Personal Accounting Services, Inc.
Part of the AssuranceSD Family

DIRECT CARE WORKER
ST. CLAIR
ENROLLMENT CHECKLIST

DOCUMENT	REQUIRED / OPTIONAL
Application Process and Training Requirements	Information
Enrollment Information	Required
Relationship Attestation	Required
Live-In Exemption	Required
Payroll Authorization	Required
Wisely Cardholder Agreement	Information
Employment Agreement	Required
Medicaid Provider Agreement	Required
Orientation Form	Required
Acknowledgement of Training Requirements	Required
Pre-Employment Training Payments	Required
IRS: I-9, Employment Eligibility Verification	Required
IRS: W-4, Employee Withholding Certificate	Required
MI: W-4, Employee's Michigan Withholding Exemption	Required

Note:

Please ensure all **REQUIRED** documents are filled out accurately before submitting them for processing.

Personal Accounting Services, Inc.
Part of the AssuranceSD Family

DIRECT CARE PROFESSIONAL APPLICATION PROCESS AND TRAINING REQUIREMENTS

1. Complete and return the application along with two forms of identification (an email is also required):
    a. Photo ID or Driver's License (address must match the address provided on the application)
    b. Social Security Card, Birth Certificate or current Passport
2. Provide a valid email address. An email address is required for Electronic Visit Verification (EVV).
3. The application is reviewed, and a background check is completed.
4. A Central Registry check will be completed. Central Registry check response times vary based on findings and volume at the state.
    a. If there is a finding, PAS will not receive the results. The employee will receive results directly from the Central Registry
    b. The employer needs to follow-up with the employee to determine if they have received a response from Central Registry, 7 days after the check was requested. PAS will provide the date of the request
5. You will receive an email with the required training information. Training must be completed before you can start. There are five (5) trainings to complete.
    1. Emergency Preparedness: Initial and every 3 years
    2. First Aid: Certification must be current at all times
    3. Individual Specific IPOS Training: Initial, Annual, and any time there is a change in the IPOS
    4. Recipient Rights: Within 30 days of hire and Annual
    5. Universal Precautions/Bloodborne Pathogens/Infection Control: Initial
6. The Agency is informed of your application being completed.
7. The Agency will inform PAS of your official Start Date.
8. You will be required to use the AssuriCare CareWhen Tracking System for Electronic Visit Verification (EVV). PAS will provide training on Electronic Visit Verification (EVV) and documentation requirements. You will receive an email from CareWhen Assuricare that will include your USERNAME, PASSWORD and a LINK to allow you to access the AssuriCare CareWhen Tracking System.
    a. Install the AssuriCare CareWhen System (free) APP.
    b. Complete a practice/test: See step-by-step instructions (when asked, allow for Location-GPS)
    Log In > Clock-In > Log Out
    Log In > Clock out > Log Out
9. Forms are sent to the employer's address (and available on our website: www.PASselfdirection.com)
    a. Employer Pay Authorization (EPA): employer and employee to sign and fax every two weeks at the end of each pay period (Billing Department Fax # is on every form)
    b. Attendance Incident Report (AIR): use sparingly and only when unable to use CareWhen due to technical issues (see troubleshooting notes in training documentation)
10. For questions regarding hours or pay, contact our Billing Department.

Thank You,
PAS Enrollment Team

Personal Accounting Services, Inc.
Part of the AssuranceSD Family

DIRECT CARE PROFESSIONAL INFORMATION

PARTICIPANT INFORMATION

Full Legal Name

Full Name (First, Middle Initial, Last): _____

Participant Program: St. Clair Support Coordinator Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Email Address: _____

Legal or Authorized Representative Name *(if applicable)*: _____

DIRECT CARE PROFESSIONAL INFORMATION

Full Name (First, Middle Initial, Last): _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Mailing Address *(if different than physical address)*: _____

City: _____ State: _____ Zip: _____

Home Phone # *(optional)*: _____ Mobile Phone #: _____

Email Address: _____

Date of Birth: _____ Social Security Number: _____

Driver's License/State ID #: _____ Driver's License/State ID Expiration Date: _____

REQUIREMENT STATEMENTS

I understand that prior to starting work, I must pass a Criminal Background Check. A Criminal Background Check will be completed annually following my start date. If during any Criminal Background Check, disqualifying convictions are found, I understand I will be terminated from providing services to the participant listed in this agreement.

