# New Hire Packet

*Payroll/FEA*

Submit completed forms to PICS Human Resources via email, mail, or fax:

**Email** hr@picsmn.org
**Mail** 1605 Eustis St, St. Paul, MN 55108
**Fax** 651-967-5061

Once employment requirements are completed, PICS Human Resources will email or mail Date of Hire notice to Representative and Worker. Please note that any hours worked prior to this date cannot be paid.

| PICS | Worker | Participant | Representative | Participant Employer |
|---|---|---|---|---|
| Processes Payroll | Provides Direct Support | Receives Services | Supervisor | Business Holder |

Worker Name: _____

Participant Name: _____

Representative Name: _____

Program Type: ☐ CDCS ☒ CSG

| Completed | Forms for Worker |
|---|---|
| ☐ | Contact Information Form |
| ☐ | Individual Support Worker Enrollment Application |
| ☐ | Provider Agreement |
| ☐ | Background Study Authorization *(Optional for CSG. Must include copy of photo ID)* |
| ☐ | Personnel File Notification |
| ☐ | Federal W-4 Form |
| ☐ | State W-4 Form |
| ☐ | Payment Options Form *(Must include bank document for direct deposit)* |
| ☐ | Self-Identification Form *(Voluntary)* |

| Completed | Forms for Worker and Representative |
|---|---|
| ☐ | I-9 Form |
| ☐ | Employment Agreement |

| *Completed* | *Required for Representative's Records* |
|---|---|
| ☐ | Employment Application |
| ☐ | Job Description |
| ☐ | Training as Identified by Representative |



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# Contact Information Form

| PRIMARY CONTACT INFORMATION | | | |
|---|---|---|---|
| ROLE (select all that apply): ☐ Representative ☐ Worker | | | |
| FULL NAME | HOME PHONE | | |
| EMAIL | CELL PHONE | | |
| ADDRESS | CITY | STATE | ZIP CODE |

**I prefer to receive communications the following way: (select one)**

☐ I prefer to receive **electronic communications** from PICS. I allow PICS to communicate with me via email.

☐ I prefer to receive **U.S. mail communications** from PICS. *Please keep in mind there may be delays outside of PICS control when receiving documents and communications via mail.*

**Acknowledgements**

- I acknowledge that if changes or updates to my contact information need to be made, I will notify PICS and will complete a Status Change Form.

_____ _____

*Worker Signature* *Date*

**Questions? Contact us.**
hr@picsmn.org **or 651.967.5064**



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DEPARTMENT OF HUMAN SERVICES

DHS-4469A-ENG 11-21

MINNESOTA HEALTH CARE PROGRAMS (MHCP)

# Individual Direct Support Worker Enrollment Application (Consumer Directed Community Supports [CDCS] and Consumer Support Grant [CSG])

Complete all fields to enroll an individual direct support worker (DSW). Complete this form, print and then submit to Minnesota Health Care Programs (MHCP). An incomplete form will delay processing of this application. Check one of the following:

◯ New Hire (requires new background study for CDCS only)

◯ Rehire (requires new background study for CDCS only) PREVIOUS EMPLOYMENT END DATE: _____

## Individual DSW Information

| PROVIDER TYPE<br>**38 - Individual (COS 021 & 105)** | **SOCIAL SECURITY NUMBER** | **NPI OR UMPI (IF REQUESTING REINSTATEMENT** |
|---|---|---|
| LEGAL NAME (FIRST) | FULL MIDDLE NAME | LAST NAME |
| DATE OF BIRTH | PHONE NUMBER | |

**If individual has been working in a different support position or was enrolled for MCO claims only, has the individual been continuously employed by your agency?** ◯ Yes ◯ No

## Individual DSW Background Study Information

PROGRAM TYPE
**CDCS (C4) (you must submit and have the individual pass a background check)**

| BGS number (required only for CDCS) | Application number | Facility ID |
|---|---|---|
| | | |
| | | |
| | | |

## Individual DSW Address

| **STREET ADDRESS (RESIDENTIAL ADDRESS ONLY – DO NOT ENTER A PO BOX** | | | |
|---|---|---|---|
| **CITY** | **STATE** | **ZIP CODE** | **COUNTY OF RESIDENCE** |

## Individual DSW Training Information

Did this worker take Qualified Enhanced Rate training? (an optional training) ◯ Yes ◯ No

| OPTIONAL TRAINING COMPLETION DATE | OPTIONAL TRAINING EXPIRATION DATE (if applicable) |
|---|---|

## Individual DSW Provider Statement

I have reviewed and certify the information provided on this form is true and correct to the best of my knowledge. **I will notify MHCP Provider Eligibility and Compliance of any additions or changes to the information.**

By signing this form, I acknowledge I have read and understand the Data Privacy Notice (DHS-6287) (PDF). I also authorize MHCP to use the information you collect about me according to the Privacy Notice.

Check if signing electronically:

☐ I am signing this form electronically. My name as typed in the signature field is my legally binding signature. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (Minnesota Statutes 325L.02(h), 325L.05 and 325L.08)

| NAME OF INDIVIDUAL SUPPORT WORKER (PRINT OR TYPE) | SIGNATURE OF INDIVIDUAL SUPPORT WORKER | DATE SIGNED |
|---|---|---|
| | | |

## Organization Affiliation Information

You may affiliate or enroll the individual DSW named on this form with another Fiscal Support Entity (FSE) or Financial Management Services (FMS) agency or location you directly own without completing another application and agreement. Do you want to affiliate this individual DSW with any other agency or location you own?

◯ Yes ◉ No

Check if signing electronically:

■ I am signing this form electronically. My name as typed in the signature field is my legally binding signature. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (Minnesota Statutes 325L.02(h), 325L.05 and 325L.08)

| ORGANIZATION NAME | FACILITY NPI OR UMPI | STUDY ID |
|---|---|---|
| Partners in Community Supports | A744938000 | |

| ORGANIZATION PERSONNEL COMPLETING FORM | ORGANIZATION PERSONNEL SIGNATURE | ORGANIZATION FAX NUMBER |
|---|---|---|
| | | 651-967-5061 |

## Next Steps

Read, sign and date the Individual Support Worker (CDCS, CSG, PCA, CFSS) Provider Agreement (DHS-4611) (PDF), and return it with this application.

Upload the application and agreement to the MPSE portal or fax to 651-431-7465. MHCP will process only complete requests.

Minnesota Department of **Human Services**

*Minnesota Health Care Programs (MHCP)*

# Data Privacy Notice

This notice describes how MHCP may use and disclose private information about you, and is provided as required by the Minnesota Government Data Practices Act and the Federal Privacy Act of 1974.

## Why do we ask for this information?

MHCP uses this information to enroll and maintain enrollment for you or your organization as a provider in MHCP and to identify individuals for the purposes of program integrity. Federal regulations require that any person or entity that enrolls as an MHCP provider discloses full and complete information as to the identity of each person with an ownership or control interest in the provider (42 CFR 455 subp. B).

## Do you have to answer the questions we ask?

Yes, completing and submitting these forms is a condition of participation in MHCP. Providers who do not complete these forms will not be enrolled, reenrolled or allowed to continue enrollment as a participating provider in MHCP.

