UnitedHealthcare

PA/Employee Enrollment Packet

Dear Prospective Personal Assistant (PA)/Employee:

Welcome aboard! You have received this packet because a UnitedHealthcare member participating in the Kansas Work Opportunities Reward Kansas (WORK) program selected you to provide services. UnitedHealthcare has contracted with Public Partnerships LLC (PPL) to issue payments on behalf of WORK Participants/Employers who hire PAs/Employees through the WORK Program. That means you will submit your timesheets twice per month to PPL for payment for services you provide for your Employer.

Once you and your employer review, sign, and complete all required program paperwork, PPL will assume responsibility for issuing your payments on behalf of your employer. PPL and UnitedHealthcare are committed to providing you with as much support as possible; however, we must adhere to federal, state, and local tax laws. Therefore, all employer and PA/Employee paperwork must be signed and returned to PPL and **PPL must notify your employer that your paperwork has been accepted before you can begin working** and before any payments can be issued to you.

This packet contains all required PA/Employee enrollment paperwork that you need to complete and return to PPL. See the bottom of the Enrollment Forms Checklist on the next page of this packet for information on where to send completed paperwork.

You must complete a copy of this PA/Employee Enrollment Packet for each participant who employs you. If two people hire you in the same house, you must complete a packet for each person. If you need another copy of this packet or a form in this packet, you can call PPL or print a copy from PPL's Web site. To print from the Web site, go to: http://www.publicpartnerships.com/programs/kansas/UHC/index.html and select "Blank PA/Employee Enrollment Packet" under the Enrollment section.

We understand that these forms can be complicated, so please call us toll-free at 1-877-908-1747or email us at pplks-unitedhealthcare@pcgus.com if you have any questions. Our customer service team is available Monday through Friday 8:00 am until 7:00 pm CST. We look forward to working with you!

Sincerely,
Public Partnerships LLC

KS WORK United
Public Partnerships LLC
One Cabot Road, Suite 102
Medford, MA 02155

Phone: 1-877-908-1747
TTY: 1-800-360-5899
Admin Fax: 1-855-344-5443

UnitedHealthcare

KS WORK UnitedHealthcare PA/Employee Checklist

BEFORE you are able to perform services, the KS WORK program, through Public Partnerships needs your properly completed forms from this packet.

Please complete and submit the following **required forms** to the KS WORK program, through Public Partnerships **immediately**:

- **Employee Information and Attestation Form:** This document collects the necessary background information used to set up an individual as a Personal Assistant (PA).
- **USCIS Form I-9 – Employment Eligibility Verification:** This form is used to confirm your immigration and US citizenship information. Your employer will verify your identity by signing section 2 of this form.
- **Form W-4 – IRS Employee's Withholding Allowance Certificate:** This form is used to calculate your federal tax withholding.
- **Form K-4 – Kansas Department of Revenue Employee's Withholding Allowance Certificate:** This form is used to calculate your state income tax withholding.
- **Criminal Background Check Application, Adult Abuse, Neglect, Exploitation Central Registry Release of Information and KS Child Abuse & Neglect Central Registry Release of Information:** The KS WORK program is required to conduct criminal background checks on all employees. By signing these forms, the PA gives the KS WORK program, through Public Partnerships consent to conduct the background checks, and to share the results with the employer, UnitedHealthcare, and to others as permitted by UnitedHealthcare.

The following form is **optional**:

- **Direct Deposit:** This form will establish direct deposit of your paycheck with the KS WORK program, through Public Partnerships. You can use direct deposit with a checking account, savings account, or debit card.

All required forms must be signed and returned to the KS WORK program, through Public Partnerships

If you have any questions, please call PPL at 1-877-908-1747.

Where to send forms:

Fax*	**Email***	**Mail**
1-855-344-5443	pplks-unitedhealthcare@pcgus.com	Public Partnerships LLC KS WORK UHC One Cabot Road, Ste. 102 Medford, MA 02155

***FOR FASTEST PROCESSING, EMAIL OR FAX FORMS**

UnitedHealthcare

Kansas Department of Health and Environment
Work Opportunities Reward Kansans Program

Employee Information and Attestation

To process your service payments, the KS WORK program must get back all pages of this Employee Information and Attestation form filled out with your information, all questions answered and signed and dated. When all pages are filled out please send to the KS WORK program, through Public Partnerships LLC (PPL), the agency for your participant. Please fax to: 1-855-344-5443 or email to: pplks-unitedhealthcare@pcgus.com.

Participant Information		
Participant First Name: John	**Participant Last Name:** Doe	**Participant ID #:** 123456

Employee Information		
Employee First Name: Jim	**Employee M.I.:**	**Employee Last Name:** Smith
Employee ID #: 654321	**Employee Maiden/Alias Name(s):**	
Date of Birth: 01/01/1960	**Social Security Number:** 123-45-6789	**Gender:** ☐ Female ☒ Male

Relationship to Participant: ☐ **Parent/Step-Parent** ☐ **Child** ☐ **Sibling** ☐ **Grandparent**

☐ **Grandchild** ☐ **Spouse** ☐ **Legal Guardian** ☐ **Non-Relative** ☒ **Other**

Physical Address		
Physical Address (Do not use P.O. Box No.): 123 S 5th St	**Physical Address 2 (apt, bldg., unit, ste.):**	
City: SomeCity	**State:** KS	**Zip Code:** 11111
County:		

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

Participant Name	Employer Name	Employee Name
John Doe	John Doe	Jim Smith

Contact Information

Preferred Method of Contact:

☐ **Home Phone Number** ☒ **Mobile Phone Number** ☐ **Email Address**

Home Phone Number:	**Mobile Phone Number:** 555-222-1111

The KS WORK program, through Public Partnerships has permission to text me using the mobile phone number above (carrier charges may apply): ☒ **Yes** ☐ **No**

Email Address: email@email.com

Emergency Contact Information

Emergency Contact Name: Sally	**Emergency Contact Phone Number:** Smith

Record Check Information

City of Birth: 01/01/1960 State/Province of Birth: KS County (if known): _____

Country of Birth: USA Country of Citizenship: USA

Race: *(check one)* ☐ American Indian and/or Alaskan ☐ Asian or Pacific Islander ☐ Black ☒ Caucasian/Latino ☐ Unknown

Ethnicity: *(check one)* ☒ Non-Hispanic ☐ Hispanic ☐ Unknown

Eye Color: *(check one)* ☐ Black ☐ Blue ☒ Brown ☐ Green ☐ Gray ☐ Hazel ☐ Maroon ☐ Pink ☐ Multi-Colored ☐ Unknown

Hair Color: *(check one)* ☐ Bald ☒ Black ☐ Blonde ☐ Blue ☐ Brown ☐ Green ☐ Gray ☐ Orange ☐ Purple ☐ Pink ☐ Red ☐ Sandy ☐ White ☐ Unknown

Preferred Language: (*check one)* ☒ English ☐ Spanish

Height: 6 Feet 1 Inches Weight (Pounds): 200

Participant Name	Employer Name	Employee Name
John Doe	John Doe	Jim Smith

Application for Difficulty of Care
Federal Income Tax Exclusion

Certain payments received by an employee for providing Medicaid services in the participant's home are considered Difficulty of Care payments excludable from federal income tax. To determine if you are eligible for the income exclusion, complete the following steps. If you are eligible, the KS WORK program 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 at: https://www.publicpartnerships.com.

STEP 2: Check all that apply:

☐ **I provide services to the participant in my home.**
(NOTE: The participant receiving care must live in the same home as the participant care provider, regardless of who owns the home.)

☐ **I do not have a separate home where I reside.**

☐ **This is the home where I reside and regularly perform the routines of private life, including shared meals and holidays with family.**

STEP 3: If all the above do not apply, you are not eligible for the Difficulty of Care Federal Income Tax Exclusion.

STEP 4: If all the above apply, you are eligible for the Difficulty of Care Federal Income Tax Exclusion.

Under penalties of perjury, I declare that I am a participant care provider receiving payments under a state Medicaid Home and Community-Based Services program. I live in the home with, and I provide services to, the participant listed at the top of this form.

IMPORTANT: If you no longer reside with the participant you provide services to, you must notify the KS WORK program through Public Partnerships and terminate your Difficulty of Care Federal Income Tax Exclusion.

Participant Name	Employer Name	Employee Name
John Doe	John Doe	Jim Smith

Payment Information ***(If a payment selection is not checked then the KS WORK program will send you your payments by debit card)***			
Payment Selection: *(check only one box)*	☐ Direct Deposit	☐ Paper Check	☒ Debit Card
Direct Deposit			
Account Type: *(check only one box)*	☒ Checking Account	☐ Savings Account	
Account Information			

1. **Direct Deposit** can be cancelled by calling Customer Service. If you are changing your bank account information, this form must be submitted.

Banking Institution Name	BankName
Routing Number	1 2 3 4 5 6 7 8 9
Account Number	2 4 4 4 5 5 5 5 1 1
Account Nickname (if desired)	

Pay Stub/Remittance Advice

GO GREEN: The KS WORK program, through Public Partnerships makes your pay stub available on the BetterOnline™ web portal. If you do not have access to the internet through a computer, tablet, or smart phone, then check the box below.

☐ **I do not have access to the internet, please send my pay stub in the mail.**

Timesheet Submission

The standard method to submit an employee's time worked to the KS WORK program is electronically, using e-Timesheets on the BetterOnline™ web portal or through your smartphone using the Time4Care™ smartphone application.

Submitting time worked through e-Timesheets or Time4Care™ allows the user to fill-out and submit timesheets online, view the status of payments, and search for timesheets previously entered and paid in the system. All of this can be done at the user's convenience and without having to call Public Partnerships Customer Service to confirm that their timesheet was received.

Participant Name	Employer Name	Employee Name
John Doe	John Doe	Jim Smith

Relationship Questionnaire

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 providing 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 provide 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 requires 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 31?

☐ **YES**, I am under 18 or am turning 18 **before December 31** ☐ **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) your principal occupation?

NOTE: Do not answer, "YES," if you are a student.

☐ **YES,** this is my main job. ☐ **NO,** this is not my main job.

Participant Name	Employer Name	Employee Name
John Doe	John Doe	Jim Smith

Personal Assistant (PA) Pay Rate Indicate which services will be provided by checking the boxes that apply.		
If PA is 18 years of age or older:* Services Covered	**Pay Rate**	**Billable Rate**
▪ **Activities of Daily Living** (bathing, grooming, toileting, eating, transferring, medication, management, and mobility) ▪ **Instrumental Activities of Daily Living** (shopping, housekeeping, laundry, meal prep, lawn care/snow removal, transportation, and money management) ▪ **Employment Related Support**	$ 15 /hr.	$_____ /hr.

*If under age 18, a PA may only provide Instrumental Activities of Daily Living.

If PA is 16–17 years of age: Services Covered	**Pay Rate**	**Billable Rate**
▪ **Instrumental Activities of Daily Living** (shopping, housekeeping, laundry, meal prep, lawn care/snow removal, transportation, and money management)	$_____ /hr.	$_____ /hr.

