Ability Care Partners, Inc.
PCA Choice Provider

5701 Kentucky Ave. N., Suite #119 - Minneapolis, MN 55428
Voice: 612-868-3270 Fax: 612-395-5593
Email: info@abilitycare.com
Web Site: www.abilitycare.com

2016 PCA Employee Information Change Forms

PCAs are required to complete enclosed forms when personal information changes. The forms vary depending on the type of information that has changed. Review the status changes below to determine what forms you will need to submit to us.

PCA Change of Address:

- **MHCP Individual PCA Information Form - DHS-5176 (1 page)**

PCA Name Change:

- **MHCP Individual PCA Information Form - DHS-5176 (1 page)**
  - **Must include copies of court documentation, marriage license or divorce decree, updated current drivers license or social security number, etc.**
- **I-9 Form (Consumer Must Verify Copies of Employee's Acceptable Documents)**
- **W-4 Form (We encourage you to consult a Tax Advisor before changing exemptions)**
- **Paychex Direct Deposit Enrollment/Change Form (Include voided check for direct deposit)**
- **Review & Sign "PCA Choice Service Agreement"**

Payroll / Direct Deposit Changes:

- **Paychex Direct Deposit Enrollment/Change Form (Include voided check for direct deposit)**

Tax Withholding Status Changes:

- **W-4 Form**
  We encourage you to consult a Tax Advisor before changing exemptions. It is your responsibility to manage your tax withholding status. We cannot offer any tax advice.

Please fax the information to 612-395-5593 as well as mail original documents to our office address.

Payroll changes take effect the next pay period if the form is completed at least 2 business days before timesheets are due.

Important Reminders:

- **We do not have regular office hours.**
  Our daily operations are mostly conducted remotely via home office.
- **Any visits to the office must be scheduled ahead of time.**
- **You may drop-off forms in our office door mail slot (Email or call us to notify us of the drop-off).**
- **When calling, please leave a voicemail and we will get back to you within 2 business days in most cases.**
- **We check and respond to email multiple times per day, this is the best way to reach us with any questions!**

Minnesota Department of **Human Services**

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DHS-5716-ENG 5-13

Minnesota Health Care Programs (MHCP)

Individual PCA Information Change Form

Complete at least all **bolded** fields to update an individual PCA record. We will return incomplete forms to you. Type or print clearly. Fax completed form to 651-431-7462. NOTE: PCA affiliation with an additional agency requires completion and submission of Individual PCA Enrollment Application (DHS-4469) and Individual PCA Provider Agreement (DHS-4611).

PCA Agency Information

AGENCY NAME		**AGENCY NPI/UMPI**
ABILITY CARE PARTNERS INC.		1629249826
END AFFILIATION (Agency Signature Required) LAST DATE WORKED: __ __/__ __/__ __ __ __ FIRST DATE NO LONGER EMPLOYED: __ __/__ __/__ __ __ __		COMPLETION OF PCA TRAINING (Agency or PCA signature required) DATE PASSED __ __/__ __/__ __ __ __ CERTIFICATION NUMBER _____
AGENCY FAX NUMBER	**AGENCY PERSONNEL COMPLETING FORM**	AUTHORIZED AGENCY SIGNATURE
612-395-5593	JOSHUA HOLLER	Joshua D Holler

☐ Change PCA Name – A name change request must be accompanied by court documentation, marriage license or divorce decree, current updated driver's license or social security number, etc. (Agency or PCA signature required)

☐ Change PCA Address (Agency or PCA signature required)

☐ Term PCA (PCA signature not required) – Receiving PCA services currently
EFFECTIVE DATE __ __/__ __/__ __ __ __

☐ Term PCA (PCA signature not required) – PCA is on the Office of Inspector General OIG Exclusions list
EFFECTIVE DATE __ __/__ __/__ __ __ __

Individual PCA Information

PREVIOUS NAME (if applicable)	**CURRENT LEGAL NAME (FIRST)**	**FULL MIDDLE**	**LAST**
ADDRESS (RESIDENTIAL ADDRESS ONLY - DO NOT ENTER A PO BOX)			**NPI/UMPI**
CITY		**STATE**	**ZIP CODE**
COUNTY OF RESIDENCE		**SOCIAL SECURITY NUMBER**	**DATE OF BIRTH** __ __/__ __/__ __ __ __

Group Disaffiliation Information

You may disaffiliate the above-named PCA with other agencies you own.