I understand that prior to receiving a start date, I must complete the required trainings and submit training verification.

(continued on next page)

REQUIREMENT STATEMENTS *(continued)*

I understand that I may not begin providing services or submitting time until I receive a start date. I understand that any time worked before my official start date will not be reimbursed.

I understand that I can only be paid for budgeted and authorized weekly hours.

I understand that I will not be paid for hours not submitted, not approved by my employer, or hours that are unauthorized.

I understand that my employer may provide employer specific training.

I understand that PAS (Personal Accounting Services) is not my employer and the individual or legal representative I support is my employer.

By signing below, I attest to my understanding of the above statements and certify that all information provided is true and accurate to the best of my knowledge.

Direct Care Professional Signature: _____ Date: _____

Participant/Employer Signature: _____ Date: _____

Personal Accounting Services, Inc.
Part of the AssuranceSD Family

DIRECT CARE PROFESSIONAL RELATIONSHIP ATTESTATION

SECTION 1

Participant

Full Name (First, Middle Initial, Last): _____

Direct Care Professional

Full Name (First, Middle Initial, Last): _____

SECTION 2

Are you under the age of 21 or will turn 21 this year?

- ☐ Yes: I am under the age of 21 or will be turning 21 this year.
- ☐ No: I am not under the age of 21.

SECTION 3 (Please select your legal relationship to the participant)

- ☐ Parent *±
- ☐ Spouse*±
- ☐ Daughter/Son Under 21±
- ☐ Daughter/Son Over 21
- ☐ Sibling/Ex-Spouse
- ☐ Friend/Neighbor
- ☐ Grandchild
- ☐ Domestic Partner
- ☐ Stepchild
- ☐ Grandparent
- ☐ Stepparent
- ☐ Daughter/Son-in-Law
- ☐ VA Programs
- ☐ No Relationship

* You are exempt from payroll taxes for unemployment insurance (SUTA) due to your relationship with the participant/employer and current legislation. If your employment with the participant/employer is terminated, you will not receive unemployment benefits.

± You are exempt from payroll taxes for Social Security and Medicare (FICA), (FUTA), it means you are not earning Social Security work credits. Due to your relationship with the participant/employer and current legislation.

By signing below, you certify that the information on this form is accurate and that you have all supporting documentation that may be needed to verify your selection. Please be aware that if any changes occur in the relationship you are required to complete a new form and submit the new form to PAS (Personal Accounting Services, Inc).

Direct Care Professional Signature: _____ Date: _____

Participant/Employer Signature: _____ Date: _____

Both the Direct Care Professional (Employee) and the Participant (Employer) or the Employer's representative (Legal Guardian or POA), must sign and date the above to be considered completed in full.

Personal Accounting Services, Inc.
Part of the AssuranceSD Family

DIRECT CARE WORKER/EMPLOYEE LIVE-IN EXEMPTION

Under the Fair Labor Standards Act (FLSA), household employers are required to pay overtime to employees who work more than 40 hours in a single workweek, unless the employee qualifies as a live-in domestic service worker.

Instructions: Please submit the completed form to PAS via one of the following options:

1. **DocuSign**
2. **Email**: StClairReferrals@PASselfdirection.com

DEFINITION OF A DOMESTIC SERVICE WORKER

A worker resides on the client's premises permanently when he or she lives, works, and sleeps on the client's premises seven days per week and therefore has no home of his or her own other than the one provided by the client under the employment agreement.

OR

A worker resides on the client's premises for an extended period when he or she lives, works and sleeps on the client's premises for five days a week (120 hours or more). If a domestic worker spends less than 120 hours per week working and sleeping on the client's premises but spends five consecutive days or nights residing on the premises, this also constitutes an extended period.

Does your Direct Care Worker/Employee qualify as a live-in worker? ☐ Yes ☐ No

Employer Name: _____

Direct Care Worker/Employee Name: _____

Client Full Name: _____

Please note that it is your responsibility to let PAS know when the Direct Care Worker/Employee no longer lives with the Employer.