Mutual Responsibilities

The parties agree to follow the policies and procedures of the Kansas WORK Program. The Employee and Employer agree to hold harmless, release, and forever discharge UnitedHealthcare Kansas, Inc. and Public Partnerships LLC from any claims and/or damages that might arise out of any action or omissions by the Employee or Employer.

The Personal Assistant (PA)/Employee is hired and supervised directly by the Kansas WORK Participant/ Employer. The PA/Employee must comply with the policies outlined below. In addition to the returning completed and signed **Employee Agreement and Attestation** form to the KS WORK program, through Public Partnerships, a copy of this document must be maintained by the Employer and Employee.

Compensation
The KS WORK program, through Public Partnerships agrees to compensate the Employee at a pay/wage rate determined by the Employer, provided that the rate is either equal to or greater than the higher of the following: minimum wage in the state of Kansas and the federal minimum wage. It is mandatory to follow these minimum wage guidelines. Rates are also subject to any maximums that may be defined by the Kansas Department of Health and Environment.

Participant Name	Employer Name	Employee Name
John Doe	John Doe	Jim Smith

The Employer and the Employee may designate and agree on distinct rates per service. Rates must be identified prior to a working period and are subject to the rules below regarding the procedure to make changes to rates.

The Employer and the Employee may only change these rates by completing and submitting to the KS WORK program through Public Partnerships a "PA/Employee Rate Change Form." The change form must be returned to the KS WORK program through Public Partnerships prior to the first day of the pay period you would like the new rate to take effect. Please note that the rate will not take effect until Public Partnerships receives confirmation of approval from UnitedHealthcare.

The KS WORK program, through Public Partnerships may not issue payment to the Employee for services that are rendered before all necessary paperwork has been submitted to the KS WORK program through Public Partnerships, or before the KS WORK program through Public Partnerships has provided notification that the Employee is authorized to begin work. The KS WORK program through Public Partnerships is required to run criminal background checks on all Employees. The Employee may not begin work prior to the completion of criminal background checks. Under certain circumstances, an Employer may choose to employ an Employee with issues identified on a criminal background check, provided the Employer completes and submits an "Acceptance of Responsibility for Employment" form provided by the KS WORK program, through Public Partnerships. However, if an Employee fails the KBI Registered Offenders check or has certain results on a background check that are included on the list of prohibited offenses for providers, then this option does not apply. This also includes Kansas Administrative Regulation 30-63-28(f) and any type of Medicaid fraud or financial abuse.

It is the Employee's responsibility to ensure timesheets accurately reflect time worked. The PA understands that they must document and sign time worked for review by the Employer.
KS WORK timesheets must be approved by both the Employer and Employee prior to submission to the KS WORK program through Public Partnerships for payment. A "Designated Representative" of the Participant/Employer may not approve timesheets. If Public Partnerships' Web Portal is used for timesheet recording and submission, electronic approval and agreement will satisfy the Employee and Employer signature requirements.

Furthermore, if the Employee fails to submit time worked to the Employer in a timely manner, or if the Employer approves and submits the time worked after the timesheet submission deadline, payment will be delayed or denied.

Timesheets should be submitted within 30 days of the end of the month of service to ensure timely payment. Timesheets submitted more than 90 days after the date the service was provided will not be paid. The preferred method for timesheet submission is via the Public Partnerships' Web Portal.

KS WORK program through Public Partnerships will issue PA/Employee paychecks twice per month based on a payroll published by Public Partnerships.

Payment to PAs/Employees is made with Medicaid funds. Any false claims, statements, documents, or concealment of material facts may be subject to prosecution under applicable federal and state laws.

Any work performed more than the approved allocation shall be the financial responsibility of the Employer. The KS WORK program, through Public Partnerships will not be financially responsible for payment for any hours that exceed the Participant/Employer's approved WORK allocation.

Participant Name	Employer Name	Employee Name
John Doe	John Doe	Jim Smith

Employees may not provide more than 40 hours of care in a seven-day work week. A work week runs from Monday through Sunday. Services exceeding 40 hours must be provided by two or more Employees. No Employee will receive overtime premium pay.

The Employee will not be paid for services provided to the Employer during the time the Employer is admitted to a hospital.

Duration of Agreement
This Agreement will be effective when it is signed by both parties. Either party may terminate this Agreement and the employment contemplated in this document at any time and without liability for doing so, by giving the other party at least 5 (five) days prior notice. Notice may be provided either orally or in writing. When employment is terminated, the Employer must send a Separation of Employment form to the KS WORK program, through Public Partnerships. This form can be obtained online at www.publicpartnerships.com or can be requested by calling Public Partnerships at 1-877-908-1747.

Modification of Agreement
This Agreement may be modified in writing by agreement of both parties. Signed copies of all new agreements must be provided to the KS WORK program, through Public Partnerships.

Scheduling
If the Employee is unable to work a scheduled time, the Employee shall provide at least 40 hours' notice to the Employer to find an appropriate alternate. A change in time by the Employer or Employee must be scheduled at least 24 hours in advance. In case of emergency, the Employee will notify the Employer or another designated person. Such person shall be designated in advance, in writing. If an Employee is knowingly going to be late, he or she shall notify the Employer by telephone.

Employee Qualifications, Duties, and Policies

The Employee attests that he or she meets the minimum qualifications for employment in the Kansas WORK UnitedHealthcare Program and hereby agrees to the duties and policies as specified below. Qualifications, duties, and policies of the Employee include, but are not limited to, the following.

