Direct Care Worker (DCW) Information and Acknowledgement

To complete your enrollment and process your pay, Tempus Unlimited, Fiscal/Employer Agent (F/EA), must collect all the information below. This form must be completed by both the Participant and the Direct Care Worker (DCW).

Please review the prefilled information and update any incorrect or blank information. Sign, date and return to Tempus Unlimited, Inc. by using any of the methods listed below:

- Fax: 1-833-5TEMPUS (1-833-583-6787)
- Email: PAFMS@tempusunlimited.org
- Mail: Tempus Unlimited, Inc., 600 Technology Center Drive, Stoughton, MA 02072

Participant & Employer Information			
Participant First Name: Patty		Participant Last Name: Participant	
Employer First Name: Patty		Employer Last Name: Participant	
Direct Care Worker (DCW) Information			
DCW First Name: Wendy	DCW MI: A	DCW Last Name: Worker	
DCW Maiden/Alias Name(s):	Date of Birth: 01/01/1980	Social Security Number: 123-45-6789	
Primary Language: English	Gender: Female		
Relationship to Participant: ☐ Parent/Step Parent ☐ Child ☐ Sibling ☐ Grandparent ☐ Grandchild ☐ Other Relative ☑ Non-Relative			
DCW Physical Address			
Physical Address (do not use a PO Box): 1 Front Street		Physical Address 2 (apt, bldg., unit, ste.):	
City: Harrisburg		State: PA	Zip Code: 17101
County: Dauphin	Municipality (Borough or Township): Harrisburg	School District: Harrisburg SD	

Tempus Unlimited, Inc. | 600 Technology Center Drive | Stoughton, MA 02072
Phone: 1-844-983-6787 | Fax to 1-833-583-6787 | Email: PAFMS@tempusunlimited.org

Participant ID C123456 DCW ID E123456

Participant Name	CLE Name	DCW Name
Patty Participant	Patty Participant	Wendy Worker

DCW Mailing Address (if different from Physical Address)		
Mailing Address:	Mailing Address 2 (apt, bldg., unit, ste.):	
City:	State:	Zip Code:

DCW Contact Information	
Preferred Method of Contact: ☐ Home Phone Number ☑ Mobile Phone Number ☐ Email Address	
Home Phone Number: (717) 123-4567	Mobile Phone Number: (717) 123-4567
Email Address: wendy@email.com	

Tempus Unlimited, Inc. may use your mobile number to text unless you opt out. If you choose to opt out of receiving text messages, please check the box (Carrier charges may apply): ☐ **Opt Out**

Program Eligibility Questions

Program Qualifications: (Direct Care Worker responses to these four (4) questions are REQUIRED)

1. Does a child under the age of 18 live in the home of the Participant? ☐ Yes ☑ No
2. Have you continuously lived in the state of PA for the past 2 years? ☑ Yes ☐ No
3. Are you a spouse of, legal guardian for, representative payee or Power of Attorney to the Participant? ☐ Yes ☑ No
4. Are you at least 18 years of age? ☑ Yes ☐ No

*If you answered **YES** to question number 3, you **DO NOT** qualify for employment in this program.*

Tempus Unlimited, Inc. | 600 Technology Center Drive | Stoughton, MA 02072
Phone: 1-844-983-6787 | Fax to 1-833-583-6787 | Email: PAFMS@tempusunlimited.org

Participant Name	CLE Name	DCW Name
Patty Participant	Patty Participant	Wendy Worker

Direct Care Worker Pay Rate	
The Direct Care Worker's pay rate for the below services is negotiated between the Participant and the Direct Care Worker up to the maximum rate allowed. Please fill in the Direct Care Worker Hourly Pay Rate for each service this Direct Care Worker will work. If no rate is shown, minimum wage will be used. If rate entered is higher than allowed in the program, the rate will be reduced to the highest rate allowed.	
Service	**DCW Pay Rate per Hour***
Personal Assistance Services (W1792) (Default)	$ 13.88
Respite (S5150)	$ 0
Participant Directed Community Supports (W1900)	$ 0

***Your final rate is dependent on the maximum rate allowed.**

Payment Information	
If a payment choice is not checked, then Tempus Unlimited will send your payments by paper check.	
Payment Selection: (Check only one box)	☑ Direct Deposit ☐ US Bank Focus Card ☐ Paper Check
Direct Deposit	
For Direct Deposit, please complete the enclosed Direct Deposit Application Form. If you are interested in applying for a US Bank Focus Card, please complete the enclosed Focus Card application.	

Tempus Unlimited, Inc. | 600 Technology Center Drive | Stoughton, MA 02072
Phone: 1-844-983-6787 | Fax to 1-833-583-6787 | Email: PAFMS@tempusunlimited.org

Participant Name	CLE Name	DCW Name
Patty Participant	Patty Participant	Wendy Worker