_____ _____

Employer Signature Date

_____ _____

Direct Care Worker Signature/Employee Date

For any questions or concerns, please contact our office at: **734.729.3100.**

Personal Accounting Services, Inc.
Part of the AssuranceSD Family

PAYROLL AUTHORIZATION FORM

Instructions: Please fill out the information, as applicable, then select the appropriate box below. After entering the Financial Institution information, please attach the required documentation as listed. Review the Authorization to Set-Up then sign and date. Please submit the completed form to PAS via one of the following options:

Mail or Drop-Off	**Email**	**Fax**
20500 Eureka Rd, Suite 112 Taylor, MI 48180	HR@PASselfdirection.com	734.206.1433

PARTICIPANT

Full Name (First, Middle Initial, Last): _____

DIRECT CARE PROFESSIONAL / VENDOR

Full Name (First, Middle Initial, Last): _____

Effective Date: _____ Last Four Digits of SSN/Vendor EIN: _____

Participant Program: St. Clair

Check One Box Only: ☐ New DD Set-Up ☐ New Paycard Set-Up

Name of Financial Institution: _____

Type of Account: ☐ Checking ☐ Savings Percentage: _____ %

FOR CHECKING ACCOUNT: Tape a voided check here.
No starter checks or deposit slips.

FOR SAVINGS ACCOUNT: Attach letter from bank with routing and account numbers. *Letter must be typed on bank's letterhead.*

(continued on next page)

Personal Accounting Services, Inc.
Part of the AssuranceSD Family

PAYROLL AUTHORIZATION FORM

(If there is a second Financial Institution)

Name of Financial Institution: _____

Type of Account: ☐ Checking ☐ Savings Percentage: _____ %

FOR CHECKING ACCOUNT: Upload a picture of a voided check.
No starter checks or deposit slips.

FOR SAVINGS ACCOUNT: Upload a picture of a letter from bank with routing and account numbers. *Letter must be typed on bank's letterhead.*

AUTHORIZATION FOR SET-UP

I hereby authorize PAS (Personal Accounting Services, LLC) to **deposit** any amount owed to me for wages and/or reimbursements. PAS is not responsible for any erroneous information provided. Also, I grant PAS permission to correct and/or adjust any electronic funds transfer resulting from an erroneous overpayment by debiting my account. This authorization is to remain in full force and effect until PAS receives written notification from me to terminate the agreement.

I hereby elect and consent to receive my wages to a **paycard** by electronic transfer. I also grant PAS (Personal Accounting Services, LLC) permission to correct and/or adjust any electronic funds transfer resulting from an erroneous overpayment by debiting my account. I acknowledge I have received a copy of the terms, conditions, and fees associated with using the aforementioned paycard. This authorization is to remain in full force and effect until PAS receives written notification from me to terminate the agreement.

Signature: _____ Date: _____

Paycard Number:
For office use only.

Personal Accounting Services, Inc.
Part of the AssuranceSD Family

DIRECT CARE PROFESSIONAL WISELY CARDHOLDER AGREEMENT

If you choose to receive your payment through a paycard, you will be issued a card through Wisely.

Please see below for a brief overview of any related fees to using the card. The complete cardholder agreement can be found here: tinyurl.com/wiselyeng

You do not have to accept this payroll card.
Ask your employer about other ways to receive your wages.

Monthly fee	Per purchase	ATM withdrawal	Cash reload
$0	**$0**	**$0** in-network **$3.00** out-of-network	**$5.95***

ATM balance inquiry (in-network or out-of-network)	$0
Customer service (automated or live agent)	$0
Inactivity (after 90 days with no transactions)	$4.00 per month

We also charge 6 other types of fees.

*This fee can be lower depending on how and where this card is used.

No overdraft/credit feature.
Your funds are eligible for FDIC insurance.

For general information about prepaid accounts, visit cfpb.gov/prepaid.

Find details and conditions for all fees and services in the cardholder agreement and in the "List of all fees for the Wisely® Pay Card."

The Wisely® Pay Mastercard® is issued by Pathward®, National Association, Member FDIC, pursuant to license by Mastercard International Incorporated. Card is serviced by Global Cash Card, Inc.

Si elige recibir su pago a través de una tarjeta de pago, se le emitirá una tarjeta a través de Wisely.

A continuación, se ofrece una breve descripción de las comisiones relacionadas con el uso de la tarjeta. El acuerdo completo del titular de la tarjeta se encuentra aquí: tinyurl.com/wiselyspn

No es necesario que acepte esta tarjeta de nómina.
Pregúntele a su empleador sobre otras formas de recibir su salario.