Organization/Agency Name	Agency NPI/UMPI	Study ID

Individual PCA Provider Statement

I have reviewed and certify the information provided above is true and correct to the best of my knowledge. **I will notify the Minnesota Department of Human Services Provider Enrollment of any additions and/or changes to the information.**

NAME OF PCA (PLEASE PRINT OR TYPE)	**SIGNATURE OF PCA**	**DATE SIGNED**
		__ __/__ __/__ __ __ __

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Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

►START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire 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 Names Used *(if any)*

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

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

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

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

☐ A citizen of the United States

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

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

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

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date *(mm/dd/yyyy):*

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

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

Signature of Preparer or Translator:	Date *(mm/dd/yyyy):*

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

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

STOP ***Employer Completes Next Page*** STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

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

List A Examples: U.S. Passport; Permanent Resident or Alien Registration Card; Foreign Passport

List B Examples: Driver's License; State I.D.; School I.D. with Photo; Voter's Registration Card; U.S. Military Card

List C Examples: Social Security Number/Card (Valid for work); Original or certified copy of birth certificate issued by state/county/municipal/territory; Cert. of birth abroad issued by Dept. of State FS-545; Employment Authorization Document.

3-D Barcode
Do Not Write in This Space

Certification

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

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

Signature of Employer or Authorized Representative	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
		CLIENT DIRECT SUPERVISOR

Last Name *(Family Name)*	First Name *(Given Name)*	Employer's Business or Organization Name
		ABILITY CARE PARTNERS INC.

Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	Zip Code
5701 KENTUCKY AVE N #119	MINNEAPOLIS	MN	55428

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

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

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current 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:	Date *(mm/dd/yyyy):*	Print 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 Birth Abroad issued by the Department of State (Form FS-545)
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.** Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
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.** Native American tribal document
		6. Military dependent's ID card		**6.** U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		**8.** Employment authorization document issued by the Department of Homeland Security
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		**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		

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.

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Form W-4 (2016)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2016 expires February 15, 2017. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2016. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	**A** _____
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	**B** _____
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	**C** _____
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	**D** _____
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	**E** _____
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	**F** _____
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child	**G** _____
H	Add lines A through G and enter total here. (**Note:** This may be different from the number of exemptions you claim on your tax return.) ►	**H** _____

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Separate here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4**
Department of the Treasury
Internal Revenue Service

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 IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2016

1 Your first name and middle initial / Last name		**2 Your social security number**
Home address (number and street or rural route)	**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code	**4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ► ☐	
5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)		**5**
6 Additional amount, if any, you want withheld from each paycheck		**6** $
7 I claim exemption from withholding for 2016, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here		**7**

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.

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

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number (EIN)
ABILITY CARE PARTNERS INC. 5701 KENTUCKY AVE N #119, CRYSTAL, MN 55428		

Deductions and Adjustments Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1 Enter an estimate of your 2016 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1952) of your income, and miscellaneous deductions. For 2016, you may have to reduce your itemized deductions if your income is over $311,300 and you are married filing jointly or are a qualifying widow(er); $285,350 if you are head of household; $259,400 if you are single and not head of household or a qualifying widow(er); or $155,650 if you are married filing separately. See Pub. 505 for details . . . **1** $

2 Enter: { $12,600 if married filing jointly or qualifying widow(er) / $9,300 if head of household / $6,300 if single or married filing separately } . . . . . **2** $

3 **Subtract** line 2 from line 1. If zero or less, enter "-0-" . . . . . **3** $

4 Enter an estimate of your 2016 adjustments to income and any additional standard deduction (see Pub. 505) **4** $

5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2016 Form W-4* worksheet in Pub. 505.) . . . . . **5** $

6 Enter an estimate of your 2016 nonwage income (such as dividends or interest) . . . . . **6** $

7 **Subtract** line 6 from line 5. If zero or less, enter "-0-" . . . . . **7** $

8 **Divide** the amount on line 7 by $4,050 and enter the result here. Drop any fraction **8**

9 Enter the number from the **Personal Allowances Worksheet,** line H, page 1 . . . . . **9**

10 **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 **10**

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note: Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) **1**

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3" **2**

3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet **3**

Note: If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4 Enter the number from line 2 of this worksheet **4**