Relationship Questionnaire
This information is necessary, so that we can determine if you are eligible for tax withholding exemptions.
1. Are you a non-resident alien temporarily in the United States on an F-1, J-1, M-1, or Q-1 visa admitted to the US for supplying domestic services? ☐ **YES**, that description fits my status. ☑ **NO**, that description does not fit my status.
2. Are you the child of the employer (includes adopted children)? ☐ **YES**, my employer is my parent (mother or father). ☑ **NO**, my employer is not my parent.
3. Are you the spouse of the employer? ☐ **YES,** my employer is my spouse (husband, wife or domestic partner). ☑ **NO**, my employer is not my spouse.
4. Are you the parent of the employer (includes adopted children)? ☐ **YES**, my employer is my child (son or daughter). ☑ **NO**, my employer is not my child.
5. If you answered, "YES" to Question 4, check any of the following that apply. ☐ **YES**, I also supply care for my grandchild or step-grandchild in my child's home. ☐ **YES**, my grandchild or step grandchild is under 18, or has a physical or mental condition that needs personal care of an adult for at least four weeks in a row during the calendar quarter in which services are performed. ☐ **YES**, my child (son or daughter) is widowed, divorced, not remarried, or living with a spouse who has a mental or physical condition, so the spouse cannot care for my grandchild for at least four weeks in a row during the calendar quarter in which services are performed. ☑ **NO,** none of the above apply.
6. Are you under the age of 18 or do you turn 18 before December 31st? ☐ **YES,** I am under 18 or am turning 18 **before December 31st** ☑ **NO**, I am over 18. *If you answered "**YES**" to Question 6, answer the following question. If you answered "**NO**", skip the question below.* **Is this job of performing household services (respite or nursing) your principal occupation?** **NOTE: Do not answer "YES" if you are a student.** ☐ **YES,** this is my principal occupation. ☐ **NO,** this is not my principal occupation.

Tempus Unlimited, Inc. | 600 Technology Center Drive | Stoughton, MA 02072
Phone: 1-844-983-6787 | Fax to 1-833-583-6787 | Email: PAFMS@tempusunlimited.org

Participant Name	CLE Name	DCW Name
Patty Participant	Patty Participant	Wendy Worker

Fair Labor Standards Act Live-In Exemption
The United States Department of Labor (US DOL) and Fair Labor Standards Act (FLSA) requires household employers to pay employees overtime pay for hours worked over 40 hours per work week unless the employee qualifies for an exemption. Complete this section to notify F/EA if employee qualifies for the live-in exemption from overtime pay. When there is any change in live-in status, it is the employee's responsibility to notify the F/EA.

1. Determine if Direct Care Worker (DCW) Qualifies for the Live-In Exemption from Overtime Pay

The live-in exemption:

- Available only in programs where the Participant or their representative is the sole employer under the FLSA;
- Applies only to the employer/DCW pair based on the "Residency Test" (below): and
- Applies to all services provided by the DCW for that Participant.

Residency Test

A live-in DCW is exempt from overtime premium pay if the DCW "…resides on the employer's premises either permanently or for extended periods of time". "Employer's premises" means the household where employed. "Permanently", or "…extended periods of time" means the DCW lives, works, and sleeps in the household where employed for at least five (5) days a week (120 hours) or more.

2. Certify the DCW's Eligibility for the Live-In Exemption from Overtime Pay

Please check one box below to identify whether the DCW qualifies for the live-in exemption.

☐ Yes, the DCW qualifies for the live-in exemption.

☑ No, the DCW does NOT qualify for the live-in exemption.

If the DCW qualifies for the live-in exemption:

- All hours, including overtime (over 40 hours per work week), will be paid at regular rates for all services provided

IMPORTANT: It is the Direct Care Worker's responsibility to inform Tempus Unlimited about any change in live-in status.

Tempus Unlimited, Inc. | 600 Technology Center Drive | Stoughton, MA 02072
Phone: 1-844-983-6787 | Fax to 1-833-583-6787 | Email: PAFMS@tempusunlimited.org

Participant Name	CLE Name	DCW Name
Patty Participant	Patty Participant	Wendy Worker

Employee Qualification

Common Law Employer, please verify your worker has the mandatory qualifications to supply self-directed services by initialing all mandatory qualification requirements in Section 1 and initialing only those qualification requirements that apply in Section 2.

Qualification Validated (Please initial)	**Section 1 – Mandatory Qualifications Requirements**
	At Least 18 years of age
	Possess a valid Social Security Number
	Possess basic math, reading and writing skills
	Demonstrate the capability to perform health maintenance activities specified in the Participant's Person-Centered Service Plan. Or Completion of pre-training or in-service training necessary to carry out the Participant's Person-Centered Service Plan.
	Agrees to carry out the service responsibilities outlined in the Participant's Person-Centered Service Plan.
	Criminal History Background Check
Qualification Validated, If applicable (Please Initial)	**Section 2 – Qualification Requirements (If applicable)**
	Federal Bureau of Investigation (FBI) Clearance (when the applicant is not currently or has not been a resident of Pennsylvania for the two years prior to this application or when the Participant receiving service is under 18 years of age or there is child under age 18 living in the home of the Participant).
	Child Abuse Clearance per Child Protective Services Law (CPSL) {23 Pa. C. S. Chapter 63} (when the Participant receiving service is under 18 years of age or there is child under age 18 living in the home of the Participant).
	Valid driver's license (if transportation is provided as part of the service).
	Automobile insurance for all automobiles used as part of the service (if transportation is provided as part of the service).
	Current state motor vehicle registration (if transportation is provided as part of the service).