1. If the Employee is providing Activities of Daily Living (ADL) services or Employment Related Supports: Employee is 18 years of age or older.
2. If the Employee is providing Instrumental Activities of Daily Living (IADL) services: Employee is 16 years of age or older.
3. Employee is not the Employer of Record, Designated Representative, or legal guardian of the WORK Participant/Employer.
4. Employee has a valid driver's license (if driving is a job requirement).
5. Employee has current automobile insurance (if driving is a job requirement).
6. Employee has the required skills to perform services identified on page 7 of this agreement as specified in the Employer's service plan.
7. Employee possesses a valid Social Security Number (SSN) and is authorized to work in the United States.
8. Employee can demonstrate the capability to perform activities required by the Employer or specified in the Employer's service plan or be willing to receive training in performance of the specified activities.

Participant Name	Employer Name	Employee Name
John Doe	John Doe	Jim Smith

9. Employee agrees that Federal Income, Medicare, and Social Security taxes shall be withheld from Employee wages per IRS Form W-4.
10. Employee understands that he/she may not work more than 40 hours per Employer per work week (Monday through Sunday) and will not be compensated for overtime.
11. Employee understands that he/she may not provide services to more than one Employer at the same time.
12. Employee acknowledges and understands that funds available for payment are authorized by UnitedHealthcare in advance of work performed. Payment to Employee shall only be made as authorized by UnitedHealthcare. Employee shall only perform work within the authorized hour amount as they will not be compensated by UnitedHealthcare through the KS WORK Program for work performed more than the authorized amount. The KS WORK program, Public Partnerships will not issue payment for any work performed over the amount authorized as approved by UnitedHealthcare.
13. The Employee will not be paid for services not performed or authorized or for time not worked. The employee will not be paid for services when the Employer is hospitalized. The only exception is if vacation or sick time is authorized as part of your Employer's spending plan by his or her Independent Living Counselor and approved by UnitedHealthcare.
14. Timesheets must be properly completed and approved by both the Employer and the Employee. Hours recorded on timesheets cannot exceed the authorized number of hours.
15. Timesheets are due to the KS WORK program, through Public Partnerships shortly after the end of the pay period, per the published pay schedule. Timesheets received after the published deadline may be paid during the next payroll cycle. Incorrectly completed timesheets will not be paid. Timesheets must be submitted by the Participant/Employer or Employee in accordance with the published Public Partnerships PA payment schedule.
16. All required documents in the Employee Enrollment Packet must be completed by the Employee (and Employer as applicable) and submitted to KS WORK program through Public Partnerships prior to performing work.
17. All paychecks are mailed directly to Employee's home or are sent by direct deposit.
18. Payment of Employee wages is from Federal and State funds. Any false claims, statements, documents, or concealment of material facts will be prosecuted under applicable Federal and State laws.
19. Employee agrees to assist the Employer by providing the services and performing the activities specified in Employer's individual service plan.
20. Employee agrees to provide service as specified in the Employer's service plan on a schedule mutually agreed upon between the Employer and the Employee. Occasional variations in the Employee tasks and in the schedule, may occur, based on mutual agreement of the parties.
21. In the event of illness, emergency, or incident preventing Employee from providing scheduled service to the Employer, the Employee agrees to notify the Employer as soon as possible so that the Employer can obtain assistance from someone else.
22. Employee agrees to participate in training in providing services, including training in performing any health activities as required by the Employer or as specified in the Employer's service plan.
23. Employee agrees to confidentially maintain all information regarding the Employer and to respect the Employer's privacy.
24. Employee understands that this Agreement does not guarantee employment or payment of wages for any time period.

Participant Name	Employer Name	Employee Name
John Doe	John Doe	Jim Smith

25. Employee understands that the Employee is employed by the KS WORK Participant/ Employer and not Public Partnerships or UnitedHealthcare.
26. Employer's property is not to be used for the Employee's personal use.
27. Employees are to be punctual, neatly dressed, and respectful of all family members. All care instructions shall be carried out appropriately. The Employer's telephone may be used only with permission of the Employer.
28. Misrepresentation of time, services, individuals and/or other information is not permitted in the KS WORK Program. If the Employer or Employee approves a timesheet that is determined to misrepresent information, the Participant/Employer may lose the option of self-direction.

Employer Responsibilities

1. Employer agrees to orient, train, and direct the Employee in providing the services identified above that are described and authorized by the Employer's service plan or that are requested by the Employer.
2. Employer agrees to establish a mutually agreeable schedule for the Employee services, either orally or in writing.
3. Employer agrees to provide adequate notice of changes in the Employee's work schedule in the event of unforeseen circumstances or emergencies, but such notice cannot be guaranteed.
4. Employees shall only perform work within the KS WORK authorized hour amount as they will not be compensated through the KS WORK Program for work performed more than the authorized amount.
5. Misrepresentation of time, services, individuals and/or other information is not permitted in the KS WORK Program. If the Employer or Employee approves a timesheet that is determined to misrepresent information, the Employer may lose the option of self-direction.

Attestation

By signing below, I and my Participant/Employer attest that we have read and understand all program rules and responsibilities. Because certain payments received by an Employee for providing Medicaid services in the Employee's home are considered Difficulty of Care payments excludable from federal income tax, some Employee(s) that provide service to Participant(s)/Employer(s) in the KS WORK program are eligible for the Difficulty of Care Exclusion. Employee(s) that provide service to Participant(s)/Employer(s) on the Interim program are not eligible for the Difficulty of Care Exclusion.

I attest that I have reviewed and understand the information regarding the Difficulty of Care Federal Income Tax

Exclusion. I understand, if I am eligible, KS WORK will not report my compensation as federal taxable wages and will not withhold or remit federal income taxes on my behalf.