## Why do we ask for Social Security Numbers (SSNs)?

Federal law allows MHCP to collect SSNs to establish the identity of persons affected by its programs (42 USC 405(c)(2)(C)(i)). Federal law allows us to collect the SSN of each person with an ownership or control interest (42 USC 1320a-3(a)(1)(B)). This information is used to check for providers who may be on the OIG List of Excluded Providers and the General Services Administration Excluded Parties List System.

## With whom may we share information?

All government data is public, unless classified otherwise by statute. The information you provide that is not public data includes: SSNs, home addresses, and driver's license or state identification card numbers. We will share that information only as needed and as allowed or required by law. We may share that information with the following individuals or entities who need the information to do their jobs:

- MHCP employees who are trained to keep information confidential as needed to do their jobs
- Court officials, attorney general, and other state and federal law enforcement officials and fraud investigators
- Anyone else the law says we can or must give the information

## How will we use this information?

MHCP will use this information to:

- Enroll you as a provider in MHCP
- Tell you apart from other people with the same or similar name
- Check your information against databases maintained by the federal government of providers excluded from participating in federal health care programs
- Investigate instances of fraud and abuse against MHCP

## What are our responsibilities?

- We must protect the privacy of information according to the terms of this notice
- We may not use your information for reasons other than the reasons listed on this form or share your information with individuals and agencies other than those listed on this form unless you tell us in writing that we can

## What if you believe your privacy rights have been violated?

If you think MHCP has violated your privacy rights, send a written complaint to:

Minnesota Department of Human Services
Attn: Privacy Official
PO Box 64998
St. Paul, MN 55164-0998

DEPARTMENT OF HUMAN SERVICES

DHS-4611-ENG 2-21

MINNESOTA HEALTH CARE PROGRAMS (MHCP)

# Individual Support Worker (CDCS, CSG, PCA, CFSS) Provider Agreement

As a participating provider in Minnesota Health Care Programs (MHCP) administered by the Minnesota Department of Human Services (DHS), the provider agrees to:

A. Submit documentation to your affiliated agency that fully discloses the extent of services provided to individuals under these programs. The documentation must be legible and meet the requirements of Minnesota Statutes, section 256B.0659, subdivision 12 for all individual support workers in Consumer Directed Community Supports (CDCS), Consumer Support Grant (CSG), Personal Care Assistance (PCA), and Community First Services and Supports (CFSS) .

B. Furnish DHS, the secretary of the U.S. Department of Health and Human Services (DHHS), or the Minnesota Medicaid Fraud Control Unit with such information as it may request regarding payments claimed for services provided under these programs.

C. Comply with all federal and state statutes and rules relating to the delivery of services to individuals and to the submission of claims for such services.

D. Accept as payment in full, amounts paid in accordance with schedules established by DHS, except where payment by the member has been authorized by DHS.

E. Make full disclosure of any conviction(s) of program crimes as required by the Code of Federal Regulations, title 42, section 455.106.

F. Comply with all federal statutes, implementing regulations and guidance prohibiting discrimination on the basis of race, color, national origin, sex, age, religion and disability in any program or activity receiving federal financial assistance from DHHS; and to comply with the Minnesota Human Rights Act.

G. Provide services to members of the same scope and quality as would be provided to the general public, within MHCP guidelines.

H. Comply with the provisions of any fully executed agreement or addendum required by DHS, which is incorporated herein by reference.

I. Comply with the advance directive requirements as required by the Code of Federal Regulations, title 42, sections 489.100 and 417.436.

J. Properly handle and safeguard protected information collected, created, used, maintained, or disclosed on behalf of DHS. For purposes of this agreement, “protected information” means data subject to any of the following laws:

1. The Minnesota Government Data Practices Act (MGDPA), Minnesota Statutes, chapter 13, section 13.46 ("welfare data");
2. The Minnesota Health Records Act, sections 144.291 and 144.298;
3. The Health Insurance Portability and Accountability Act (“HIPAA”), including but not limited to the requirements of the Privacy Rule and the Security Regulations, the Code of Federal Regulations, title 45, parts 160 and 164, subparts A and E.
4. Federal law and regulations that govern the use and disclosure of substance abuse treatment records, the United States Code, title 42, section 290dd-2 and the Code of Federal Regulations, title 42, sections 2.1 to 2.67; and

Electronic initials accepted.

| DIRECT SUPPORT WORKER INITIALS |
|---|
| |

| NAME OF SUPPORT WORKER (TYPE OR PRINT) | UMPI |
|---|---|
| | |

5. Any other applicable state and federal statutes, rules, and regulations affecting the collection, storage, use and dissemination of private or confidential information.

K. Comply with the laws described in section J. This includes the provider:

1. Not using or further disclosing protected information created, collected, received, stored, used, maintained or disseminated in the course or performance of this agreement other than as necessary to perform its obligations under this Provider Agreement, or as required by law, either during the period of this agreement or after. See, respectively, the Code of Federal Regulations, title 45, sections 164.502(b) and 164.514(d), and Minnesota Statutes, 13.05 subdivision 3.
2. Using appropriate administrative, physical, and technical safeguards to prevent use or disclosure of the protected information other than as provided for by this agreement and to ensure the confidentiality, integrity, and availability of any electronic protected health information (PHI) that it creates, receives, maintains, or transmits on behalf of DHS. The provider will not transmit PHI over the Internet or any other unsecure or open communications channel unless such information is encrypted or otherwise safeguarded using procedures no less stringent than those described in the Code of Federal Regulations, title 45, section 164.312. If the provider stores or maintains PHI in encrypted form, the provider shall, at DHS' request, promptly provide DHS with the key or keys to decrypt such information. The provider shall not forward previously encrypted data to any other party, unless otherwise required by this agreement.
3. Mitigating, to the extent practicable, any harmful effects known to the provider of a use, disclosure, or breach of security with respect to protected information by the provider in violation of this agreement.

L. Agree that this agreement may be immediately terminated at the discretion of DHS if it determines that the provider has violated a material term of the agreement, including but not limited to, non-compliance by the provider with the HIPAA Privacy Rule and Security Standards. If termination is not feasible, DHS shall report the breach to the Secretary of DHHS.
Upon termination of this agreement, all of the protected information provided by DHS to the provider, or created or received by the provider on behalf of DHS, that the provider still maintains in any form, including information that is in the hands of subcontractors or agents of the provider, shall be destroyed or returned to DHS, and the provider shall retain no copies of such information. If it is infeasible to return or destroy the information, the provider shall provide DHS notification of the conditions that make return or destruction infeasible, and shall extend the protections of this agreement to such information and limit further use and disclosure of such information to those purposes that make return or destruction infeasible, for as long as the provider maintains the information.

M. Agree that any ambiguity in this agreement shall be resolved to permit DHS to comply with HIPAA, MDGPA, and other applicable state and federal statutes, rules, and regulations affecting the collection, storage, use and dissemination of private or confidential information and other state and federal laws and regulations.

Upon signature, this Provider Agreement supersedes and replaces all former Provider Agreements the provider has with DHS.

An individual applicant must personally sign the Provider Agreement. Sign and date this form, initial page 1, and return both page 1 and page 2 of this agreement.