Tarifa mensual	Por compra	Retiro en ATM	Recarga con dinero en efectivo
$0	**$0**	**$0** dentro de la red **$3.00** fuera de la red	**$5.95***

Consulta de saldo en ATM (dentro o fuera de la red)	$0
Servicio al cliente (automatizado o agente en vivo)	$0
Inactividad (después de 90 días sin transacciones)	$4.00 por mes

También cobramos otros 6 tipos de tarifas.

*Esta tarifa puede ser menos dependiendo de cómo y dónde se use esta tarjeta.

No hay función de sobregiro/crédito.
Sus fondos son elegibles para el seguro de la FDIC.

Para obtener información general sobre las cuentas prepagadas, visite cfpb.gov/prepaid.

Encuentre detalles y condiciones para todas las tarifas y los servicios en el acuerdo del titular de la tarjeta y en la "Lista de todas las tarifas para la tarjeta Wisely® Pay".

La tarjeta Wisely® Pay Mastercard® es emitida por Pathward®, National Association, miembro de la FDIC, de conformidad con licencia de Mastercard International Incorporated. La tarjeta es administrada por Global Cash Card, Inc.

Personal Accounting Services, Inc.
Part of the AssuranceSD Family

DIRECT CARE WORKER EMPLOYMENT AGREEMENT

Participant/Representative, _____, herein referred to as Employer.

Direct Care Professional/Employee _____.

The purpose of this agreement is to describe the supports that the Employee will provide to the Employer and the terms and conditions of employment. It is understood by and between the Employer and Employee that a binding agreement shall commence on the date of acceptance as indicated by signatures on behalf of the Employer.

Article 1

Employee Responsibilities

I am aware and agree that my employment is conditioned on my Employer's participation in the Self-Directed Program administered by St. Clair. I am also aware that if my Employer ends participation in the Self-Directed Program, my employment may end. I agree to the following terms of employment:

During the term of this Agreement, I shall provide support to my Employer by performing the duties outlined in this agreement and any attachments to it.

I agree to assist my Employer in maintaining the documentation and records required by my Employer and/or Program Administrator/Agencies. I agree to complete all necessary paperwork to secure mandatory payroll deductions from my pay. All records I may have or assist in maintaining are the property of my Employer. I will keep these records confidential, release them only with the consent of my Employer and return them to my Employer if my employment ends. In addition, I will complete illness and incident reports when necessary, as required or requested by my Employer and/or Program Administrator/Agencies.

I shall immediately notify _____, Phone #: _____ if my Employer experiences a medical emergency or illness, in which they are unable to communicate their wishes. I will contact 911 if necessary.

I agree to participate in any meetings if requested to do so by my Employer.

I agree to provide support to my Employer. The Employer or Employee may modify any supports provided to the Employer at any time; provided both parties are in agreement.

I understand that I may receive an employment start date that is prior to the results of the Central Registry Check and Recipient Rights Verification being returned to my employer. Pending the results of all required background checks, my employment is conditional. Upon receipt of all background checks, my employer may decide to end my employment. My employer is within their rights to end my employment following receipt of all required background checks.

I understand that this is an employment "at will" relationship, which can be terminated by me or my Employer at any time. However, my Employer cannot terminate my employment on the basis of my race, religion, sex, disability or other protected status under federal or Michigan law. In addition, I agree to give 30 days written notice to my Employer if I terminate my employment.

DIRECT CARE WORKER EMPLOYMENT AGREEMENT

I understand and acknowledge that the Participant listed above is my Employer and that I am not an employee of St. Clair, which authorizes the supports I provide, or of Personal Accounting Services, Inc., which is the Fiscal Intermediary of the Self-Directed Program funds used to pay me.

I agree to complete the required training and/or provide proof of previous training (completed within last six months) prior to the start of my employment.

As an employee, I understand I am required to complete training renewals timely. Failure to complete and submit proof of training renewals may result in a delay in payment, until proof of training completion is submitted.

I understand my employment is contingent on successful completion of required trainings which include but are not limited to training in: First Aid, Universal Precautions, Blood Born Pathogens and any additional training(s) specific to my employer's care/needs.

My employment will begin after the completion of the application packet, background check, and required training(s). Proof of training must be submitted. The employee and employer are responsible for submitting current training & documentation. I agree to the following compensation:

Service Code and Modifiers	Hourly Wage

I agree to execute a Medicaid Provider Agreement with St. Clair and acknowledge that this agreement does not alter the fact that St. Clair is only the project administrator of the Self-Directed Program and not my employer. I understand that my employment is contingent on completing this agreement.