5 Enter the number from line 1 of this worksheet **5**

6 **Subtract** line 5 from line 4 . . . . . **6**

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . . **7** $

8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . **8** $

9 Divide line 8 by the number of pay periods remaining in 2016. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2016. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck **9** $

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $6,000	0	$0 - $9,000	0
6,001 - 14,000	1	9,001 - 17,000	1
14,001 - 25,000	2	17,001 - 26,000	2
25,001 - 27,000	3	26,001 - 34,000	3
27,001 - 35,000	4	34,001 - 44,000	4
35,001 - 44,000	5	44,001 - 75,000	5
44,001 - 55,000	6	75,001 - 85,000	6
55,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 100,000	10	140,001 and over	10
100,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $75,000	$610	$0 - $38,000	$610
75,001 - 135,000	1,010	38,001 - 85,000	1,010
135,001 - 205,000	1,130	85,001 - 185,000	1,130
205,001 - 360,000	1,340	185,001 - 400,000	1,340
360,001 - 405,000	1,420	400,001 and over	1,600
405,001 and over	1,600		

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 who claims no withholding allowances; 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.

Ability Care Partners, Inc.
PCA Choice Provider

5701 Kentucky Ave. N., Suite #119 - Minneapolis, MN 55428
Voice: 612-868-3270 Fax: 612-395-5593
Email: info@abilitycare.com
Web Site: www.abilitycare.com

Payroll Information

All employees must register for our direct deposit payroll which is provided by Paychex. Please complete the **Paychex Direct Deposit Enrollment/Change Form** (enclosed). We no longer offer paper payroll checks.

Complete the form with your bank account information and required account number documentation (voided check or bank letter) and send it to us by fax or email.

If you do not have a bank account, you will be required to setup direct deposit to a reloadable debit card. You can obtain these at most major retailers such as Walgreens, Walmart, CVS, Target, etc. If you would like to order a reloadable card from our payroll provider, there is a **Skylight PayOptions Program** brochure on our web site.

Once you have registered for a reloadable debit card, you will need to login to the debit card web site and print a direct deposit form to fax or email this to us.

If you have any questions or concerns in completing the forms, contact us via email or telephone.

Online Paystubs via Paychex Flex

Effective July 1, 2015 all employees will be able to access their paystubs online 24/7 via computer or smartphone through the **https://myapps.paychex.com** web site and the **Paychex Flex app** (iOS & Android). Instructions will be published on our company web site. Overall the registration to access the paystubs is very easy and takes only a few minutes by simply registering your personal information to create a Paychex Flex user account (you must register on their web site before using the phone/tablet apps). If you need a copy of your paystub and do not have internet access, please contact us to make arrangements to get copies. **Beginning with the August 14th, 2015 payroll we will no longer mail paystubs.**

Employee Benefits & Paid Time-Off

A. **Paid Time-Off** - ***ACP* PCA Choice employees will begin accruing Paid Time-Off (PTO) beginning July 1, 2015 as required by the collective bargaining agreement between the State of Minnesota and the SEIU Healthcare Minnesota (PCA Union)**. PCA Choice employees will earn 1 hour of PTO for every 52 hours worked. Once an employee has worked 600 hours (after July 1, 2015) they will be eligible to redeem PTO pay by submitting a PTO Request Form to their Consumer for advance approval and eventual processing on the applicable payroll. ***Employees cannot take PTO without approval of their Consumer.***

B. **Health & Dental Insurance** - ACP currently does not pay for health/dental insurance. If required by the government, *ACP* will allow eligible employees to use pre-tax dollars to be applied for employee paid health plan benefits. ***ACP* currently does not have enough "Full Time Equivalent" employees to be required to offer health insurance under the Affordable Care Act (ACA). When this changes, employees will be required to complete paperwork to meet the ACA requirements.**

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PAYCHEX

Direct Deposit Enrollment/Change Form

Company Name Ability Care Partners Inc. **Client Number**_____

Employee/Worker Name_____ **Employee/Worker Number**_____

EMPLOYEE/WORKER: Retain a copy of this form for your records. Return the original to your employer.

EMPLOYERS: Return this form to your local Paychex office. For clients using on-line services, please retain a copy of this document for your records.