Check if signing electronically:

☐ I am signing this form electronically. My name as typed in the signature field is my legally binding signature. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (Minnesota Statutes 325L.02(h), 325L.05 and 325L.08)

| NAME OF SUPPORT WORKER (TYPE OR PRINT) | TITLE<br>Direct Support Professional |
|---|---|
| SIGNATURE OF SUPPORT WORKER | DATE |

**Keep a copy of the Provider Agreement for your files and upload the original** form using the online Minnesota Provider Screening and Enrollment (MPSE) portal, or fax to 651-431-7465.

# Agreement Summary

As an individual support worker, you are providing health care services to individuals. We require your enrollment in the Minnesota Health Care Programs (MHCP) and to be listed as the rendering provider on the claim so that you are represented as the person who provided the services. Knowing that a qualified individual provided the service ensures the safety of the people that the Minnesota Department of Human Services (DHS) serves. It also allows DHS to perform auditing and tracking of services which protects against double-billing and other types of fraud. Before enrollment is approved, MHCP must make certain that:

1. There is no legal or other reason why you shouldn't provide these services,
2. You understand what is necessary to properly provide these services, and
3. You understand the need to protect the privacy of the people you care for.

To help ensure that each of these conditions is met, MHCP requires that you agree to the terms in the attached Provider Agreement. In general, this agreement requires that you:

A. Provide documents to your employer about the services you provide.

B. Provide documents to MHCP or other state and federal agencies related to the services you provide, when requested.

C. Comply with federal and state laws about the services you provide.

D. Accept payment made to your employer as payment in full for the services you provide. You cannot ask for nor accept additional payment from the member.

E. Disclose any criminal convictions you have related to Medicare, Medicaid, or title XX services.

F. Not discriminate against individuals because of their race, color, national origin, sex, age, religion or disability when you provide these services.

G. Provide the same quality of service to persons receiving public assistance as those who don't receive such assistance.

H. If you are enrolled to provide and bill for other services, you must continue to follow the requirements of the agreement you signed when you enrolled for those services. The terms of that agreement are different than the terms in the attached agreement.

I. Comply with federal requirements about advance directives. An advance directive is written instruction, such as a living will, to give a patient control over medical treatment decisions.

J. Properly protect private information about the people to whom you provide services, especially their health information.

K. Don't disclose the private information of someone for whom you provide services, unless it is needed for your work. This includes not discussing someone's private information unless your job requires it. Also, ensure that the information could not be accessed by someone who does not have permission to see it. This includes not leaving paperwork out where others can see it, and not sending private information over the internet.

L. Understand that this agreement may be canceled if you violate its terms. If this agreement is canceled, you must properly dispose of any private information you have about the people you serve so that it is not discovered by someone who does not have permission to see it.

M. Understand that by signing this agreement, you are agreeing to protect any private information you come in contact with in your job. When you protect private information, you are complying with federal and state laws, and you help DHS comply with these laws, as well.

This is a basic description of the terms of this agreement.

By signing this agreement, you are agreeing to be legally bound by all of its terms. If you have questions about it, you should get answers to them before signing this agreement. If you need or want legal advice, you should contact your own attorney. For more information, call 651-431-2700.

# Background Study Authorization

## *(Optional for CSG Program)*

***Please Note**:*

- *If requested, background study results must be complete and in accordance with Minnesota Statute 245c.14 before being hired.*
- *Background studies are processed through backgroundchecks.com and fingerprinting is not required.*

### Background Study Instructions

**1** If requested, Worker submits Background Study Form to PICS.

**2** PICS submits Worker's information to backgroundchecks.com.

**3** PICS receives background study results within 1-2 business days.

### Request an Optional Background Study

| REPRESENTATIVE NAME | PARTICIPANT NAME |
|---|---|
| | |

*As the Representative, I authorize Partners in Community Supports (PICS) to process a Criminal Background Study on my Worker through www.backgroundchecks.com.*

_____ _____

*Representative Signature* *Date*

### Worker Information

| FIRST NAME | MIDDLE NAME (FULL) | LAST NAME (LEGAL) | | |
|---|---|---|---|---|
| DATE OF BIRTH | GENDER | DRIVER'S LICENSE/STATE ID # | | |
| STREET ADDRESS | CITY | STATE | ZIP CODE | COUNTY |
| PHONE NUMBER | | EMAIL | | |
| SOCIAL SECURITY NUMBER | | PRIOR NAMES AND ALIASES USED | | |

*I authorize PICS to conduct a background study for the purpose of evaluating my potential employment with PICS. I verify that all the above information is correct to the best of my knowledge.*

_____ _____

*Worker Signature* *Date*



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Minnesota Department of **Human Services**

# BACKGROUND STUDY NOTICE OF PRIVACY PRACTICES

Because the Department of Human Services (DHS) is asking you to provide private information, you have privacy rights under the Minnesota Government Data Practices Act. This law protects your privacy, but also allows DHS to give information about you to others when the law requires it. This notice describes how your private information may be used and disclosed, and how you may access your information.

## Why is DHS asking me for my private information?

A background study from the Department of Human Services (DHS) is required for your job or position. The private information is needed to conduct the background study.

## How will I be notified that a background study was submitted on me?

DHS will mail you a notice within three working days after a request for a background study is submitted on you. The notice will contain the background study result or let you know that more time is needed to complete the background study. The notice will also identify the entity that submitted the background study request.

## What information must I provide to complete the background study?

You are required to provide enough information to ensure an accurate and complete background study. This includes your:

- first, middle, and last name and all names you have ever been known by or used;
- current home address, city, zip code, and state of residence;
- previous home addresses, city, county, and states of residence for the last five years;
- sex and date of birth;
- driver's license or other identification number, and;
- fingerprints and a photograph.

## How will the information that I give be used?

The information will be used to perform a background study that will include a check to determine whether you have any criminal records and/or have been found responsible for substantiated maltreatment of a vulnerable adult or child. Background study data is classified as "private data" and cannot be shared without your consent except as explained in this notice.

## What may happen if I provide the information?

You could be disqualified from positions that require a DHS background study if you are found to have committed certain crimes, been determined responsible for maltreatment of a vulnerable adult or child, or have other records that require a disqualification. If you do not have a disqualifying record, you will be cleared to work.

## What if I refuse to provide the information?

You will be disqualified if you refuse to provide information to complete an accurate background study. You will not be able to work in a position that requires a DHS background study.

## Who will DHS give my information to?

DHS will only share information about you as needed and as allowed or required by law. The identifying information you provide will be shared with the Minnesota Bureau of Criminal Apprehension and in some cases the Federal Bureau of Investigation (FBI). If there is reasonable cause to believe that other agencies may have information related to a disqualification, your identifying information may also be shared with:

- county attorneys, sheriffs, and agencies;
- courts and juvenile courts;
- local police;
- the Office of the Attorney General, and;
- agencies with criminal record information systems in other states.

## What information will DHS share with the entity that requested my background study?

The entity that requested the background study will be notified of your background study determination.

If you are disqualified**,** the entity will not be told the reason unless you were disqualified for refusing to cooperate with the background study or for substantiated maltreatment of a minor or vulnerable adult.

## What other entities might DHS share information with?

Information about your Background study may be shared with:

- the Minnesota Department of Health;
- the Minnesota Department of Corrections;
- the Office of the Attorney General, and;
- health-related licensing boards.