I understand that I may not begin providing services or submitting time until I receive a start date. I understand that any time worked before my official start date will not be reimbursed.

I understand that I can only be paid for budgeted and authorized weekly hours.

I understand that I will not be paid for hours not submitted, not approved by my employer, or hours that are unauthorized.

Article 2

Employer/Participant Responsibilities

I, the Employer listed above agree to the following:

I will provide the Fiscal Intermediary with the necessary documentation to assure timely compensation of my employee.

I will compensate my Employee as listed under Article 1, in this agreement. Payroll will be handled by the Fiscal Intermediary:

PAS (Personal Accounting Services, Inc.)
20500 Eureka Rd. Ste. 112
Taylor, MI 48180
734.729.3100

The Fiscal Intermediary will withhold all necessary tax, unemployment and other withholdings from the Employee's paycheck.

I will assure my Employee receives appropriate training. I understand that my employee is required to renew required trainings and that failure to complete the training renewal and submit proof may result in a delay in payment.

I will evaluate the performance of my Employee and provide appropriate feedback to assure that I am receiving quality supports.

I will assure that my Employee executes a Medicaid Provider Agreement with St. Clair.

I understand that I am responsible for scheduling my employee.

I understand that I cannot schedule my employee for more hours than my approved budget supports.

I agree to review and sign timesheets timely.

I agree to provide on the job training and provide feedback to my employee.

Employer and Employee agree to the terms and conditions of this Agreement.

Direct Care Worker/Employee Signature: _____ Date: _____

Participant/Employer Signature: _____ Date: _____

Personal Accounting Services, Inc.
Part of the AssuranceSD Family

DIRECT CARE PROFESSIONAL MEDICAID PROVIDER AGREEMENT

THIS AGREEMENT is entered into by and between: _____ and Agency: St. Clair _____, herein referred to as Waiver Agent, and:

Medicaid Provider (DCP/Employee): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ E-mail: _____

Federal ID#: _____ Social Security#: _____ Birth Date: _____

The purpose of this agreement is to define the roles and responsibilities of the above named parties. It is understood by and between the Medicaid Provider and Waiver Agent that a binding agreement shall commence on the date of acceptance as indicated by signatures on behalf of the Waiver Agent. This agreement shall remain in effect until such time it must be terminated or modified. Any party can initiate a termination or modification by providing written notice to the other of the desire to terminate or modify this agreement.

Upon receipt of this agreement, the Waiver Agent will certify the Medicaid Provider as available to provide services to individuals receiving services and/or supports in accordance with their service plans developed through the person-centered planning process, authorized by the Waiver Agent or one of its subcontractors, and funded through the MI-Choice Waiver.

The Medicaid Provider stipulates that it agrees to the following:

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

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

This agreement sets forth the entire understanding between the parties with respect to the subject matters, and supersedes any and all other agreements, either oral or in writing between the parties pertaining to these matters. No change or modification of the terms of this agreement is valid unless it is in writing and signed by the parties.