COMPLETE TO ENROLL / ADD / CHANGE BANK ACCOUNTS – *PLEASE PRINT IN BLACK/BLUE INK ONLY*

Type of Account	Routing/Transit Number	Checking/Savings Account Number*	Financial Institution ("Bank") Name	I wish to deposit (check one):
☐ Checking ☐ Savings				☐ _____ % of Net ☐ Specific Dollar Amount $_____ .00 ☐ Remainder of Net Pay
☐ Checking ☐ Savings				☐ _____ % of Net ☐ Specific Dollar Amount $_____ .00 ☐ Remainder of Net Pay

One of the following is required to process this enrollment (check one):

☐ Voided check with name imprinted (no starter checks)

☐ Deposit slip (only accepted if the verbiage "ACH R/T" appears before the routing number)

☐ Bank letter or specification sheet (the signature of your local bank representative MUST be included)

☐ Other Bank Documentation from your Financial Institution – If this box is checked the employer must sign this confirmation:
I confirm that the above named employee/worker has added or changed a bank account for direct deposit transactions processed by Paychex, Inc.

Employer Signature:_____ **Date** _____

***Certain accounts may have restrictions on deposits and withdrawals. Check with your bank for more information specific to your account.**

COMPLETE IF CHANGING EXISTING DEPOSIT AMOUNTS – *PLEASE PRINT IN BLACK/BLUE INK ONLY*

Routing/Transit Number	Checking/Savings Account Number*	Financial Institution ("Bank") Name	Change My Deposit Amount to:
			☐ From _____% to____% of Net ☐ From $ _____.00 To $_____.00 ☐ Remainder of Net Pay
			☐ From _____% to____% of Net ☐ From $ _____.00 To $_____.00 ☐ Remainder of Net Pay

EMPLOYEE/WORKER CONFIRMATION STATEMENT

PLEASE SIGN IN BLACK/BLUE INK ONLY

I authorize my employer to deposit my wages/salary into the bank accounts specified above. I agree that direct deposit transactions I authorize comply with all applicable law. My signature below indicates that I am agreeing that I am either the accountholder or have the authority of the accountholder to authorize my employer to make direct deposits into the named account.

Employee/Worker Signature _____ **Date** _____

Note: Digital or Electronic Signatures are **not** acceptable.

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Ability Care Partners, Inc.
PCA Choice Provider

5701 Kentucky Ave. N., Suite #119 - Minneapolis, MN 55428
Voice: 612-868-3270 Fax: 612-395-5593
Email: info@abilitycare.com
Web Site: www.abilitycare.com

PCA EMPLOYMENT AGREEMENT

This agreement is entered into effective on _____/_____/_____ by and between the following:

The parties entering this agreement are hereby identified as; **Ability Care Partners Inc.**, an enrolled PCA Choice Provider with the state of Minnesota, hereby referred to as "Ability Care Partners" or "ACP";

"Consumer"_____, and;
(First Name) (Last Name)

"Responsible Party"_____, and;
**If applicable* (First Name) (Last Name)

"Personal Care Assistant *(PCA)*"_____, and;
(First Name) (Last Name)

We enter into this employment agreement to provide Personal Care Assistant services for the Consumer.

Consumer (or Responsible Party) Roles and Responsibilities

As a consumer using Ability Care Partners as my PCA Choice provider, I, or my responsible party (if applicable), agree to the following responsibilities:

1. Accept responsibility for my health and safety by finding staff or supports that ensure my needs are met.
2. Develop and maintain a care plan with the QP that details my cares and health/safety needs based on my physician's orders and the public health nurse assessment.
3. Recruit, interview, hire and provide training for my own PCA staff.
4. Review, sign and submit the employment application for my PCAs to *ACP*. I will verify the PCA's employment eligibility on form I-9 by reviewing their "acceptable documents" (i.e. ID, SSN, Passport, Work Authorization)
5. Not allow my PCA to work any shifts until they have passed a criminal background check, facilitated by *ACP* to ensure they have no prior criminal record that disqualifies them from being employed as a PCA. *ACP* will notify the consumer with the date the PCA is officially eligible to start working. No exceptions.
6. As a joint employer with *ACP*, sign a written agreement with each of my PCAs before I receive their services.
7. Schedule my PCA staff to meet the needs specified in my care plan and develop a Back-up Support Plan that I will follow in case a regularly scheduled PCA is unable to fulfill their duties as scheduled.
8. Provide information, orientation and training to my PCA staff including safety and emergency procedures in their applicable service/working environment.
9. Provide and maintain my emergency contact information and any Health Care Directives (if applicable), to my PCA staff for my own safety. I will also recommend to my PCA that they provide their emergency contact information to utilize in the event of emergency while on the job.
10. **Manage the use of my PCA allocated hours/units to ensure I do not use more than allocated in my Service Authorization (SA). I will monitor my use of flexible PCA units, and if I run out of units before my services authorization expires I understand my care services will be suspended until the new SA starts or I will personally pay for my continued care. *ACP* will provide "Service Hours Used" reports upon request.**
11. **Communicate with my PCA about their total hours worked with ALL PCA agencies, to ensure they do not go over the 275 hour per month rule.**
12. Abide by Department of Labor regulations and *ACP* policies regarding overtime.
13. Monitor, ensure accuracy, and verify time worked by my PCAs.
14. Submit complete and accurate timesheets to *ACP* as outlined in the company policies and procedures.
15. Notify *ACP* of my in-patient treatment or hospitalization dates throughout our service agreement.

16. Notify the county public health nurse, waiver caseworker or other appropriate individual when it is time for a reassessment of my need for PCA services or if there is a change in condition or change in the level of services that I need. I will inform them of my intent to use a PCA Choice provider.
17. I will notify *ACP* prior to terminating any PCAs and inform them of the effective date. I will notify *ACP* if assistance is needed in terminating an employee.
18. Comply with company policies and procedures and make sure all of my PCAs receive any updated policies.

Provider Roles and Responsibilities

As your PCA Choice provider, *ACP* agrees to perform the following responsibilities:

1. Enroll and meet all standards as a PCA Choice Provider with the Minnesota Department of Human Services, including passing a criminal background study.
2. As a joint employer with the consumer (or RP), enter into a written agreement with each PCA before services are provided to the consumer.
3. Process a DHS criminal background study through the BCA for all PCA and QP applicants.
4. Submit billing to DHS / MA or other applicable health insurance plan for PCA services rendered.
5. Pay the PCAs at the rate specified in the "PCA Wage Statement".
6. Issue paychecks, withhold and remit all applicable state and federal taxes from PCAs paychecks.
7. Arrange for and pay the employers share of payroll taxes, unemployment insurance, worker's compensation insurance and liability insurance for all staff.
8. Keep records of the hours worked by PCAs as submitted by the consumer or responsible party.
9. Assist consumer in terminating PCAs, if requested to do so by the consumer.
10. Assess an administrative fee for PCA provider services in each consumer's "PCA Service Rate Agreement"
11. Ensure arm's length transactions without undue influence or coercion with the consumer, PCA or qualified professional.

Personal Care Assistant (PCA) Responsibilities

As a PCA employed by the consumer and *ACP*, I agree with the following statements and responsibilities:

1. **I have completed and passed the required Individualized Personal Care Assistant Training** offered through the MN –DHS. I will send *ACP* a copy of my certificate of completion before working as a PCA.
2. I am not a recipient of PCA services myself.
3. I am not the: responsible party of the consumer; spouse of the consumer, paid guardian of the consumer, parent or step parent of a minor child consumer (under 18 years old)
4. I will enter into a written agreement with the consumer and *ACP*, as joint employers.
5. I understand and agree that all employment with *ACP* and the consumer is "at-will" and can be ended by any of the parties, at any time, with or without reason.
6. I will complete all required forms and provide necessary information to *ACP*, including criminal background study release and my Individual PCA Provider ID number prior to providing services to the consumer.
7. **I must complete and pass a MN-DHS Criminal Background Study submitted through *ACP* (a requirement of eligibility to be a PCA), before working any shifts and submitting a timesheet for payroll.**
8. Until *ACP* notifies me (or the consumer) with my official start date, I understand I CANNOT report to work for the consumer under any circumstances. No exceptions.
9. I will obtain and maintain an active Individual PCA Provider ID (UMPI) number from MN-DHS. I agree to complete and submit updated PCA Enrollment forms to *ACP* any time my personal information changes (legal name, residential address, phone #, etc.)
10. I will obtain training from the consumer, RP or QP to ensure I can satisfactorily perform all responsibilities in the consumer's care plan. I agree to communicate with the consumer (or RP) directly, regarding any safety, health or training concerns.
11. **I agree to review the consumer's care plan and emergency procedures to orient myself to their care needs and only provide cares specified in this plan.**
12. I will provide and maintain my personal emergency contact information to the consumer (or RP).