## What if my disqualification is set aside?

If you request reconsideration of your disqualification and your disqualification is set aside, the entity that requested the background study will be informed of the reason(s) for your disqualification unless the law states otherwise. DHS will provide information about the decision to set aside your disqualification if the entity requests it.

Unless prohibited by law, your name and the reason(s) for your disqualification will become public data if your set aside is for:

- a child care center or a family child care provider licensed under chapter 245A, or;
- an offense identified in section 245C.15, subdivision 2.

For future background studies submitted by entities that provide the same type of services as the services you were set aside for, the set aside will apply unless:

- you were disqualified for an offense in section 245C.15, subdivision 1 or 2, or;
- DHS receives additional information indicating that you pose a risk of harm, or;
- your set aside was limited to a specific person receiving services.

In addition, those entities will be informed of the reason(s) for your disqualification unless prohibited by law.

## Will my fingerprints be kept?

DHS and the Bureau of Criminal Apprehension will not keep your fingerprints. However, if an FBI check is required for your background study, the Federal Bureau of Investigation (FBI) will keep your fingerprints and may use them for other purposes.

## What information can the fingerprint and photo site view and keep?

The fingerprint and photo site can view identifying information to verify your identify. The fingerprint and photo site will not keep your fingerprints, photo, or most other information. The fingerprint and photo site can keep your name and the date and time your fingerprints were recorded and sent, for auditing and billing purposes.

## Who can see my photo?

Your photo will be kept by DHS. If you provide your social security number to allow your background study to be transferable to future entities, your photo will be available to those entities to verify your identity.

## What are my rights about the information you have about me?

- You may ask if we have information about you and request in writing to get copies. You may have to pay for copies.
- You may give other people permission to see and have copies of private information about you.
- You may ask in writing a report that lists the entities that submitted a background study request on you.
- You may ask in writing that the information used to complete your background study be destroyed. The information will be destroyed if you have:

  (1) not been affiliated with any entity for the previous two years, and;
  (2) no current disqualifying characteristic(s).

Please send all written requests to:

Minnesota Department of Human Services
Background Studies Division
NETStudy 2.0 Coordinator
PO Box 64242
St. Paul, MN 55164-0242

## How long will DHS keep my background study information?

DHS will destroy:

- your photo when you have not been affiliated with an entity for two years.
- any background data collected on a you after two years following your death or 90 years after your date of birth, except when readily available data indicates that you are still living.

## What is the legal authority for DHS to conduct background studies?

Background studies are completed by DHS according to the requirements in Minnesota Statutes, chapter 245C. Background studies are authorized under Minnesota Statutes, sections 256B.0943, subdivision 5a; 256B.0659, subdivision 11(a)(3); 241.021, subdivision 6(a);144.057, subdivision 1; 518.165, subdivision 4, and 524.5-118;

## What if I think my privacy rights have been violated?

You may report a complaint if you believe your privacy rights have been violated. If you think that the Minnesota Department of Human Services violated your privacy rights, you may send a written complaint to the Minnesota Department of Human Services, Privacy Official at:

Minnesota Department of Human Services
Privacy Official
PO Box 64998
St. Paul, MN 55164-0998

# Personnel File Notification

*Workers' rights and remedies regarding review of personnel file under PICS policies and in compliance with Minnesota state law.*

Worker Name: _____

**A. Review of Personnel File**

**How:** Workers may make a written request to the Human Resources Department to review their personnel file; however, such requests may be limited to no more than once every six months and may be denied if we determined that the request was not made in good faith. Upon separation from employment a former worker may make such a written request once each year after separation for as long as the personnel record is maintained.

**When:** Upon receipt of a written request from a worker or former worker to review their personnel file it is our practice to comply no later than 7 working days.

**What:** Arrangements will be made for current workers to inspect their personnel record during normal business hours. An accurate copy of the personnel file may be used or simply provided; a copy will be mailed to any former worker at an address disclosed in a written request and onsite inspections will not be allowed for former workers.

**B. Removal or Revision of Personnel File Information**

If a worker disputes any of the specific information contained in their personnel file, there are three different courses of action that may be taken:

1. Worker may do nothing about the disagreement;
2. Worker may seek management's agreement to revise/remove disputed information, which may or may not be granted; and
3. If no agreement is reached to revise or remove the disputed information, the worker may submit a written statement specifically identifying the disputed information and explaining their position on the information in question. This position statement may be no longer than 5 written pages and will be included with worker's personnel file with the disputed information, for as long as the disputed information is contained in the record.

**C. Worker Records**

Our employment records also require that contract and other information be maintained current and updated as needed. Workers are responsible for notifying the Human Resource Generalist promptly and accurately in writing of any changes relating to personal information, such as home address, telephone number, marital status, and/or number of dependents.

**D. Remedies/Retaliation Prohibited**

In addition to other remedies provided by law, if any, worker may bring a civil action in an attempt to compel compliance with these provisions regarding their right to inspect his or her personnel file and potentially seeking the following relief:

1. Actual damages only, plus costs, under Minn. Stats. 181.960 to 181.963; and
2. Actual damages, back pay, and reinstatement or other make-whole equitable relief, plus reasonable attorney's fees, under Minn. Stat. 181.964.

Any worker who in good faith exercises their rights and remedies regarding review of the personnel record under these provisions may not be retaliated against.

## Acknowledgement of Receipt

I hereby acknowledge that I have received a copy of the foregoing Personnel File Notification and I understand that I am obligated to read and familiarize myself with its terms.

_____ _____

*Worker Signature* *Date*



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Form **W-4**

Department of the Treasury
Internal Revenue Service

# Employee's Withholding Certificate

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

OMB No. 1545-0074

2023

**Step 1: Enter Personal Information**

| (a) First name and middle initial | Last name | (b) Social security number |
|---|---|---|
| Address | | **Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*. |
| City or town, state, and ZIP code | | |

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

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

**Step 2: Multiple Jobs or Spouse Works**

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

Do **only one** of the following.

**(a)** Reserved for future use.

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

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

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

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

**Step 3: Claim Dependent and Other Credits**

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

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

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

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

**Step 4 (optional): Other Adjustments**

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

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

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

**Step 5: Sign Here**

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

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

**Employers Only**

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

# General Instructions

Section references are to the Internal Revenue Code.