Direct Care Professional Signature: _____ Date: _____

Personal Accounting Services, Inc.
Part of the AssuranceSD Family

DIRECT CARE PROFESSIONAL ORIENTATION

Participant
Full Name (First, Middle Initial, Last): _____

Direct Care Professional
Full Name (First, Middle Initial, Last): _____

REVIEW

1. Employment Application
2. Direct Care Professional Relationship Attestation
3. Employment Agreement: Participant is the Employer
4. Medicaid Provider Agreement: PAS bills the insurance to pay the Employee
5. Training Acknowledgement of Required Trainings & Documentation
6. Mileage Reimbursement Requirements/Only if Authorized: Must have current Auto Insurance & Registration on file
7. We can not make payment without active authorization or above the authorized amount. Never work before a start date is provided.
8. For billing questions regarding a payment you received, please call: **734.729.3100 Prompt 3**
   For payroll questions regarding a missed payment, please call: **734.729.3100 Prompt 4**
9. Employee Start Date: _____
   Determined by completion of requirements and agency approval/active authorizations
10. Pay Period Schedule
11. Billing Forms: Provided on initial hire; also located on website at: PASselfdirection.com
    a. EPA - Employer Pay Authorization: Backup documentation for time worked and logged in Assuricare CareWhen
    b. AIR - Attendance Incident Report: Limitations Apply: Must be submitted within 48 hours of the attendance incident. Failure to provide documentation timely may result in payment delay.
    c. PVN - Progress Note: Restrictions Apply
12. Assuricare CareWhen Attendance System (free APP) with GPS.
    Your enrollment specialist will ensure you are able to clock in successfully for the first time. We are available to help over Teams, Zoom, our office, or by phone. If you have additional questions about EVV, contact our dedicated EVV team at: **734.729.3100 Prompt 2**
    a. Assuricare CareWhen is a free mobile app
    b. Step by Step Instructions will be provided to you
13. PAS Contact List
14. Overview of Program Rules and Requirements
15. Reporting of Incident(s): Medicaid Fraud/ Accident/ Hospital/ Protective Services/ Recipient Rights
16. False Claim Act (FCA)

By signing below:

I acknowledge that I have reviewed and received a copy of the above information.

I understand the requirements as provided to me.

I will not hold PAS responsible for hours worked that have not been submitted, approved by my employer, or that are unauthorized.

Direct Care Professional Signature: _____ Date: _____

Participant/Employer Signature: _____ Date: _____

Personal Accounting Services, Inc.
Part of the AssuranceSD Family

DIRECT CARE PROFESSIONAL ACKNOWLEDGEMENT OF TRAINING REQUIREMENTS

TRAINING REQUIREMENTS

St. Clair will provide training information. Training must be completed before you can start. There are five (5) trainings to complete.

1. Emergency Preparedness: Initial and every three years
2. First Aid: Certification must be current at all times
3. Individual Specific IPOS Training: Initial, Annual and any time there is a change in the IPOS
4. Recipient Rights: Within 30 days of hire and Annual
5. Universal Precautions/Bloodborne Pathogens/Infection Control: Initial

St. Clair will provide completed training information to PAS.

PARTICIPANT (EMPLOYER) ACKNOWLEDGEMENT

By signing below, I acknowledge that I have been informed that prior to any payroll being processed by PAS (Personal Accounting Services) my employee must meet all training requirements set forth by St. Clair. My employee will be provided with the training materials and both I, as the employer and my employee must sign that the training has taken place.

As the Employer, I also have the right to waive the training requirements for my employee.

Participant/Employer

Full Name (First, Middle Initial, Last): _____

Signature: _____ Date: _____

DIRECT CARE PROFESSIONAL (EMPLOYEE) ACKNOWLEDGEMENT

By signing below, I acknowledge that I have been informed that prior to any payroll being processed by PAS (Personal Accounting Services), I must meet all training requirements set forth by St. Clair. As the employee, I will be provided with the training materials and both I, as the employee and my employer must sign to acknowledge that the training has taken place.

My Employer also has the right to waive the training requirements.

After the training is complete, it is my responsibility to return proof of such to Personal Accounting Services before any payroll will be processed.

Direct Care Professional/Employee

Full Name (First, Middle Initial, Last): _____

Signature: _____ Date: _____

Personal Accounting Services, Inc.
Part of the AssuranceSD Family

DIRECT CARE WORKER
ST. CLAIR COUNTY CMH
PRE-EMPLOYMENT TRAINING PAYMENTS

Participant/Employer Full Name: _____

Direct Care Worker/Employee Full Name: _____

Submission Date: _____

PARTICIPANT/EMPLOYER STATEMENTS

By submitting this form, I certify that my Direct Care Worker/Employee has completed the trainings listed below. By signing this form, I attest that my worker has completed the required training and submitted documentation of completion to Personal Accounting Services.

I understand that my Direct Care Worker/Employee will be reimbursed at the training rate of pay multiplied by the number of eligible training hours completed.

Training hours were allocated by St. Clair County CMH and are a set amount.

I understand that my Direct Care Worker/Employee will be paid for the pre-employment training:

☐ With their first paycheck (for new Participants/Employers).

☐ In an off-cycle payment (for existing Participants/Employers).

I understand that payment will be delayed if proof of training completion has not been provided to Personal Accounting Services.

I understand that the pre-employment training payment is a one-time payment.

Hourly Rate of Pay: $15 per hour.

Training Hours: 4.5 hours total is the maximum number of hours eligible.