13. I must work at scheduled times as determined by the consumer (or RP), notifying them of changes as early as possible to enact their Back-Up Staff Plan.
14. I will provide personal care services to the consumer as specified in their care plan, following written and verbal directions from the consumer (or RP).
15. I will inform the consumer about all visible bodily changes that may need medical attention.
16. I will not violate the Home Care Bill of Rights, Maltreatment of Vulnerable Adults Act, Maltreatment of Minors Act, nor engage in any other unsafe acts or illegal conduct including PCA service fraud. I understand I am a Mandated Reporter of any abuse or neglect and will report it to *ACP* and the applicable county's Common Entry Point. *(See Policies & Procedures)*
17. I will focus on job related activities, maintain respect for professional boundaries, perform duties in an ethical matter while preserving and respecting the rights and dignity of the consumer.
18. I will keep the consumer's personal life as confidential, respect their personal property and adhere to *ACP* data privacy policies.
19. I agree to not bring any children or friends to work and that I will not provide care to *anyone* other than the consumer.
20. I agree to be present when working with the consumer in their service environment, and leave only when the shift is completed.
21. I understand and will follow safety and emergency procedures in my applicable service/working environment and work to identify my safety needs and along with those of the consumer.
22. I am required to accurately document time worked for consumer by promptly completing and signing time sheets. I will complete my time entry and initial cares provided on the agency timesheet after each shift.
23. I will communicate with the consumer to ensure submission of my timesheet to *ACP* by the company deadline and follow policies and procedures for completing timesheets. I may also elect to submit my own timesheet (completed and signed by all parties) to *ACP* by notifying them of my request in writing.
24. **I understand that the consumer's Medical Assistance (MA) funding pays for their PCA services and that if the consumer becomes ineligible for MA, all PCA services and my employment will be suspended until the consumer is eligible again.** *ACP* will notify the consumer of any lapses in MA eligibility and the consumer will notify me.
25. **I understand that MN-DHS issues a Service Authorization (SA) that determines the dates and amount of PCA hours the consumer receives. If the SA ends or is exhausted early (run out of hours), PCA services and my employment will be suspended effective on the date of ineligibility or exhaustion of hours and I will not be allowed to work as a result of this.** The consumer will be notified by *ACP* staff and the consumer will notify me that services have stopped. No timesheets shall be submitted until services are re-authorized and *ACP* informs the consumer that my employment has been re-instated.
26. I understand that I cannot submit timesheets for any PCA services when the consumer is receiving any type of in-patient treatment, in-patient hospitalization or nursing home services.
27. **I agree to notify *ACP* in writing when I work for another PCA agency.**
28. **I agree to monitor my total hours worked with all agencies/consumers actively I am employed with.**
29. **I fully understand that PCAs cannot work more than 275 hours per month.** <u>If working for multiple consumers or agencies I understand my combined totals cannot exceed these limits.</u> If I am found to have violated this policy, I will be required to return wages paid or have future wages garnished due to exceeding the 275 hour rule.
30. **I understand and agree that *ACP* reserves the right to collect (take-back) wages of any PCA due to ineligibility, erroneous payment or overpayment.** This includes: PCA being over 275 hours per month, consumer being out of service hours authorized, consumer not being eligible for services, PCA disqualifications, non-covered cares, fraudulent activity, payroll error or over-payment (regardless of who is at fault for the error).