Tempus Unlimited, Inc. | 600 Technology Center Drive | Stoughton, MA 02072
Phone: 1-844-983-6787 | Fax to 1-833-583-6787 | Email: PAFMS@tempusunlimited.org

Participant Name	CLE Name	DCW Name
Patty Participant	Patty Participant	Wendy Worker

Direct Care Worker (DCW) Acknowledgements	
• As a DCW, you are employed by a Community HealthChoices (CHC) Participant (Participant) or their Representative. • The Participant or the Participant's Representative who employs you is known as a Common Law Employer (CLE). • Tempus Unlimited Inc. is a Fiscal/Employer Agent (F/EA) who processes payroll on behalf of your employer. • Tempus cannot process payments for a DCW on behalf of their CLE until all required paperwork is received and complete. • DCWs must submit to Tempus all paperwork required by Tempus and the Community HealthChoices Managed Care Organizations (CHC-MCOs) who administer the Participant-Directed Program.	• The CHC-MCOs and Tempus cannot process payments to a DCW when: ○ The Participant is in an inpatient facility, such as a hospital or nursing facility; or ○ The hours authorized by the Pennsylvania CHC-MCOs has been exhausted or is insufficient.

I understand that my employer is the CLE (the Participant or the Participant's Representative). My employer is responsible for hiring, firing, training and scheduling DCWs. I must notify my employer of any changes that would affect my ability to perform my duties as a DCW. I must record my time worked in the assigned Electronic Visit Verification (EVV) system per instructions from Tempus or the CHC-MCO. Tempus will process payroll for my employer. I must provide proof of my identity to my employer to complete the Employment Eligibility Verification form (Form I-9), which the Department of Homeland Security requires all employees to complete. (Tempus will give my employer this form.)

I understand that the CHC Participant-Directed Program distributes payments for personal care services provided only when approved in a Participant's Person-Centered Service Plan (PCSP). DCW services must be provided according to the Participant's PCSP. PCSPs approve DCWs to help with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).

I understand that ADLs include physically assisting the Participant with transferring, walking, using medical equipment, taking medications, bathing, and grooming, dressing, and undressing, passive range-of-motion exercises, eating, and toileting.

Tempus Unlimited, Inc. | 600 Technology Center Drive | Stoughton, MA 02072
Phone: 1-844-983-6787 | Fax to 1-833-583-6787 | Email: PAFMS@tempusunlimited.org

Participant Name	CLE Name	DCW Name
Patty Participant	Patty Participant	Wendy Worker

I understand that IADLs include household services that are essential to the Participant's care such as laundry, shopping, housekeeping, meal preparation and cleanup, transportation to medical appointments, activities such as maintenance of wheelchairs or medical equipment, completing the paperwork required for receiving personal care services, and other activities approved in the PCSP as being instrumental to the health care needs of the Participant.

I understand that my employer will tell me which of these services require me to provide physical assistance.

I understand that I cannot be paid as a DCW if I am the CLE; or a spouse, legal guardian, representative payee or Power of Attorney of the Participant.

I understand and consent to having State Police Criminal Background Checks, Child Abuse Clearances (when needed), and Federal Criminal History Records (when needed) completed on me. My employment is contingent on my CLE's review and approval of those background check results.

I understand that the results of my background checks will be made available to my prospective employer and other program administrators as necessary and/or needed.

I understand that I cannot begin supplying services in this program before I have successfully cleared the background checks and the employer has signed off in accordance with the applicable regulations governing the program.

1. **I understand and acknowledge that Tempus Unlimited, Inc. is not my employer.**
2. I understand that the Participant or their designated representative is my employer. My employer is not Tempus Unlimited, CHC-MCOs, or any other entity involved with the CHC PDS Program.
3. I understand that my paychecks will be processed by Tempus Unlimited. Tempus Unlimited is directed by the CHC-MCOs to serve as the Fiscal/Employer Agent (F/EA). I understand that Tempus Unlimited is not authorized to pay for any service not approved and authorized in the PCSP or the authorization issued by the CHC-MCO. For any request that exceeds the Participant's authorization, I understand that my employer will handle any payment.
4. I understand and agree that any payments made for services that I have not performed will be subject to withholdings from future paychecks. This includes overpayments made because of error or omission. Applicable law will govern the withholding process. Tempus Unlimited will pursue all legal means to recover the amount of overpayment.
5. I understand and acknowledge that any false claims or untruthful submission of services provided, statements, or document, or concealment of material facts to obtain improper payment is reportable as Medicaid Fraud and subject to investigation. Medicaid Fraud is a felony and can lead to substantial penalties and/or imprisonment.

Tempus Unlimited, Inc. | 600 Technology Center Drive | Stoughton, MA 02072
Phone: 1-844-983-6787 | Fax to 1-833-583-6787 | Email: PAFMS@tempusunlimited.org

Participant Name	CLE Name	DCW Name
Patty Participant	Patty Participant	Wendy Worker

I understand and acknowledge that information I provide may be shared with business partners who work with the CHC-MCOs and the F/EA, Tempus Unlimited, to supply services to my employer. Business partners include, but not limited to, Pennsylvania Department of Human Services, Office of Long-Term Living, Pennsylvania Office of Attorney General, Office of Inspector General and any other individuals as required by law.

I agree that the information on this form and any accompanying statement that I have provided has been reviewed and signed by me, and is true, accurate, and complete to the best of my knowledge. I also agree that I understand my duties, rights, and responsibilities as a DCW. All the information I have provided to my employer, to the F/EA, or to CHC-MCOs is true and accurate to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein. I understand and acknowledge that the F/EA does not make any decisions about my employment.

Direct Care Worker Attestation

By signing below, I agree that I have read this document in its entirety. I understand that failure to complete this form may make it impossible for Tempus Unlimited to verify my eligibility to provide services or process payments on behalf of my employer. I further agree by signing below, that all of the information I have provided in this document is true and correct to the best of my knowledge.