TRAINING	NUMBER OF ALLOCATED HOURS	ELIGIBLE FOR PAYMENT (PAS USE ONLY)
First Aid	15 minutes	
Recipient Rights in Person	3.5 hours	
Recipient Rights Refresher Test	1 hour	
Universal Precautions	15 minutes	
Emergency Preparedness	15 minutes	
IPOS Training	15 minutes	

Total eligible training hours to be paid: _____

Personal Accounting Services, Inc.
Part of the AssuranceSD Family

DIRECT CARE WORKER
ST. CLAIR COUNTY CMH
PRE-EMPLOYMENT TRAINING PAYMENTS

DIRECT CARE WORKER/EMPLOYEE STATEMENTS

By signing this document requesting payment for pre-employment training, I certify that I have completed the trainings listed above. I have provided proof of training completion to PAS.

I understand that failure to provide proof of training completion will delay my training payment.

I understand that the training payment is considered taxable income.

I understand that I will not be paid for trainings by Personal Accounting Services if they were taken previously with another employer. PAS will identify the trainings I am eligible for payment for.

Direct Care Worker/Employee Full Name: _____

_____ _____

Direct Care Worker/Employee Signature Date

Participant/Employer Full Name: _____

_____ _____

Participant/Employer Signature Date

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. An alien authorized to work until (exp. date, if any)

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

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

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

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

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

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

Additional Information

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, sex, 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, sex, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Acceptable Receipts

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

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

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

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

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

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 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.

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

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 *Exemption from withholding* on page 2. I understand I will need to submit a new Form W-4 for 2027 . ☐

Step 5: Sign Here

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

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

Employers Only

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

General Instructions

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

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 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** $ 0.00

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	$	0.00
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	$	0.00
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	$	0.00
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: • $768,700 if you're married filing jointly or a qualifying surviving spouse • $640,600 if you're single or head of household • $384,350 if you're married filing separately	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: • $32,200 if you're married filing jointly or a qualifying surviving spouse • $24,150 if you're head of household • $16,100 if you're single or married filing separately	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	$	0.00
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	$	0.00

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

MI-W4

(Rev. 12-20)

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

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

Issued under P.A. 281 of 1967.

▸ 1. Full Social Security Number	▸ 2. Date of Birth
▸ 3. Name (First, Middle Initial, Last)	4. Driver's License Number or State ID
Home Address (No., Street, P.O. Box or Rural Route)	▸ 5. Are you a new employee? ☐ Yes If Yes, enter date of hire..... (mm/dd/yyyy) ☐ No
City or Town / State / ZIP Code	

6. Enter the number of personal and dependent exemptions (see instructions) ..... ▸ 6.

7. Additional amount you want deducted from each pay (if employer agrees) .....7. $ .00

8. I claim exemption from withholding because (see instructions):

a. ☐ A Michigan income tax liability is not expected this year.

b. ☐ Wages are exempt from withholding. Explain: _____

c. ☐ Permanent home (domicile) is located in the following Renaissance Zone: _____

EMPLOYEE: If you fail or refuse to file this form, your employer must withhold Michigan income tax from your wages without allowance for any exemptions. Keep a copy of this form for your records. See additional instructions on page 2.

Under penalty of perjury, I certify that the number of withholding exemptions claimed on this certificate does not exceed the number I am allowed to claim. If claiming exemption from withholding, I certify that I do not anticipate a Michigan income tax liability this year.

9. Employee's Signature	▸ Date

EMPLOYER: Complete the below section.

10. Employer's Name	▸ 11. Federal Employer Identification Number		
Address (No., Street, P.O. Box or Rural Route)	City or Town	State	ZIP Code
Name of Contact Person	Contact Phone Number		

INSTRUCTIONS TO EMPLOYER: Keep a copy of this certificate with your records. All new hires must be reported to the State of Michigan. See **www.mi-newhire.com** for information.

In addition, a copy of this form must be sent to the Michigan Department of Treasury if the employee claims 10 or more exemptions or claims they are exempt from withholding. Send a copy to:

Michigan Department of Treasury
Tax Technical Section
P.O. Box 30477
Lansing, MI 48909

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

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

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

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

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

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

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

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

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

i) Your employment is intermittent, temporary, or less than full time;

ii) Your personal and dependency exemptions exceed your annual taxable compensation;

iii) You claimed exemption from federal withholding; and

iv) You did not incur a Michigan income tax liability for the previous year.

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

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

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