I further attest by signing below that I have filled out the Relationship Questionnaire to indicate my relationship to my employer, and that KS WORK, through Public Partnerships 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 an under withholding of tax, it is my responsibility to pay the under withheld tax.

Participant Name	Employer Name	Employee Name
John Doe	John Doe	Jim Smith

I understand I must sign and return this form as a condition of employment in this program. I further attest by signing below, that I understand what is being requested of me, and I agree to abide by these terms and conditions. I further understand and agree that violation of any of the terms and/or conditions may result in termination of this agreement.

I authorize the Participant/Employer and KS WORK to proceed with all registry and criminal record checks required by state and federal law. This information cannot be released for any other purpose without my written permission.

The Participant/Employer understands that it is their responsibility to properly execute the USCIS Form I-9, as defined in Instructions for Employment Eligibility Verification by the Department of Homeland Security. KS WORK, through Public Partnerships provides the Form I-9 in the employment packets, and the Participant/Employer retains the original Form I-9 and forwards a completed copy to KS WORK , through Public Partnerships; which Public Partnerships will retain in the Employee's files.

If I request the Direct Deposit payment selection, I authorize KS WORK, through Public Partnerships to process payments owed to me for services authorized by KS WORK. Public Partnerships will deposit my payment directly into my bank account using Automated Clearing House (ACH) transaction. I recognize that if I fail to provide complete and accurate information on this form, processing may be delayed or made impossible, or my electronic payments may be erroneously made. I certify that I have read and agree to comply with KS WORK, through Public Partnerships rules governing payments and electronic transfers. I authorize KS WORK, through Public Partnerships 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 KS WORK, through Public Partnerships to withhold any payment owed to me by Public Partnerships until the erroneous deposited amounts are repaid. If I decide to change or revoke this authorization, I recognize that I must forward such notice to KS WORK, through Public Partnerships.

John Doe

Participant/Employer (Authorized Representative) Name

Participant/Employer (Authorized Representative) Signature Date

Jim Smith

Employee Name

Employee Signature Date

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2020

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Jim	Smith	123-45-6789

Address: 123 S 5th St

City or town, state, and ZIP code: SomeCity, KS 11111

► **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 widow(er))
- ☐ **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, when to use the online estimator, and privacy.

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **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 accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ► ☐

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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 Dependents

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

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

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

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

General Instructions

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.

Exemption from withholding. You may claim exemption from withholding for 2020 if you meet both of the following conditions: you had no federal income tax liability in 2019 **and** you expect to have no federal income tax liability in 2020. You had no federal income tax liability in 2019 if (1) your total tax on line 16 on your 2019 Form 1040 or 1040-SR is zero (or less than the sum of lines 18a, 18b, and 18c), 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 2020 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2021.

Your privacy. If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

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

1. Expect to work only part of the year;

2. Have dividend or capital gain income, or are subject to additional taxes, such as the additional Medicare tax;

3. Have self-employment income (see below); or

4. Prefer the most accurate withholding for multiple job situations.

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.

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

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

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

Step 3. Step 3 of Form W-4 provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2020 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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

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

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 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . **1** $ _____

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

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

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

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

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

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

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

1 Enter an estimate of your 2020 itemized deductions (from Schedule A (Form 1040 or 1040-SR)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $ _____

2 Enter:
- $24,800 if you're married filing jointly or qualifying widow(er)
- $18,650 if you're head of household
- $12,400 if you're single or married filing separately

. . . . . **2** $ _____

3 If line 1 is greater than line 2, subtract line 2 from line 1. If line 2 is greater than line 1, enter "-0-" . . **3** $ _____

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

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

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions 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 Widow(er)

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	$220	$850	$900	$1,020	$1,020	$1,020	$1,020	$1,020	$1,210	$1,870	$1,870
$10,000 - 19,999	220	1,220	1,900	2,100	2,220	2,220	2,220	2,220	2,410	3,410	4,070	4,070
$20,000 - 29,999	850	1,900	2,730	2,930	3,050	3,050	3,050	3,240	4,240	5,240	5,900	5,900
$30,000 - 39,999	900	2,100	2,930	3,130	3,250	3,250	3,440	4,440	5,440	6,440	7,100	7,100
$40,000 - 49,999	1,020	2,220	3,050	3,250	3,370	3,570	4,570	5,570	6,570	7,570	8,220	8,220
$50,000 - 59,999	1,020	2,220	3,050	3,250	3,570	4,570	5,570	6,570	7,570	8,570	9,220	9,220
$60,000 - 69,999	1,020	2,220	3,050	3,440	4,570	5,570	6,570	7,570	8,570	9,570	10,220	10,220
$70,000 - 79,999	1,020	2,220	3,240	4,440	5,570	6,570	7,570	8,570	9,570	10,570	11,220	11,240
$80,000 - 99,999	1,060	3,260	5,090	6,290	7,420	8,420	9,420	10,420	11,420	12,420	13,260	13,460
$100,000 - 149,999	1,870	4,070	5,900	7,100	8,220	9,320	10,520	11,720	12,920	14,120	14,980	15,180
$150,000 - 239,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,190	16,050	16,250
$240,000 - 259,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,520	17,170	18,170
$260,000 - 279,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	13,120	15,120	17,120	18,770	19,770
$280,000 - 299,999	2,040	4,440	6,470	7,870	9,190	10,720	12,720	14,720	16,720	18,720	20,370	21,370
$300,000 - 319,999	2,040	4,440	6,470	8,200	10,320	12,320	14,320	16,320	18,320	20,320	21,970	22,970
$320,000 - 364,999	2,720	5,920	8,750	10,950	13,070	15,070	17,070	19,070	21,290	23,590	25,540	26,840
$365,000 - 524,999	2,970	6,470	9,600	12,100	14,530	16,830	19,130	21,430	23,730	26,030	27,980	29,280
$525,000 and over	3,140	6,840	10,170	12,870	15,500	18,000	20,500	23,000	25,500	28,000	30,150	31,650