I further attest by signing below that I have filled out the Relationship Questionnaire to show my relationship to my employer, and that Tempus Unlimited will use this information to properly withhold my taxes. If any misrepresentation of information in the Relationship Questionnaire or Difficulty of Care Federal Income Tax Exclusion sections results in the under withholding of tax, it is my responsibility to pay the under-withheld tax.

I authorize the Employer and Tempus Unlimited to go ahead with all registry and criminal record checks needed by state and federal law. This information cannot be released for any other purpose without my written permission.

I agree that I have reviewed and understand the information about the Fair Labor Standards Act Live-In Exemption. I understand if I qualify for the live-in exemption, all hours, including overtime (over 40 hours per work week), will be paid at regular rates for all services provided. I understand that it is the DCWs responsibility to inform Tempus Unlimited about any change in live-in status.

I authorize Tempus Unlimited to process payments owed to me for services authorized by the CHC-MCOs. Tempus Unlimited will deposit my payment directly into my bank account using an Automated Clearing House

Tempus Unlimited, Inc. | 600 Technology Center Drive | Stoughton, MA 02072
Phone: 1-844-983-6787 | Fax to 1-833-583-6787 | Email: PAFMS@tempusunlimited.org

Participant Name	CLE Name	DCW Name
Patty Participant	Patty Participant	Wendy Worker

(ACH) transaction. I understand that if I do not supply complete and correct information, processing may be delayed or made impossible, or my electronic payment may be erroneously made.

I certify that I have read and agree to follow rules governing payments and electronic transfers. I authorize Tempus Unlimited to withdraw from the designated account all amounts deposited electronically in error. If the designated account is closed or has an insufficient balance to allow withdrawal, then I authorize Tempus Unlimited, fully allowed by law, to withhold any payment owed to me until the mistaken deposited amounts are repaid. If I decide to change or revoke this authorization, I recognize that I must send in such notice to the F/EA, Tempus Unlimited.

Common Law Employer Attestation

The Common Law Employer understands that it is their exclusive responsibility to accurately complete and properly execute the USCIS I-9, as defined in Instruction for Employment Eligibility Verification by the Department of Homeland Security and give a correct and complete USCIS Form I-9. Tempus Unlimited supplies the Form I-9 in the employment packets, and the Employer keeps the original Form I-9 and sends a completed copy to Tempus Unlimited; which will keep in the Direct Care Worker's files. Neither the CHC-MCOs nor Tempus Unlimited will verify the accuracy or completeness of the Form I-9.

Common Law Employer agrees that to the best of their knowledge all of the information provided in this form is correct and understands and agrees to all the information provided.

Wendy Worker _____

Direct Care Worker Name (Print)

_____ _____

Direct Care Worker Signature Date

Patty Participant _____

Common Law Employer Name (Print)

_____ _____

Common Law Employer Signature Date

Tempus Unlimited, Inc. | 600 Technology Center Drive | Stoughton, MA 02072
Phone: 1-844-983-6787 | Fax to 1-833-583-6787 | Email: PAFMS@tempusunlimited.org

Direct Care Worker (DCW) Agreement

This Agreement is made between __Patty Participant_____, a Common Law Employer (CLE) who is a Participant or the Participant's Authorized Representative in the Community HealthChoices (CHC) Participant-Directed Services Program administered by the Community HealthChoices Managed Care Organizations (CHC-MCOs), and __Wendy Worker_____, a Direct Care Worker (DCW) who will provide services under the CHC Program. This contract is effective the date signed below (Effective Date).

BACKGROUND

1. CLE is a Participant in the CHC Program, or a representative acting on behalf of the Participant. This program is administered by Managed Care Organizations (CHC-MCOs) contracted by the Commonwealth's Office of Long-Term Living (OLTL). It follows Federal Medicaid regulations.

2. DCW is a Direct Care Worker who will provide services to the Participant according to all applicable laws and regulations.

THEREFORE, in exchange for good and valid consideration which is hereby acknowledged:

1. COMMON LAW EMPLOYER RESPONSIBILITIES

a. CLE, and no one else, will be responsible to pay the DCW.
b. CLE will create the DCW's schedule, determine the DCW's responsibilities, and direct the DCW in the performance of responsibilities.
c. CLE will employ the DCW at CLE's sole discretion and will have the sole authority to dismiss DCW.
d. CLE will work with the Fiscal/Employer Agent (F/EA) selected by the CHC-MCOs to provide F/EA services to the CLE to: (i) make sure that the DCW is qualified in line with applicable regulations and (ii) process pay to DCW for actual hours worked by the DCW for the agreed wage.

2. DCW RESPONSIBILITIES

a. DCW agrees to complete all required paperwork correctly and truthfully.
b. DCW will not provide services until DCW is notified by CLE that DCW has met all the requirements in line with the applicable regulations ("Active Status").
c. DCW will provide the services following the outcome of health and safety requirements named in the Person-Centered Service Plan (PCSP).
d. DCW has received, read, and understood all of the following information:
    i. CHC program policies and procedures regarding Participant-Directed Services
    ii. The Person-Centered Service Plan (PCSP)
e. DCW agrees to complete the required training and meet all necessary qualifications in the Participant's PCSP and applicable CHC-MCO policies and procedures.