## Future Developments

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

## Purpose of Form

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

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

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

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

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

# Specific Instructions

**Step 1(c).** Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

**Step 2.** Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

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

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

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

**Step 4 (optional).**

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

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

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

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

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

**Note:** If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables.

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

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

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

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

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

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

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

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

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

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

. . . . . **2** $

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

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

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

**Privacy Act and Paperwork Reduction Act Notice.** We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

## Married Filing Jointly or Qualifying Surviving Spouse

| Higher Paying Job Annual Taxable Wage & Salary | Lower Paying Job Annual Taxable Wage & Salary | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | $0 - 9,999 | $10,000 - 19,999 | $20,000 - 29,999 | $30,000 - 39,999 | $40,000 - 49,999 | $50,000 - 59,999 | $60,000 - 69,999 | $70,000 - 79,999 | $80,000 - 89,999 | $90,000 - 99,999 | $100,000 - 109,999 | $110,000 - 120,000 |
| $0 - 9,999 | $0 | $0 | $850 | $850 | $1,000 | $1,020 | $1,020 | $1,020 | $1,020 | $1,020 | $1,020 | $1,870 |
| $10,000 - 19,999 | 0 | 930 | 1,850 | 2,000 | 2,200 | 2,220 | 2,220 | 2,220 | 2,220 | 2,220 | 3,200 | 4,070 |
| $20,000 - 29,999 | 850 | 1,850 | 2,920 | 3,120 | 3,320 | 3,340 | 3,340 | 3,340 | 3,340 | 4,320 | 5,320 | 6,190 |
| $30,000 - 39,999 | 850 | 2,000 | 3,120 | 3,320 | 3,520 | 3,540 | 3,540 | 3,540 | 4,520 | 5,520 | 6,520 | 7,390 |
| $40,000 - 49,999 | 1,000 | 2,200 | 3,320 | 3,520 | 3,720 | 3,740 | 3,740 | 4,720 | 5,720 | 6,720 | 7,720 | 8,590 |
| $50,000 - 59,999 | 1,020 | 2,220 | 3,340 | 3,540 | 3,740 | 3,760 | 4,750 | 5,750 | 6,750 | 7,750 | 8,750 | 9,610 |
| $60,000 - 69,999 | 1,020 | 2,220 | 3,340 | 3,540 | 3,740 | 4,750 | 5,750 | 6,750 | 7,750 | 8,750 | 9,750 | 10,610 |
| $70,000 - 79,999 | 1,020 | 2,220 | 3,340 | 3,540 | 4,720 | 5,750 | 6,750 | 7,750 | 8,750 | 9,750 | 10,750 | 11,610 |
| $80,000 - 99,999 | 1,020 | 2,220 | 4,170 | 5,370 | 6,570 | 7,600 | 8,600 | 9,600 | 10,600 | 11,600 | 12,600 | 13,460 |
| $100,000 - 149,999 | 1,870 | 4,070 | 6,190 | 7,390 | 8,590 | 9,610 | 10,610 | 11,660 | 12,860 | 14,060 | 15,260 | 16,330 |
| $150,000 - 239,999 | 2,040 | 4,440 | 6,760 | 8,160 | 9,560 | 10,780 | 11,980 | 13,180 | 14,380 | 15,580 | 16,780 | 17,850 |
| $240,000 - 259,999 | 2,040 | 4,440 | 6,760 | 8,160 | 9,560 | 10,780 | 11,980 | 13,180 | 14,380 | 15,580 | 16,780 | 17,850 |
| $260,000 - 279,999 | 2,040 | 4,440 | 6,760 | 8,160 | 9,560 | 10,780 | 11,980 | 13,180 | 14,380 | 15,580 | 16,780 | 18,140 |
| $280,000 - 299,999 | 2,040 | 4,440 | 6,760 | 8,160 | 9,560 | 10,780 | 11,980 | 13,180 | 14,380 | 15,870 | 17,870 | 19,740 |
| $300,000 - 319,999 | 2,040 | 4,440 | 6,760 | 8,160 | 9,560 | 10,780 | 11,980 | 13,470 | 15,470 | 17,470 | 19,470 | 21,340 |
| $320,000 - 364,999 | 2,040 | 4,440 | 6,760 | 8,550 | 10,750 | 12,770 | 14,770 | 16,770 | 18,770 | 20,770 | 22,770 | 24,640 |
| $365,000 - 524,999 | 2,970 | 6,470 | 9,890 | 12,390 | 14,890 | 17,220 | 19,520 | 21,820 | 24,120 | 26,420 | 28,720 | 30,880 |
| $525,000 and over | 3,140 | 6,840 | 10,460 | 13,160 | 15,860 | 18,390 | 20,890 | 23,390 | 25,890 | 28,390 | 30,890 | 33,250 |

## Single or Married Filing Separately

| Higher Paying Job Annual Taxable Wage & Salary | Lower Paying Job Annual Taxable Wage & Salary | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | $0 - 9,999 | $10,000 - 19,999 | $20,000 - 29,999 | $30,000 - 39,999 | $40,000 - 49,999 | $50,000 - 59,999 | $60,000 - 69,999 | $70,000 - 79,999 | $80,000 - 89,999 | $90,000 - 99,999 | $100,000 - 109,999 | $110,000 - 120,000 |
| $0 - 9,999 | $310 | $890 | $1,020 | $1,020 | $1,020 | $1,860 | $1,870 | $1,870 | $1,870 | $1,870 | $2,030 | $2,040 |
| $10,000 - 19,999 | 890 | 1,630 | 1,750 | 1,750 | 2,600 | 3,600 | 3,600 | 3,600 | 3,600 | 3,760 | 3,960 | 3,970 |
| $20,000 - 29,999 | 1,020 | 1,750 | 1,880 | 2,720 | 3,720 | 4,720 | 4,730 | 4,730 | 4,890 | 5,090 | 5,290 | 5,300 |
| $30,000 - 39,999 | 1,020 | 1,750 | 2,720 | 3,720 | 4,720 | 5,720 | 5,730 | 5,890 | 6,090 | 6,290 | 6,490 | 6,500 |
| $40,000 - 59,999 | 1,710 | 3,450 | 4,570 | 5,570 | 6,570 | 7,700 | 7,910 | 8,110 | 8,310 | 8,510 | 8,710 | 8,720 |
| $60,000 - 79,999 | 1,870 | 3,600 | 4,730 | 5,860 | 7,060 | 8,260 | 8,460 | 8,660 | 8,860 | 9,060 | 9,260 | 9,280 |
| $80,000 - 99,999 | 1,870 | 3,730 | 5,060 | 6,260 | 7,460 | 8,660 | 8,860 | 9,060 | 9,260 | 9,460 | 10,430 | 11,240 |
| $100,000 - 124,999 | 2,040 | 3,970 | 5,300 | 6,500 | 7,700 | 8,900 | 9,110 | 9,610 | 10,610 | 11,610 | 12,610 | 13,430 |
| $125,000 - 149,999 | 2,040 | 3,970 | 5,300 | 6,500 | 7,700 | 9,610 | 10,610 | 11,610 | 12,610 | 13,610 | 14,900 | 16,020 |
| $150,000 - 174,999 | 2,040 | 3,970 | 5,610 | 7,610 | 9,610 | 11,610 | 12,610 | 13,750 | 15,050 | 16,350 | 17,650 | 18,770 |
| $175,000 - 199,999 | 2,720 | 5,450 | 7,580 | 9,580 | 11,580 | 13,870 | 15,180 | 16,480 | 17,780 | 19,080 | 20,380 | 21,490 |
| $200,000 - 249,999 | 2,900 | 5,930 | 8,360 | 10,660 | 12,960 | 15,260 | 16,570 | 17,870 | 19,170 | 20,470 | 21,770 | 22,880 |
| $250,000 - 399,999 | 2,970 | 6,010 | 8,440 | 10,740 | 13,040 | 15,340 | 16,640 | 17,940 | 19,240 | 20,540 | 21,840 | 22,960 |
| $400,000 - 449,999 | 2,970 | 6,010 | 8,440 | 10,740 | 13,040 | 15,340 | 16,640 | 17,940 | 19,240 | 20,540 | 21,840 | 22,960 |
| $450,000 and over | 3,140 | 6,380 | 9,010 | 11,510 | 14,010 | 16,510 | 18,010 | 19,510 | 21,010 | 22,510 | 24,010 | 25,330 |