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	$460	$940	$1,020	$1,020	$1,470	$1,870	$1,870	$1,870	$1,870	$2,040	$2,040	$2,040
$10,000 - 19,999	940	1,530	1,610	2,060	3,060	3,460	3,460	3,460	3,640	3,830	3,830	3,830
$20,000 - 29,999	1,020	1,610	2,130	3,130	4,130	4,540	4,540	4,720	4,920	5,110	5,110	5,110
$30,000 - 39,999	1,020	2,060	3,130	4,130	5,130	5,540	5,720	5,920	6,120	6,310	6,310	6,310
$40,000 - 59,999	1,870	3,460	4,540	5,540	6,690	7,290	7,490	7,690	7,890	8,080	8,080	8,080
$60,000 - 79,999	1,870	3,460	4,690	5,890	7,090	7,690	7,890	8,090	8,290	8,480	9,260	10,060
$80,000 - 99,999	2,020	3,810	5,090	6,290	7,490	8,090	8,290	8,490	9,470	10,460	11,260	12,060
$100,000 - 124,999	2,040	3,830	5,110	6,310	7,510	8,430	9,430	10,430	11,430	12,420	13,520	14,620
$125,000 - 149,999	2,040	3,830	5,110	7,030	9,030	10,430	11,430	12,580	13,880	15,170	16,270	17,370
$150,000 - 174,999	2,360	4,950	7,030	9,030	11,030	12,730	14,030	15,330	16,630	17,920	19,020	20,120
$175,000 - 199,999	2,720	5,310	7,540	9,840	12,140	13,840	15,140	16,440	17,740	19,030	20,130	21,230
$200,000 - 249,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
$250,000 - 399,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
$400,000 - 449,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,450	19,940	21,240	22,540
$450,000 and over	3,140	6,230	8,810	11,310	13,810	15,710	17,210	18,710	20,210	21,700	23,000	24,300

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	$830	$930	$1,020	$1,020	$1,020	$1,480	$1,870	$1,870	$1,930	$2,040	$2,040
$10,000 - 19,999	830	1,920	2,130	2,220	2,220	2,680	3,680	4,070	4,130	4,330	4,440	4,440
$20,000 - 29,999	930	2,130	2,350	2,430	2,900	3,900	4,900	5,340	5,540	5,740	5,850	5,850
$30,000 - 39,999	1,020	2,220	2,430	2,980	3,980	4,980	6,040	6,630	6,830	7,030	7,140	7,140
$40,000 - 59,999	1,020	2,530	3,750	4,830	5,860	7,060	8,260	8,850	9,050	9,250	9,360	9,360
$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,780	10,980	11,180	11,580	12,380
$80,000 - 99,999	1,900	4,300	5,710	7,000	8,200	9,400	10,600	11,180	11,670	12,670	13,580	14,380
$100,000 - 124,999	2,040	4,440	5,850	7,140	8,340	9,540	11,360	12,750	13,750	14,750	15,770	16,870
$125,000 - 149,999	2,040	4,440	5,850	7,360	9,360	11,360	13,360	14,750	16,010	17,310	18,520	19,620
$150,000 - 174,999	2,040	5,060	7,280	9,360	11,360	13,480	15,780	17,460	18,760	20,060	21,270	22,370
$175,000 - 199,999	2,720	5,920	8,130	10,480	12,780	15,080	17,380	19,070	20,370	21,670	22,880	23,980
$200,000 - 249,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
$250,000 - 349,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
$350,000 - 449,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,900	25,200
$450,000 and over	3,140	6,840	9,560	12,140	14,640	17,140	19,640	21,530	23,030	24,530	25,940	27,240

500518

K-4
(Rev. 11-18)

KANSAS
EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

Use the following instructions to accurately complete your K-4 form, then detach the lower portion and give it to your employer. For assistance, call the Kansas Department of Revenue at 785-368-8222.

Purpose of the K-4 form: A completed withholding allowance certificate will let your employer know how much *Kansas* income tax should be withheld from your pay on income you earn from Kansas sources. Because your tax situation may change, you may want to re-figure your withholding each year.

Exemption from Kansas withholding: To qualify for exempt status you must verify with the Kansas Department of Revenue that: **1)** last year you had the right to a refund of **all** STATE income tax withheld because you had **no** tax liability; and **2)** this year you will receive a full refund of **all** STATE income tax withheld because you will have **no** tax liability.

Basic Instructions: If you are not exempt, complete the **Personal Allowance Worksheet** that follows. The total on line F should **not** exceed the total exemptions you claim under "Exemptions and Dependents" on your Kansas income tax return.
***NOTE**: Your status of "Single" or "Joint" may differ from your status claimed on your federal Form W-4).*

Using the information from your **Personal Allowance Worksheet**, complete the **K-4** form below, sign it and provide it to your employer. If your employer does not receive a K-4 form from you, they must withhold Kansas income tax from your wages without exemption at the "Single" allowance rate.

Head of household: Generally, you may claim head of household filing status on your tax return only if you are **unmarried and pay more than 50% of the cost of keeping up a home for yourself and for your dependent(s).**

Non-wage income: If you have a large amount of non-wage Kansas source income, such as interest or dividends, consider making Kansas estimated tax payments on Form K-40ES. Without these payments, you may owe additional Kansas tax when you file your state income tax return.