Tempus Unlimited, Inc. | 600 Technology Center Drive | Stoughton, MA 02072
Phone: 1-844-983-6787 | Fax to 1-833-583-6787 | Email: PAFMS@tempusunlimited.org

f. DCW will not submit time if the Participant is admitted to a hospital, nursing home, rehabilitation facility or for any period for which the Participant is not eligible for waiver services.
g. DCW will keep all documents and records as needed by the CHC Participant-Directed Services Program, the Participant, and the CLE confidential.
h. DCW will report incidents to Participant's Service Coordinator, including suspected abuse, neglect, exploitation, or any event involving error in service/support implementation, critical events involving personal injury, illness, medical emergency, or any event determined to be atypical as needed or as determined by the CHC-MCOs.
i. DCW will take part in any meetings if requested by and/or about the CLE or Participant.
j. DCW will follow all applicable rules, regulations, and policies about providing support services through the CHC Program.
k. DCW will review any/all program updates made available by Participant or CLE.
l. DCW understands and acknowledges that the CHC-MCOs shall coordinate with the F/EA to verify that the DCW does not appear on the Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE). If the DCW appears on this list, DCW will not be allowed to work or be paid in this program.
m. DCW understands they will be paid only for those services approved by employer and authorized in the PCSP.
n. DCW understands and acknowledges that their employment is at the will of the CLE and is also subject to DCW's continued interest to provide services for Participant.
o. DCW understands that DCW paychecks will be processed by the F/EA selected by the CHC-MCOs. DCW understands and acknowledges that the F/EA will not process payments for any service not approved and authorized in the PCSP or any request that exceeds the Participant's authorization for such services. DCW understands and acknowledges that neither the F/EA nor the CHC-MCOs are the DCW's employer.
p. DCW understands and agrees that any payments made for services that were not performed, including payments due to error by the DCW, the CLE, the Participant, or the F/EA, will be subject to withholdings from future paychecks. This includes overpayments made because of error or omission. Applicable law will govern the withholding process.
q. DCW understands and acknowledges that any false claims or untruthful submission of services provided, statements, or document, or concealment of material facts to obtain improper payment is reportable as Medicaid Fraud and subject to investigation. Medicaid Fraud is a felony and can lead to substantial penalties and/or imprisonment.
r. DCW understands and acknowledges that information it provides may be shared with business partners who work with CHC-MCOs and the F/EA for purpose of administering services and remaining compliant with applicable laws and regulations. Business partners include, but not limited to, Pennsylvania Department of Human Services, Office of Long-Term Living, Pennsylvania Office of Attorney General, Office of Inspector General and any other individuals as required by law.

Tempus Unlimited, Inc. | 600 Technology Center Drive | Stoughton, MA 02072
Phone: 1-844-983-6787 | Fax to 1-833-583-6787 | Email: PAFMS@tempusunlimited.org

s. DCW understands and acknowledges that failure to complete forms provided by the F/EA and CHC-MCOs, including authorization to conduct a background check, may make it impossible for the F/EA to process payroll or validate the DCW's eligibility for employment on behalf of the CLE.
t. DCW understands and acknowledges that DCW has the right to seek counsel to advise DCW's decision on whether to accept the terms of this Agreement.

3. TERM AND TERMINATION

This Agreement will begin on the Effective Date and will terminate upon the earliest of the following:

a. The date on which Participant ceases participation in the CHC Program.
b. The date on which CLE terminates the DCW.
c. The date on which the DCW resigns.
d. The date on which DCW becomes ineligible to provide services under applicable regulations.

4. ENTIRE AGREEMENT

This document represents the entire understanding between CLE and DCW regarding CLE's employment of DCW. This Agreement may not be altered except in writing, signed by the Parties.

5. GOVERNING LAW

This Agreement is governed by the laws of the Commonwealth of Pennsylvania. Any dispute arising under this Agreement will be heard by a Court of competent jurisdiction in the Commonwealth of Pennsylvania.

6. SEVERABILITY

If any provision or part of this Agreement is found to be invalid and/or unenforceable by law or a Court of competent jurisdiction, only that provision or part of the Agreement will be invalid and/or unenforceable, and not the entire Agreement.

By signing below, I agree to the terms and conditions of this Agreement.

Wendy Worker
Direct Care Worker Name

_____ _____
Direct Care Worker Signature Date

Patty Participant
Common Law Employer Name

_____ _____
Common Law Employer Signature Date

Tempus Unlimited, Inc. | 600 Technology Center Drive | Stoughton, MA 02072
Phone: 1-844-983-6787 | Fax to 1-833-583-6787 | Email: PAFMS@tempusunlimited.org

PENNSLYVANIA DIRECT DEPOSIT
APPLICATION FORM

Direct Care Worker (DCW) Name: Wendy A. Worker **DCW Phone Number:** (717) 123-4567

Participant C#: C123456 **CLE Name:** Patty Participant **DCW E#:** E123456

Participant Name: Patty Participant **DCW SSN:** 123456789

☐ **By checking this box and signing below, I hereby authorize Tempus Unlimited, Inc. to opt out of receiving my DCW pay stubs by mail. This authorization is to remain in effect until Tempus Unlimited, Inc. has received written notice from me of its termination in such time and in such manner as to afford Tempus Unlimited, Inc. reasonable opportunity to act on it. (OPTIONAL)**

Account Information

Name on Bank Account: Wendy Worker
(Direct Deposit Accounts must include the name of the DCW)