## Head of Household

| Higher Paying Job Annual Taxable Wage & Salary | Lower Paying Job Annual Taxable Wage & Salary | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | $0 - 9,999 | $10,000 - 19,999 | $20,000 - 29,999 | $30,000 - 39,999 | $40,000 - 49,999 | $50,000 - 59,999 | $60,000 - 69,999 | $70,000 - 79,999 | $80,000 - 89,999 | $90,000 - 99,999 | $100,000 - 109,999 | $110,000 - 120,000 |
| $0 - 9,999 | $0 | $620 | $860 | $1,020 | $1,020 | $1,020 | $1,020 | $1,650 | $1,870 | $1,870 | $1,890 | $2,040 |
| $10,000 - 19,999 | 620 | 1,630 | 2,060 | 2,220 | 2,220 | 2,220 | 2,850 | 3,850 | 4,070 | 4,090 | 4,290 | 4,440 |
| $20,000 - 29,999 | 860 | 2,060 | 2,490 | 2,650 | 2,650 | 3,280 | 4,280 | 5,280 | 5,520 | 5,720 | 5,920 | 6,070 |
| $30,000 - 39,999 | 1,020 | 2,220 | 2,650 | 2,810 | 3,440 | 4,440 | 5,440 | 6,460 | 6,880 | 7,080 | 7,280 | 7,430 |
| $40,000 - 59,999 | 1,020 | 2,220 | 3,130 | 4,290 | 5,290 | 6,290 | 7,480 | 8,680 | 9,100 | 9,300 | 9,500 | 9,650 |
| $60,000 - 79,999 | 1,500 | 3,700 | 5,130 | 6,290 | 7,480 | 8,680 | 9,880 | 11,080 | 11,500 | 11,700 | 11,900 | 12,050 |
| $80,000 - 99,999 | 1,870 | 4,070 | 5,690 | 7,050 | 8,250 | 9,450 | 10,650 | 11,850 | 12,260 | 12,460 | 12,870 | 13,820 |
| $100,000 - 124,999 | 2,040 | 4,440 | 6,070 | 7,430 | 8,630 | 9,830 | 11,030 | 12,230 | 13,190 | 14,190 | 15,190 | 16,150 |
| $125,000 - 149,999 | 2,040 | 4,440 | 6,070 | 7,430 | 8,630 | 9,980 | 11,980 | 13,980 | 15,190 | 16,190 | 17,270 | 18,530 |
| $150,000 - 174,999 | 2,040 | 4,440 | 6,070 | 7,980 | 9,980 | 11,980 | 13,980 | 15,980 | 17,420 | 18,720 | 20,020 | 21,280 |
| $175,000 - 199,999 | 2,190 | 5,390 | 7,820 | 9,980 | 11,980 | 14,060 | 16,360 | 18,660 | 20,170 | 21,470 | 22,770 | 24,030 |
| $200,000 - 249,999 | 2,720 | 6,190 | 8,920 | 11,380 | 13,680 | 15,980 | 18,280 | 20,580 | 22,090 | 23,390 | 24,690 | 25,950 |
| $250,000 - 449,999 | 2,970 | 6,470 | 9,200 | 11,660 | 13,960 | 16,260 | 18,560 | 20,860 | 22,380 | 23,680 | 24,980 | 26,230 |
| $450,000 and over | 3,140 | 6,840 | 9,770 | 12,430 | 14,930 | 17,430 | 19,930 | 22,430 | 24,150 | 25,650 | 27,150 | 28,600 |

DEPARTMENT OF REVENUE

# 2023 W-4MN, Minnesota Withholding Allowance/Exemption Certificate

## Employees

Complete Form W-4MN so your employer can withhold the correct Minnesota income tax from your pay. Consider completing a new Form W-4MN each year and when your personal or financial situation changes. If no Form W-4MN is in effect, the number of withholding allowances claimed will be zero.

First Name and Initial | Last Name | Social Security Number

Permanent Address | **Marital Status *(Check one):***

City | State | ZIP Code

- ☐ Single; Married, but legally separated; or Spouse is a nonresident alien
- ☐ Married
- ☐ Married, but withhold at higher Single rate

**Complete Section 1 OR Section 2, then sign the bottom and give the completed form to your employer.**

### ☐ Section 1 — Determining Minnesota Allowances

**A** Enter "1" if no one else can claim you as a dependent . . . . . **A** _____

**B** Enter "1" if any of the following apply: . . . . . **B** _____

- You are single and have only one job
- You are married, have only one job, and your spouse does not work
- Your wages from a second job or your spouse's wages are $1500 or less

**C** Enter "1" if you are married. Or 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 the number of dependents (other than your spouse or yourself) you will claim on your tax return. . . . . **D** _____

**E** Enter "1" if you will use the filing status Head of Household *(see instructions)*. . . . . **E** _____

**F** Add steps A through E. If you plan to itemize deductions on your 2023 Minnesota income tax return, you may also complete the Itemized Deductions and Additional Income Worksheet. . . . . **F** _____

**1 Minnesota Allowances.** Enter Step F from Section 1 above or Step 10 of the Itemized Deductions Worksheet . . . . . **1** _____

**2** Additional Minnesota withholding you want deducted for each pay period *(see instructions)* . . . . . **2** $_____

### ☐ Section 2 — Exemption From Minnesota Withholding

Complete Section 2 if you claim to be exempt from Minnesota income tax withholding *(see Section 2 instructions for qualifications)*. If applicable, check one box below to indicate why you believe you are exempt:

☐ **A** I meet the requirements and claim exempt from both federal and Minnesota income tax withholding

☐ **B** Even though I did not claim exempt from federal withholding, I claim exempt from Minnesota withholding, because:

- I had no Minnesota income tax liability last year
- I received a refund of all Minnesota income tax withheld
- I expect to have no Minnesota income tax liability this year

☐ **C** All of these apply:

- My spouse is a military service member assigned to a military location in Minnesota
- My domicile (legal residence) is in another state
- I am in Minnesota solely to be with my spouse. My state of domicile is _____

☐ **D** I am an American Indian that resides and works on a reservation for which I am enrolled *(see instructions)*.
Enter the reservation name: _____
Enter your Certificate of Degree of Indian Blood (CDIB)/Enrollment number: _____

☐ **E** I am a member of the Minnesota National Guard or an active-duty U.S. military member and claim exempt from Minnesota withholding on my military pay

☐ **F** I receive a military pension or other military retirement pay as calculated under U.S. Code, title 10, sections 1401 through 1414, 1447 through 1455, and 12733, and I claim exempt from Minnesota withholding on this retirement pay

*I certify that all information provided in Section 1* ***OR*** *Section 2 is correct. I understand there is a $500 penalty for filing a false Form W-4MN.*

Employee's Signature | Date | Daytime Phone Number

**Employees:** Give the completed form to your employer.

## Employers

See the employer instructions to determine if you must send a copy of this form to the Minnesota Department of Revenue. If required, enter your information below and mail this form to the address in the instructions. (Incomplete forms are considered invalid.) We may assess a $50 penalty for each required Form W-4MN not filed with us. Keep a copy for your records.