Personal Allowance Worksheet (Keep for your records)

A Allowance Rate: If you are a single filer mark "Single"
If you are married and your spouse has income mark "Single"
If you are married and your spouse does not work mark "Joint"
A ☐ Single ☐ Joint

B Enter "0" or "1" if you are married or single and no one else can claim you as a dependent (entering "0" may help you avoid having too little tax withheld) ..... **B** _____

C Enter "0" or "1" if you are married and only have one job, and your spouse does not work (entering "0" may help you avoid having too little tax withheld) ..... **C** _____

D Enter "2" if you will file head of household on your tax return (see conditions under *Head of household* above) ..... **D** _____

E Enter the number of dependents you will claim on your tax return. **Do not** claim yourself or your spouse or dependents that your spouse has already claimed on their form K-4 ..... **E** _____

F **Add lines B through E** and enter the total here ..... **F** _____

▼ Cut here and give the lower portion to your employer. Keep the top portion for your records. ▼

Kansas Employee's Withholding Allowance Certificate

Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the Kansas Department of Revenue. Your employer may be required to send a copy of this form to the Department of Revenue.

1 Print your First Name and Middle Initial	Last Name	2 Social Security Number
Jim	Smith	123-45-6789

Mailing address	3 Allowance Rate
123 S 5th St	Mark the allowance rate selected in Line A above.
SomeCity KS 11111	☐ Single ☐ Joint

4	Total number of allowances you are claiming (from Line F above)	4	
5	Enter any additional amount you want withheld from each paycheck (this is optional)	5	$
6	I claim exemption from withholding. (You must meet the conditions explained in the "Exemption from withholding" instructions above.) If you meet the conditions above, write "Exempt" on this line. **Note: The Kansas Department of Revenue will receive your federal W-2 forms for all years claimed *Exempt*.**	6	

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

SIGN HERE ▶ **Date**

7 Employer's Name and Address	8 EIN (Employer ID Number)
John Doe, 4545 N West St, SomeCity KS 11111	123456

Employment Eligibility Verification

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

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

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

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

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

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

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code
123 S 5th St		SomeCity	KS	11111

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
01/01/1960	123 - 45 - 6789		555-222-1111

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

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

- [X] 1. A citizen of the United States
- [ ] 2. A noncitizen national of the United States *(See instructions)*
- [ ] 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____
- [ ] 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
  Some aliens may write "N/A" in the expiration date field. *(See instructions)*

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

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

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

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

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

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

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

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

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

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

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

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

Section 2. Employer or Authorized Representative Review and Verification

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

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

List A OR List B AND List C	List A Identity and Employment Authorization	List B Identity	List C Employment Authorization
Document Title		Driver's License	Social Security Card
Issuing Authority		KS MVD	SS Administration
Document Number		K00-44-3333	123-45-6789
Expiration Date *(if any)(mm/dd/yyyy)*		01/19/2021	NA
Document Title			
Issuing Authority			
Document Number			
Expiration Date *(if any)(mm/dd/yyyy)*			
Document Title			
Issuing Authority			
Document Number			
Expiration Date *(if any)(mm/dd/yyyy)*			

Additional Information

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

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

The employee's first day of employment *(mm/dd/yyyy)*: 09/09/2019 ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
John Doe	09/01/2019	Employer of Record

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

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code
4545 N West St	SomeCity	KS	11111

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

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

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

STATE OF KANSAS
Department for Children and Families
Prevention and Protection Services

ADULT ABUSE, NEGLECT, EXPLOITATION
CENTRAL REGISTRY
RELEASE OF INFORMATION

PPS 10400
REV 1/18

I, Jim Smith , give permission for the release of information concerning
(PRINT ONLY)

myself in the Adult Abuse, Neglect, Exploitation Central Registry to:

Contact Person(s)* KS WORK UHC Program **Phone** 1-877-908-1747

Agency name Public Partnerships LLC

Agency mailing address ATTN: KS WORK UHC, One Cabot Road, Suite 102, Medford MA 02155

Agency email address pplks-unitedhealthcare@pcgus.com

☐ **Check box if agency is a CDDO, CMHC, or ILRC**

Maiden Name and/or Other Names Known By: _____
(PRINT ONLY)

Address:	123 S 5th St	SomeCity	KS	11111
	Street	**City**	**State**	**Zip Code**

DOB: 01 / 01 / 1960 **(mm/dd/yyyy)** **SS#:** 123 - 45 - 6789 ☒ Male ☐ Female **(mark one)**

I understand that all information released will be for the exclusive and confidential use of the above-named organization/person. I have read and understand this form and the information provided is true and correct to the best of my knowledge.

I give permission for the release of any information concerning myself in the Adult Abuse and Neglect Central Registry each year while I am employed or associated with the above agency. ____ Yes __x__ No

Signature: *Jim Smith* **Date**: 09 / 01 / 2019 **(mm/dd/yyyy)**

Per statute 65-6205: Community Service Providers, Mental Health Centers and Independent Living Centers may request information for the purpose of obtaining background information on applicants for employment without signed consent. Signature is not required from the individual for which the inquiry is made.

RETURN TO:

DCF.APSRegistry@KS.GOV
or
Adult Abuse Registry
555 S. Kansas Ave
Topeka, Kansas 66603-3444

(Please allow 3-5 days for processing email requests and an additional 5-7 days if returning by US Postal Service)

FOR PPS ADMINISTRATION USE ONLY:

Record Found? ☐ No ☐ Yes "Yes" indicates the individual is listed on the adult abuse, neglect, exploitation registry.