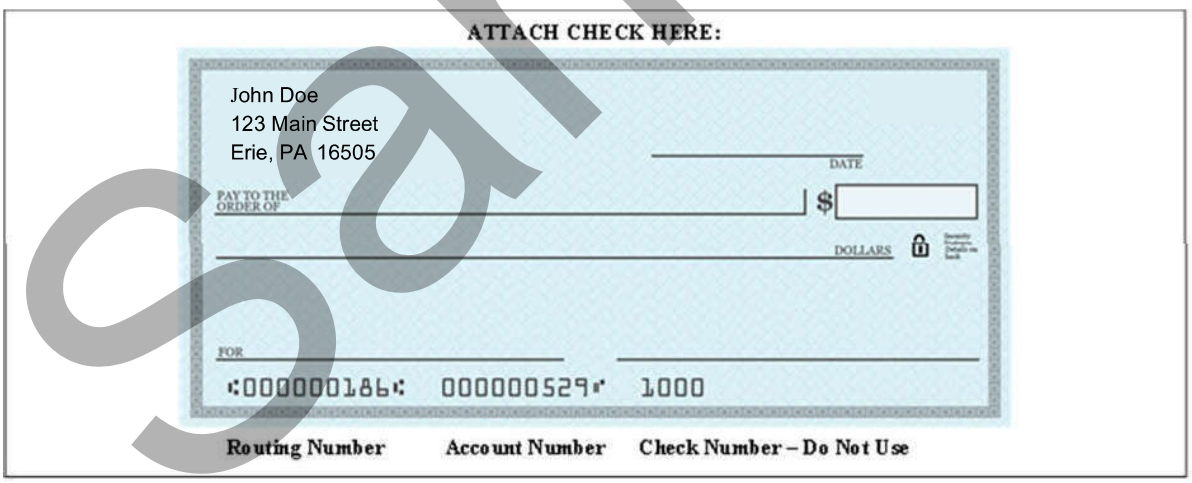
Bank Name: M&T Bank

Bank Routing #: 031302955 **Bank Account #:** 12345678

This is a ◉ **Checking Account** ○ **Savings Account**

For a checking account, please attach a voided check or a copy of a check (Starter checks must contain a preprinted DCW name and account number). For a savings account, please attach a document from the bank indicating the DCW's name, the routing number and account number (cannot be handwritten). **Do not attach a deposit slip. We will not process this application without a voided check, a copy of a check, or a document from your bank indicating the routing number and account number.**

ATTACH CHECK HERE:



I hereby authorize Tempus Unlimited, Inc. (hereinafter "Company") to deposit any amounts owed to me by initiating credit entries to my account at the financial institution (hereinafter "Bank") indicated on this form. Further, I authorize the Bank to accept and to credit any credit entries indicated by the Company to my account. In the event that the Company deposits funds erroneously into my account, I authorize the Company to debit my account for an amount not to exceed the original amount of the erroneous credit. This authorization is to remain in full force and effect until the Company and the Bank have received written notice from me of its termination. The termination can take up to seven (7) business days of receipt of written notice for termination to be effective.

DCW Signature:_____ Date: _____

Tempus Unlimited, Inc. | 600 Technology Center Drive | Stoughton, MA 02072
Phone: 1-844-983-6787 | Fax to 1-833-583-6787 | Email: PAFMS@tempusunlimited.org

ALXDBWQVOV

Employment Eligibility Verification

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

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

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

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

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

Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	Other Last Names Used (if any)
Worker	Wendy	A	N/A

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code
1 Front Street	N/A	Harrisburg	PA	17101

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number
01/01/1980	123456789	wendy@email.com	(717) 123-4567

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.):

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

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

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

Signature of Employee

Today's Date (mm/dd/yyyy)

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

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

	List A	OR	List B	AND	List C
Document Title 1			Driver's license issued by state/territory		(Unrestricted) Social Security Card
Issuing Authority			PA DMV		Social Security Administration
Document Number (if any)			12345678		123456789
Expiration Date (if any)			12/31/2024		N/A
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): 08/05/2024

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)
Participant Patty C123456		

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
C123456	100 Park Road, Harrisburg, PA, 17101

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

ALXDBWQVOV C123456

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2024

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Wendy A.	Worker	123-45-6789

Address: 1 Front Street

City or town, state, and ZIP code: Harrisburg, PA 17101

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, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

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

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

Step 3: Claim Dependent and Other Credits

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

Multiply the number of qualifying children under age 17 by $2,000 $ 0

Multiply the number of other dependents by $500 . . . . . $ 0

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** $ 0.0

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)
Patty Participant	08/05/2024	

01/01/1980

CLGS-32-6 (05/17)

RESIDENCY CERTIFICATION FORM
Local Earned Income Tax Withholding

TO EMPLOYERS/TAXPAYERS:

This form is to be used by employers and taxpayers to report essential information for the collection and distribution of Local Earned Income Taxes to the local EIT collector. This form must be used by employers when a new employee is hired or when a current employee notifies employer of a name or address change. Use the Address Search Application at dced.pa.gov/Act32 to determine PSD codes, EIT rates, and tax collector contact information.