Name of Employer | Minnesota Tax ID Number | Federal Employer ID Number (FEIN)

Address | City | State | ZIP Code

DEPARTMENT OF REVENUE

# Form W-4MN Instructions for Employees

*Complete this form for your employer to calculate the amount of Minnesota income tax to be withheld from your pay.*

## When must I complete Form W-4MN?

Complete Form W-4MN if any of these apply:

- You begin employment
- You change your filing status
- You reasonably expect to change your filing status in the next calendar year
- Your personal or financial situation changes
- You claim exempt from Minnesota withholding (see Section 2 instructions for qualifications)

If you have not had sufficient Minnesota income tax withheld from your wages, we may assess penalty and interest when you file your state income tax return.

**Note:** Your employer may be required to submit a copy of your Form W-4MN to the Minnesota Department of Revenue. You may be subject to a $500 penalty if you provide a false Form W-4MN.

**You must enter your Social Security Number for this Form W-4MN to be valid.**

## What if I have completed federal Form W-4?

If you completed a 2023 Form W-4, you must complete Form W-4MN to determine your Minnesota withholding allowances.

## What if I am exempt from Minnesota withholding?

If you claim exempt from Minnesota withholding, complete only Section 2 of Form W-4MN and sign and date the form to validate it. If you complete Section 2, you must complete a new Form W-4MN by February 15 in each following year in which you claim an exemption from Minnesota withholding.

You cannot claim exempt from withholding if all of these apply:

- Another person can claim you as a dependent on their federal tax return
- Your annual income exceeds $1,100
- Your annual income includes more than $350 of unearned income

## What if I am a nonresident alien for U.S. income taxes?

If you are a nonresident alien, you are not allowed to claim exempt from withholding. You will check the single box for marital status regardless of your actual marital status and may enter one personal allowance on Step A of Section 1. Enter zero on steps B, C, and E of Section 1.

If you are resident of Canada, Mexico, South Korea, or India, and are allowed to claim dependents, enter the number of dependents on Step D.

## Section 1 — Minnesota Allowances Worksheet

Complete Section 1 to find your allowances for Minnesota withholding tax. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

If you expect to owe more income tax for the year than will be withheld, you can claim fewer allowances or request additional Minnesota withholding from your wages. Enter the amount of additional Minnesota income tax you want withheld on line 2 of Section 1.

### Nonwage Income

Consider making estimated payments if you have a large amount of "nonwage income." Nonwage income (other than tax-exempt income) includes interest, dividends, net rental income, unemployment compensation, gambling winnings, prizes and awards, hobby income, capital gains, royalties, and partnership income.

### Two Earners or Multiple Jobs

If your spouse works or you have 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-4MN. Usually, your withholding will be more accurate when all allowances are claimed on the Form W-4MN for the highest paying job and zero allowances are claimed on the others.

### Head of Household Filing Status

You may claim Head of Household as your filing status if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependents. Enter "1" on Step E if you may claim Head of Household as your filing status on your tax return.

### What if I itemize deductions on my Minnesota return or have other nonwage income?

Use the Itemized Deductions and Additional Income Worksheet to find your Minnesota withholding allowances. Complete Section 1 on page 1, then follow the steps in the worksheet on the next page to find additional allowances.

*Continued*

**Itemized Deductions and Additional Income Worksheet**

1 Enter an estimate of your 2023 Minnesota itemized deductions. For 2023, you may have to reduce your itemized deductions if your income is over $220,650 ($110,325 for Married Filing Separately). . . . . _____

2 Enter one of the following based on your filing status: . . . . . _____

a. $27,650 if Married Filing Jointly

b. $20,800 if Head of Household

c. $13,825 if Single or Married Filing Separately

3 Subtract step 2 from step 1. If zero or less, enter 0 . . . . . _____

4 Enter an estimate of your 2023 additional standard deduction (from page 11 of the Form M1 instructions) . . . . . _____

5 Add steps 3 and 4 . . . . . _____

6 Enter an estimate of your 2023 taxable nonwage income . . . . . _____

7 Subtract step 6 from step 5. If zero, enter 0. If less than zero, enter the amount in parentheses. . . . . _____

8 Divide the amount on step 7 by $4,800. If a negative amount, enter in parentheses. Do not include fractions . . . . . _____

9 Enter the number on step F of Section 1 on page 1 . . . . . _____

10 Add step 8 and 9 and enter the total here. If zero or less, enter 0. Enter this amount on line 1 of page 1. . . . . _____

## Section 2 — Minnesota Exemption

Your employer will not withhold Minnesota taxes from your pay if you are exempt from Minnesota withholding. You cannot claim exempt from withholding if all of these apply:

- Another person can claim you as a dependent on their federal tax return
- Your annual income exceeds $1,100
- Your annual income includes more than $350 of unearned income

### Box A

Check box A of Section 2 to claim exempt if all of these apply:

- You meet the requirements to be exempt from federal withholding
- You had no Minnesota income tax liability in the prior year and received a full refund of Minnesota tax withheld
- You expect to have no Minnesota income tax liability for the current year

### Box B

Check box B of Section 2 if you are not claiming exempt from federal withholding, but meet the second and third requirements for box A.

### Box C

Check box C in Section 2 to claim exempt if all of these apply:

- You are the spouse of a military member assigned to duty in Minnesota
- You and your spouse are domiciled in another state
- You are in Minnesota solely to be with your active duty military spouse member

### Boxes D-F

If you receive income from the following sources, it is exempt from Minnesota withholding. Your employer will not withhold Minnesota tax from that income when you check the appropriate box in Section 2.

- **Box D:** You receive wages as a member of an American Indian tribe living and working on the reservation of which you are an enrolled member. Enter the name of your reservation and your Certificate of Degree of Indian or Alaskan Blood (CDIB) number/enrollment number. **Members of the Minnesota Chippewa Tribe** can exclude income regardless of which Minnesota Chippewa Tribe reservation you live and work on. This affects members of these tribes:
  - Mille Lacs
  - Nett Lake (Bois Forte)
  - Fond du Lac
  - Leech Lake
  - White Earth
  - Grand Portage
- **Box E:** You receive wages for Minnesota National Guard (MNG) pay or for active duty U.S. military pay. MNG and active duty U.S. military members can claim exempt from Minnesota withholding on these wages, even if they are taxable federally. For more information, see Income Tax Fact Sheet 5, *Military Personnel*.
- **Box F:** You receive a military pension or other military retirement pay calculated under U.S. Code title 10, sections 1401 through 1414, 1447 through 1455, and 12733. You may claim exempt from Minnesota withholding on this income even if it is taxable federally.

**Note:** You may not want to claim exempt if you (or your spouse if filing a joint return) expect to have other forms of income subject to Minnesota tax and you want to avoid owing tax at the end of the year.

If you complete Section 2, you must complete a new Form W-4MN by February 15 in each following year.

### Nonresident Alien

If you are a nonresident alien for federal tax purposes, do not complete Section 2. See IRS Publication 519, *U.S. Tax Guide for Aliens*.

*Continued*

## Line 2 — Additional Minnesota Withholding

If you would like an additional amount of tax to be deducted per payment period, enter the amount on line 2. Do not enter a percentage of the payment you want to be deducted.