If yes, check all that apply ☐ Abuse ☐ Neglect ☐ Exploitation ☐ Fiduciary Abuse

Perpetrator's Name: _____ Date Substantiated: _____

Initial: _____ Date: _____

KANSAS DEPARTMENT FOR CHILDREN AND FAMILIES

Child Abuse and Neglect Central Registry
P.O. Box 2637 ● Topeka, KS 66601 ● DCF.CentralRegistry@ks.gov

Release of Information

Complete form by printing legibly in ink. Fee of $10.00 per Release of Information form may be required prior to processing.

All releases and fees are to be sent to the address or email listed above (see below for specifics)

CONFIDENTIALITY: ***Kansas Department for Children and Family records are confidential. No individual, association, partnership, corporation, or other entity shall willfully or knowingly disclose, permit, or encourage disclosure of the contents of records or reports in violation of the confidentiality requirements of K.S.A. 38-2209. Violation of this statute is a class A nonperson misdemeanor and the court may impose a civil penalty of up to $1,000.***

Contact Person: KS WORK UHC Program Agency/Org.: Public Partnerships LLC

Phone #: 1-877-908-1747 Address: ATTN: KS WORK UHC, One Cabot Road, Ste. 102

Email: pplks-unitedhealthcare@pcgus.com City/State/Zip: Medord, MA 02155

Return Results by: ☐ Encrypted email (list if different than above): _____ ☐ Postal Mail

Payment/Account Information (check box which applies)

☐ *Fee included*	$10 per request. Check, Money Order (payable to DCF) or cash. ***Postal mail only.***
☐ *Online Payment**	www.dcf.ks.gov – 'Online DCF Payments' icon at bottom of page. Submit receipt with ROI form(s).
☒ *Pre-Pay Account**	Agency/Org. has Pre-Pay Account. FEIN: 04-3468852
☐ *Mentoring Account**	As listed in the Kansas Mentors' Partner Directory. http://mentorkansas.org/Find-a-Program
☐ *Exempt**	No fee for State government agencies (Sub-contracting agencies not included).

*Release of Information forms may be submitted via email to DCF.CentralRegistry@ks.gov

APPLICANT: *Instructions: PRINT CLEARLY. All requested information is required for processing. Incomplete or illegible information will result in processing delays for the Release of Information. Use 'N/A' rather than leaving a space blank.*

FIRST, MIDDLE, LAST NAME: _____

I give permission for the release of any of my information in the Child Abuse/Neglect Central Registry to the contact listed above. I understand the information released is for their exclusive and confidential use: ☐ *Yes* ☐ *No*

This organization/person/agency may check my information each year I am employed or associated with them: ☐ *Yes* ☐ *No*

OTHER NAMES USED: (Any/all aliases, married, maiden, nicknames, etc. 'N/A' if none used.): _____

DATE OF BIRTH: 01/01/1960 **RACE:** _____

SOCIAL SECURITY #: 123-45-6789 **GENDER:** ☒ *Male* ☐ *Female*

CURRENT ADDRESS: 123 S 5th St

CITY, STATE, ZIP: SomeCity, KS 11111

PHONE: 555-222-1111 **EMAIL:** _____

SIGNATURE: *Jim Smith* **DATE:** *09/01/2019*

DCF ONLY:

MATCH		CLEARED
This applicant is listed in the Child Abuse/Neglect Central Registry. *Per KSA 65-504 and 65-516 this person prohibited from working, residing, or volunteering in a licensed child care home or facility.* (see attached document for more info.)		

Participant Name	Employer Name	Employee Name
John Doe	John Doe	Jim Smith

KS WORK UnitedHealthcare Criminal Background Check Application

The KS WORK UnitedHealthcare program requires a criminal background check on all employees. By signing this form, the Personal Assistant (PA)/employee gives PPL consent to conduct the background checks listed below, and to share the results with the Employer, UnitedHealthcare, and to others as permitted by UnitedHealthcare.

KS WORK UHC program, through PPL will perform the following background checks.

1. The Kansas Bureau of Investigation (KBI) Offender Registry ("KBI Check")
2. The Kansas Department of Social and Rehabilitation Services Adult Abuse, Neglect, Exploitation Central Registry
3. A County Criminal Record Search and U.S. Criminal Records Indicator Search using HireRight Background Screening
4. The Kansas Department of Social and Rehabilitation Services Kansas Child Abuse and Neglect Central Registry
5. Kansas Nurse Aid Registry
6. KDADS Health Occupations Credentialing
7. Motor Vehicle Screen ***PA's Driver's License Number** K00-44-3333

UnitedHealthcare and the participant/employer reserve the right to disqualify a person from employment based on the results of this request and based on any information they become aware of in relation to Medicaid fraud or financial abuse.

As a prospective PA/employee, I authorize KS WORK UnitedHealthcare program, through PPL, to submit my information and facilitate the background, checks listed above, on me. I am providing the information to support the performance of these checks. I certify that the information is correct to the best of my knowledge. I authorize the KS WORK UnitedHealthcare program, through PPL, to share the results of these checks with the participant/employer for whom I perform services, with UnitedHealthcare, and as authorized by UnitedHealthcare.

Participant/Employer Signature:	Participant ID #:	Date:
John Doe	123456	*09/01/2019*
PA/Employee Signature:	PA/Employee ID #:	Date:
Jim Smith	654321	*09/01/2019*

Send completed and signed form to the KS WORK program, through PPL via fax, email, or mail

Fax*	**Email***	**Mail**
1-855-344-5443	pplks-unitedhealthcare@pcgus.com	KS WORK UHC Public Partnerships LLC One Cabot Road, Ste. 102 Medford, MA 02155
***FOR FASTEST PROCESSING, EMAIL OR FAX FORMS**		