EMPLOYEE INFORMATION – RESIDENCE LOCATION

NAME (Last Name, First Name, Middle Initial)			SOCIAL SECURITY NUMBER
Worker, Wendy A.			1 2 3 4 5 6 7 8 9
STREET ADDRESS **(No PO Box, RD or RR)**			
1 Front Street			
ADDRESS LINE 2			
CITY	STATE	ZIP CODE	DAYTIME PHONE NUMBER
Harrisburg	PA	17101	(717) 123-4567
MUNICIPALITY (City, Borough or Township)			
Harrisburg			
COUNTY	RESIDENT PSD CODE		TOTAL RESIDENT EIT RATE
Dauphin			

EMPLOYER INFORMATION – EMPLOYMENT LOCATION

EMPLOYER BUSINESS NAME (Use Federal ID Name)			EMPLOYER FEIN
Participant, Patty			
STREET ADDRESS WHERE ABOVE EMPLOYEE REPORTS TO WORK **(No PO Box, RD or RR)**			
100 Park Road			
ADDRESS LINE 2			
CITY	STATE	ZIP CODE	PHONE NUMBER
Harrisburg	PA	17101	() -
MUNICIPALITY (City, Borough or Township)			
Harrisburg City			
COUNTY	WORK LOCATION PSD CODE		WORK LOCATION NON-RESIDENT EIT RATE
Dauphin			

CERTIFICATION

Under penalties of perjury, I (we) declare that I (we) have examined this information, including all accompanying schedules and statements and to the best of my (our) belief, they are true, correct and complete.

SIGNATURE OF EMPLOYEE	DATE (MM/DD/YYYY)
PHONE NUMBER	EMAIL ADDRESS
(717) 123-4567	wendy@email.com

For information on obtaining the appropriate MUNICIPALITY (City, Borough, Township), PSD CODES, and EIT (Earned Income Tax) RATES, please refer to the Pennsylvania Department of Community & Economic Development website:

dced.pa.gov/Act32

WORKERS' COMPENSATION EMPLOYEE NOTIFICATION

The Pennsylvania Workers' Compensation Act is designed to provide reimbursement for reasonable medical care for someone who suffers an injury arising during his/her employment and causally related thereto. Pursuant to the Act, your employer will provide payment for reasonable surgical and medical services, services rendered by physicians or other health care providers, medicines and supplies, as and when needed.

If you require emergency medical treatment, you may seek it from any provider; however, any subsequent non-emergency treatment shall be obtained from one of the designated health care providers whose names appear on the list posted on your employer's premises. If you are faced with a medical emergency, you may secure assistance from a hospital or physician/health care provider of your choice. However, once the emergency no longer exists, the employee must treat with a listed provider for the remainder of ninety (90) day period.

During the initial ninety (90) days from the date of your first visit, you have the right to switch from one health care provider on the list to another, and your employer will pay for that treatment.

If a designated health care provider refers you for treatment to another health care provider whose name is not on the list, your employer will pay for the treatment rendered by the provider to whom you were referred.

Naturally, you have the right to seek treatment or medical consultation from a non-designated health care provider during the initial ninety (90) day period following the first visit, but you are personally responsible for payment for those services.

You have the right to seek treatment from any health care provider at the expiration of the ninety (90) day period from the date of your first visit. Your employer will pay for this treatment unless the treatment is found to be unreasonable or unnecessary by a utilization review organization pursuant to the utilization review process contained in the Workers' Compensation Act.

Your employer will be responsible for the cost of that treatment after the initial ninety (90) day period has ended but only if you notify the employer that you are receiving treatment from non-designated health care provide and can only if that notice is provided to your employer within five (5) days of the first visit to that provider. If you provide notice to your employer of treatment by a non-designation provider more than five (5) days after the first visit to that provider, the employer will not be responsible to pay for treatment rendered by that non-designated provider until it receives notification from you that you are receiving such treatment.

Should a designated health care provider prescribe invasive surgery, your employer will pay for an additional opinion from a health care provider of your choice. If the additional opinion differs from the opinion of the designated health care provider and if the additional opinion provides a specific and detailed course of treatment, you will then determine which course of treatment to follow. If you choose to follow the procedures recommended in the additional opinion, your employer will pay to have such procedures performed by one of its designated health care providers and will not be responsible for payment for treatment provided by a non-designated provider for a period of ninety (90) days from the date of your visit to the health care provider from whom you obtained the additional opinion.

I HEREBY ACKNOWLEDGE THAT I HAVE BEEN INFORMED OF AND UNDERSTAND MY RIGHTS AND DUTIES UNDER THE PENNSYLVANIA WORKERS' COMPENSATION ACT AS SET FORTH HEREIN.

Wendy Worker	_____	_____
Employee Name	Employee Signature	Date

EMPLOYEE RE-NOTIFICATION AT OR NEAR THE TIME OF THE CLAIMED WORK INJURY

I hereby acknowledge that I have been informed again and that I understand my rights and duties under the Pennsylvania Workers' Compensation Act. I have received a copy of this workers' compensation employee notification form.

_____	_____	_____
Employee Name	Employee Signature	Date

Application for the Difficulty of Care Federal Income Tax Exclusion

Participant Name: Patty Participant	**Participant ID:** C123456
Direct Care Worker: Wendy Worker	**Direct Care Worker ID:** E123456

Section A: Applying for Difficulty of Care Federal Income Tax Exclusion

Certain payments received by an employee for supplying Medicaid services in the Participant home are considered Difficulty of Care payments that can be excluded from federal income tax. To determine if you are eligible for the income tax exclusion, complete the following steps. If you are eligible, Tempus Unlimited will not report the payments as income and will not withhold federal income taxes.

