$150,000 - 174,999	2,040	4,440	6,070	7,980	9,980	11,980	13,980	15,980	17,420	18,720	20,020	21,280
$175,000 - 199,999	2,190	5,390	7,820	9,980	11,980	14,060	16,360	18,660	20,170	21,470	22,770	24,030
$200,000 - 249,999	2,720	6,190	8,920	11,380	13,680	15,980	18,280	20,580	22,090	23,390	24,690	25,950
$250,000 - 449,999	2,970	6,470	9,200	11,660	13,960	16,260	18,560	20,860	22,380	23,680	24,980	26,230
$450,000 and over	3,140	6,840	9,770	12,430	14,930	17,430	19,930	22,430	24,150	25,650	27,150	28,600

Form MO W-4

MISSOURI DEPARTMENT OF REVENUE

Employee's Withholding Certificate

Reset Form | Print Form

This certificate is for income tax withholding and child support enforcement purposes only. Type or print.

Employee

Full Name		Social Security Number
Home Address (Number and Street or Rural Route)	City or Town	State / ZIP Code

1. Filing Status: Check the appropriate filling status below.
   - ☐ Single or Married Spouse Works or Married Filing Separate
   - ☐ Married (Spouse does not work)
   - ☐ Head of Household

2. Additional withholding: If you expect to have a balance due (as a result of interest income, dividends, income from a part-time job, etc.) on your tax return, you may request your employer to withhold an additional amount of tax from each pay period. To calculate the amount needed, divide the amount of the expected tax by the number of pay periods in a year. Enter the additional amount to be withheld each pay period on line 2. 2

3. Reduced withholding: If you expect to receive a refund (as a result of itemized deductions, modifications or tax credits) on your tax return, you may direct your employer to only withhold the amount indicated on line 3. Your employer will not use the standard calculations for withholding. If you designate an amount that is too low, it could result in you being under withheld. To calculate the amount needed, divide the amount of your expected tax by the number of pay periods in a year. Enter the amount to be withheld instead of the standard calculation. If no amount is indicated on line 3, the standard calculations will be used. 3

4. Exempt Status: Select the appropriate reason you are claiming an exemption from withholding below and indicate EXEMPT on line 4. 4

   - ☐ I am exempt because I had a right to a refund of all Missouri income tax withheld last year and expect to have no tax liability this year. A new MO W-4 must be completed annually if you wish to continue the exemption.
   - ☐ I am exempt because I meet the conditions set forth under the Servicemember Civil Relief Act, as amended by the Military Spouses Residency Relief Act and have no Missouri tax liability.
   - ☐ I am exempt because my income is earned as a member of any active duty component of the Armed Forces of the United States and I am eligible for the military income deduction.

Signature

Under penalties of perjury, I certify that the information provided on this form is true and accurate.

Employee's Signature (Form is not valid unless you sign it)	Date (MM/DD/YYYY)
	__ __ / __ __ / __ __ __ __

Employer

Employer's Name	Employer's Address	
City	State	ZIP Code
Date Services for Pay First Performed by Employee (MM/DD/YYYY) __ __ / __ __ / __ __ __ __	Federal Employer I.D. Number	Missouri Tax Identification Number

Notice To Employer:
Within 20 days of hiring a new employee, send a copy of Form MO W-4 to the Missouri Department of Revenue, P.O. Box 3340, Jefferson City, MO 65105-3340 or fax to (573) 526-8079.
Please visit http://dss.mo.gov/child-support/employers/new-hire-reporting.htm for additional information regarding new hire reporting.

Notice to Employee:
Return completed form to your Employer. Consider completing a new Form MO W-4 each year and when your personal or financial situation changes. Visit our online withholding calculator https://mytax.mo.gov/rptp/portal/home/withholding-calculator.

Items to Remember:
- Employees must complete a new form if their filing status changes or to adjust the amount of withholding.
- If you are claiming an "Exempt" status due to the Military Spouses Residency Relief Act you must provide one of the following to your employer: Leave and Earnings Statement of the non-resident military servicemember, Form W-2 issued to the nonresident military servicemember, a military identification card, or specific military orders received by the servicemember. You must also provide verification of residency such as a copy of your state income tax return filed in your state of residence, a property tax receipt from the state of residence, a current drivers license, vehicle registration or voter ID card. For additional assistance in regard to Military, visit the department's website https://dor.mo.gov/military/.
- Additional information can be found at https://dor.mo.gov/business/withhold/.

Mail to: Taxation Division
P.O. Box 3340
Jefferson City, MO 65105-3340

Phone: (573) 522-0967
Fax: (573) 526-8079

DIRECT DEPOSIT ENROLLMENT FORM	
Print your name	Date of Birth (MM/DD/YYYY)
Physical Address	City, State, Zip
Mailing Address (P.O. Box)	City, State, Zip
Home Phone Cell Phone	Social Security Number
Email Address	Driver's License Number and State
Bank Routing Number Checking Savings	Bank Account Number Checking Savings
Name of Bank Checking Savings	

NOTE: If you only receive mail at a PO Box, you must also provide a physical address.
One phone number is required for registration.

Please check one box below for the deposit of your paycheck.

☐ Checking Account: Please deposit 100% of my pay to my checking account.

☐ Savings: Please deposit $_____or %_____to my personal savings account and the balance will be deposited into checking.

I hereby authorize my Payroll agent, **Services for Independent Living** (the Company) to deposit any amounts owed me by my employer by initiating credit entries to my account at the financial institution indicated above. Further, I authorize Bank to accept and to credit electronic entries and any necessary adjustments to the account identified. It is agreed that these entries will be made under the Rules of the National Automated Clearing House Association (NACHA).

For my convenience, I request that **SERVICES FOR INDEPENDENT LIVING** directly deposit my wages/salary earned from my employer into my bank account. I agree to hold **SERVICES FOR INDEPENDENT LIVING** harmless from loss and to indemnify it, limited to the amount of deposit.

This authorization is to remain in full force and effect until the Company and Bank have received written notice from me of its termination in such a manner as to afford Company and Bank a reasonable opportunity to act on it.
There will no longer be paper checks available.

By signing this I confirm that the above information is complete and accurate.

Signature Date

Updated 4/1/2022

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

►**START HERE:** **Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.**

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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

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

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

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

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

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

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

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

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	**OR**	**List B** Identity	**AND**	**List C** Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

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

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

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

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

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

Refer to the instructions for more information about acceptable receipts.