31. **I agree that *ACP* can take-back wages deemed ineligible, erroneous or over-paid, and will notify me in writing of the ineligible service hours or over-payment amount to be collected.** The first method of collection is withholding from the PCAs next payroll payment. If the next payroll amount is insufficient to cover the outstanding balance due, *ACP* will continue to withhold from the next payroll(s). If the PCAs employment is interrupted or discontinued, an invoice will be mailed to them with repayment instructions. Any non-repayment over 60 days past due will accrue interest charges (the maximum allowed by law) and may result in suspension, termination, civil lawsuit and reporting to a collections agency.
32. **I will report any service/work related injuries or accidents to the consumer (or responsible party) AND *ACP* within 24 hours of the incident**, as outlined in the company policies and procedures.
33. I agree that when necessary or requested, I will meet with the Qualified Professional (QP) within a maximum of 14 calendar days from the date the QP requested or be subject to suspension until the meeting is conducted.
34. **I agree that if my employment is resigned by myself or that if I am terminated, I will submit my fully completed timesheet to *ACP* and will be paid at the next scheduled payroll date.**
35. I will update *ACP* staff anytime my status changes (legal name, address, phone #, tax exemptions, etc.).
36. **I have read, understood and will comply with current *ACP* Policies & Procedures. *(ACP will publish any changes to the Policies & Procedures which are available on our web site.)***

Grievance Procedures

ACP asks that if any PCA has any concerns they shall bring them up to the consumer first. Consumers are encouraged to address issues directly with their PCA. If the PCA/consumer is unable to resolve the issue, they may bring the issue to the *ACP* Program Coordinator and file a Grievance Report (available on our web site). *ACP* is committed to providing a timely response to concerns brought forward. Our formal grievance procedures are outlined in the company policies and procedures.

Regulatory Compliance

All parties are responsible for complying with all rules and regulations related to the PCA Choice program, including but not limited to: Maltreatment of Vulnerable Adults Act, Maltreatment of Minors Act, Data Privacy, HIPAA, MN-DHS PCA Program Regulations and Department of Labor Laws.

Cancellation and Amendments

PCAs may resign their employment with the consumer and Ability Care Partners at any time, for any or no reason, and the consumer and Ability Care Partners reserve the same right regarding discontinuation of signed individual's employment. If the PCA elects to resign, they agree to provide a minimum two weeks written notice to be eligible for future rehire with *ACP*. Any party may choose to cancel or amend this agreement in writing at any time.

Signed _____ _____

Consumer (or Responsible Party) **Date**

Signed _____ _____

Personal Care Assistant (PCA) **Date**

Signed _____ _____

Provider (Ability Care Partners Inc.) **Date**

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Ability Care Partners, Inc.
PCA Choice Provider

5701 Kentucky Ave. N., Suite #119 - Minneapolis, MN 55428
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Email: info@abilitycare.com
Web Site: www.abilitycare.com

PCA Wage Statement

Ability Care Partners offers a fair and competitive wage structure that meets or exceeds the Legislative requirement that at least 72.5% of the current reimbursement rate must be allocated to PCAs total compensation.

DHS Policy states: *Effective 8/01/10, "wages and benefits" means wages and salaries, the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, mileage reimbursement, health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance and contributions to employee retirement accounts. This provides clarification on what is included in the minimum of 72.5% of the revenue generated by the MA rate for PCA services that must be used for employee PCA wages and benefits, as required in Minnesota Statute 256B.0659, Subd. 20. (Ch 352, Art 2, Sec 2).*

PCA Starting Wage Structure (Effective January 1, 2015) - For individuals with:

- No prior work experience in health care - $11.00 / hour.
- Prior health care work experience and/or documented training - $11.75 / hour.
- Any PCA's who want to be eligible to work over-time (only allowed with written authorization from *ACP*) - $11.00 / hour.

Competitive Wage Match - *ACP* reserves the right to offer a competitive wage match or competitive wage increase to any PCA. *ACP* may request proof in the form of an original pay stub issued by the competing PCA agency.

Wage Changes & Raises - *ACP* determines the rate of pay for all PCAs, in accordance with DHS policy regarding reimbursement rates. Any wage reductions or raises are based on the result of reimbursement rate changes issued by the Minnesota State legislature.

PCA First Name:_____ **Last Name:**_____

Effective Date: _____

Hourly Rate for Personal Care Assistant named above: $ _____
Rate remains in effect until further notice and supersede any previously published rates.

Benefits and Rates for PCAs

ACP does not offer any benefits at this time. *ACP* does not pay for health/dental insurance, vacation time, sick time, paid time off or any other employee benefits. If required by the government, *ACP* will allow eligible employees to use pre-tax dollars to be applied for employee paid health plan benefits.

X_____ _____
Consumer (or Responsible Party) Signature **Date**

X_____ _____
PCA Signature **Date**

X_____ _____
Provider (Ability Care Partners) Signature **Date**