STEP 1: Read the information about the Difficulty of Care Federal Income Tax Exclusion. You can read the information that is found on the IRS Website at https://www.irs.gov/individuals/certain-medicaid-waiver-payments-may-be-excludable-from-income.

STEP 2: Check **all** that apply:

- ☐ **I supply services to the Participant in my home.**
  (NOTE: The Participant receiving care must live in the same house as the Direct Care Worker (DCW) Regardless of who owns the home.)
- ☐ **I do not have a separate home where I live.**
- ☐ **This is the home where I live and regularly perform the routines of private life, including meals and holidays with family.**

STEP 3: If you checked **all** three, you are **eligible** for the Difficulty of Care Federal Income Tax Exclusion.

Under penalties of lying under oath, I declare that I am a Direct Care Worker (DCW) receiving payments under a Medicaid Home and Community-Based Services Program. I live in a home with, and provide services to, the Participant listed at the top of this form. In reliance on my declaration, I understand Tempus Unlimited will not report my compensation as federal taxable wages and will not withhold or remit federal income taxes on my behalf.

IMPORTANT: If you no longer live with the Participant you provide services to, you must notify your employer and submit the Difficulty of Care Termination to Tempus Unlimited to remove.

Direct Care Worker Signature: _____ **Date:** _____

Section B: Terminating Difficulty of Care Federal Income Tax Exclusion

Under penalties of lying under oath, I declare that I no longer reside with a Participant that I provide services to and I am no longer eligible for the Difficulty of Care Federal Income Tax Exclusion.

Direct Care Worker Signature:_____ **Date:** _____

Tempus Unlimited, Inc. | 600 Technology Center Drive | Stoughton, MA 02072
Phone: 1-844-983-6787 | Fax to 1-833-583-6787 | Email: PAFMS@tempusunlimited.org

SP 4-164 (12-2017)

PENNSYLVANIA STATE POLICE

REQUEST FOR CRIMINAL RECORD CHECK

1-888-QUERYPA (1-888-783-7972)

This form is to be completed in ink by the requester – (information will be mailed to the requester only). If this form is not legible or not properly completed, it will be returned unprocessed to the requester. *A response may take four weeks or longer.*

TRY OUR WEBSITE FOR A QUICKER RESPONSE
https://epatch.state.pa.us

REQUESTER NAME	TEMPUS UNLIMITED, INC.
ADDRESS	600 TECHNOLOGY CENTER DRIVE
CITY/STATE/ ZIP CODE	STOUGHTON, MA. 02072
TELEPHONE NO. (AREA CODE)	844-983-6787

FOR CENTRAL REPOSITORY USE ONLY
CONTROL NUMBER

AFTER COMPLETION MAIL TO:

PENNSYLVANIA STATE POLICE
CENTRAL REPOSITORY – 164
1800 ELMERTON AVENUE
HARRISBURG, PA 17110-9758

DO NOT SEND CASH OR PERSONAL CHECK

CHECK ONE BLOCK

☐ INDIVIDUAL/NONCRIMINAL JUSTICE AGENCY – ENCLOSE A CERTIFIED CHECK/MONEY ORDER IN THE AMOUNT OF $22.00, PAYABLE TO: "*COMMONWEALTH OF PENNSYLVANIA*" THE FEE IS NONREFUNDABLE

☐ NOTARIZED INDIVIDUAL/NONCRIMINAL JUSTICE AGENCY – ENCLOSE A CERTIFIED CHECK/MONEY ORDER IN THE AMOUNT OF $27.00, PAYABLE TO: "*COMMONWEALTH OF PENNSYLVANIA*" THE FEE IS NONREFUNDABLE

☐ FEE EXEMPT-NONCRIMINAL JUSTICE AGENCY – NO FEE

SUBJECT OF RECORD CHECK

(FIRST)	(MIDDLE)	(LAST)		
Wendy	A	Worker		
MAIDEN NAME AND/OR ALIASES	**SOCIAL SECURITY NUMBER**	**DATE OF BIRTH (MM/DD/YYYY)**	**SEX**	**RACE**
	123-45-6789	01/01/1980	Female	

The Pennsylvania State Police response will be based on the comparison of the data provided by the requester against the information *contained in the files of the Pennsylvania State Police Central Repository only.*

FEES FOR REQUESTS - $22.00. NOTARIZED FEE REQUESTS - $27.00.
******MAKE ALL MONEY ORDERS PAYABLE TO: COMMONWEALTH OF PENNSYLVANIA ******

REASON FOR REQUEST

◄◄◄◄◄◄CHECK THE BOX THAT MOST APPLIES TO THE PURPOSE OF THIS REQUEST►►►►►►

☐ **INTERNATIONAL ADOPTION -** INTERNATIONAL ADOPTION MUST BE NOTARIZED AND MAILED IN. ($27.00 FOR REQUEST)

☐ ADOPTION (DOMESTIC) ■ EMPLOYMENT ☐ VISA ☐ OTHER

WARNING: 18 Pa.C.S. 4904(b) UNDER PENALTY OF LAW - MISIDENTIFICATION OR FALSE STATEMENTS OF IDENTITY TO OBTAIN CRIMINAL HISTORY INFORMATION OF ANOTHER IS PUNISHABLE AS AUTHORIZED BY LAW.

Homeland Security is Everyone's Responsibility - Pennsylvania Terrorism Tip Line 1-888-292-1919