## Use of Information

All information on Form W-4MN is private by state law. It cannot be given to others without your consent, except to the IRS, other states that guarantee the same privacy, or by court order. Your name, address, and Social Security Number are required for identification. Information about your allowances is required to determine your correct tax. We ask for your phone number so we can call if we have a question.

## Questions?

- Website: www.revenue.state.mn.us
- Email: withholding.tax@state.mn.us
- Phone: 651-282-9999 or 1-800-657-3594 (toll-free)

*Employer instructions are on the next page.*

# Payment Options Form

Partners in Community Supports (PICS) requires electronic payment for payroll.
**Important Note:** *Option 2 below will be issued if form is not completed prior to submitting your first timesheet.*

**Choose one option:** ☒ New Authorization ☐ Change Authorization ☐ Cancel Authorization *(default to Option 2)*

| FULL NAME | EMAIL | |
|---|---|---|
| FULL MAILING ADDRESS | | |
| PHONE NUMBER | DATE OF BIRTH | SSN (LAST 4 DIGITS) |

**Choose payment type below:**

☐ **OPTION 1 - Direct Deposit**

**Bank Document is Required for Direct Deposit -** Bank document must show your typed name, bank name, full routing, and full account number. You can submit a voided check, bank statement, or typed bank letter. See back page for Terms of Agreement.

| BANK NAME | 2nd BANK NAME *(optional)* |
|---|---|
| ROUTING NUMBER | ROUTING NUMBER |
| ACCOUNT NUMBER | ACCOUNT NUMBER |
| ACCOUNT TYPE ☐ CHECKING ☐ SAVINGS | ACCOUNT TYPE ☐ CHECKING ☐ SAVINGS |
| AMOUNT TO DEPOSIT $_____ *or* ☐ Entire Check | AMOUNT TO DEPOSIT $_____ *or* ☐ Remaining Amount |

☐ **OPTION 2 - Payroll Debit Card**

PICS will issue and mail a payroll debit card to you. Your NET pay will be deposited into the TotalPay Card and Money Network Check Program account on payday. Card is the default payment option if no form is received. See back page for Terms of Agreement.

*I certify the information provided is correct. I authorize Partners in Community Supports (PICS) to withhold the indicated amount(s), if available, from my pay, and deposit directly into the account(s) shown above. All deposits will be made on each payday. In the event that funds are transmitted in error to my account, I authorize PICS to reverse the deposit or debit the funds from my account. I understand that if a reversal of funds is necessary, I will be advised by PICS in advance. I understand failure to complete a Payment Options Form, will result in being assigned the default pay method for PICS, a TotalPay Money Network pay card. At any time, I may request PICS to cancel my pay card and choose Direct Deposit. Upon receipt to cancel or change your payment options as listed above, the change will become effective the following pay period. This authorization will remain in effect until I have cancelled it in writing or until termination.*

_____ _____

*Signature* *Date*

www.picsmn.org | hr@picsmn.org | Phone: 651-967-5060 | Fax: 651-967-5061 | 1605 Eustis Street, St. Paul, MN 55108

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# *Additional Information for Payment Options*

## OPTION 1 *- Direct Deposit*

Complete the form with your account information and return it to PICS along with a bank document that includes:

- Your typed name
- Bank's typed name
- Full routing number
- Full account number

This bank document must come directly from the bank and must be computer-generated (not handwritten). It can be a:

- Voided check
- Bank statement
- Typed letter from the bank

**Deposit slips and handwritten documents are *NOT* accepted.**

**Terms of Agreement for Direct Deposit:** *To cancel my direct deposit, I understand that it must be done by providing written notice to PICS at least 10 business days before the next pay date. If I change or close my bank account, I understand that it is solely my responsibility to notify Payroll immediately of any changes that affect my direct deposit.*

---

## OPTION 2 *- Payroll Debit Card*

*ADP TotalPay® Visa® Debit Card and Money Network™ Checks*

To receive a TotalPay Debit Card, complete form on the front side and return to PICS. PICS will issue and mail the debit card to you before your first pay check. Upon receipt, you will activate the card and begin to use the benefits of the TotalPay Debit Card.

The TotalPay® Card and Money Network™ Checks offer you a complete and convenient package of services you can use to access and manage your money instantly. Your pay will be deposited into the TotalPay® Card and Money Network™ Check Program Account ("Account") every payday so you have immediate access to your money.

**Advantages to TotalPay®**

- Check account balance for free online or by phone
- Pay bills online with TotalPay® Card
- Manage account online or by phone
- Get cash at an ATM
- Use a Money Network™ Check
- Make purchases

**Terms of Agreement for Pay Card***: If I choose the TotalPay Money Network pay card option, I hereby authorize PICS to assign me a TotalPay Money Network pay card. By accepting and using the pay card, I agree to be bound by the terms and conditions outlined in the cardholder agreement, including but not limited to the cardholder fees summary.*



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# Voluntary Self-Identification Form

**Please read carefully** (voluntary disclosure): In an effort to monitor our outreach and diversity efforts, we provide Participants, Representatives, and Workers an opportunity to voluntarily provide certain demographic information. If you choose not to provide some or all of this information, you will not be subject to any negative or adverse treatment. The information you provide is completely voluntary and will only be used to monitor our outreach and diversity efforts.

**Please answer the following questions:**

**I am a** *(please select all that apply)***:**

- ☐ Participant
- ☐ Worker
- ☐ Representative
- ☐ Vendor

**Gender** *(please check all that apply):*

- ☐ Female
- ☐ Male
- ☐ Nonbinary
- ☐ Transgender
- ☐ My gender is not listed above: _____
- ☐ I do not wish to disclose this information

**Pronouns**

- ☐ She/her/hers
- ☐ He/him/his
- ☐ They/them/their
- ☐ My pronouns are: _____

**Race/Ethnicity** *(please check one):*

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White or Caucasian
- ☐ Two or more races
- ☐ I do not wish to disclose this information

**Veteran Status** *(please check one)***:**

- ☐ I am a veteran
- ☐ I am not a veteran
- ☐ I do not wish to disclose this information

**Primary Language** *(please check one):*

- ☐ English
- ☐ Spanish / Español
- ☐ Hmong / Hmoob
- ☐ Somali / Soomaali
- ☐ Arabic / اللغة العربية
- ☐ Karen / ကညီ
- ☐ Russian / Русский
- ☐ Amharic / አማርኛ
- ☐ Vietnamese / Tiếng Việt
- ☐ American Sign Language
- ☐ Other: _____

**Need Interpreter** *(please check one):*

- ☐ Yes
- ☐ No

**Special accommodations needed (ie large print, braille):**

_____

_____ _____

***Name*** *(print full name)* ***Today's Date***

It is PICS policy to provide equal opportunity to all in accordance with all applicable Equal Employment Opportunity and Affirmative Action laws, directives and regulations of federal, state and local governing bodies or agencies. We use the self-identified information provided to monitor our compliance.



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# I-9 Form Sample (FEA)

*If the I-9 Form does not meet Homeland Security requirements, it is considered invalid. Human Resources will request the completion of a new form if invalid. The Federal instructions are available on our website.*

**Front Page:** Worker will complete steps 1 – 9. Please note that you **cannot use an electronic signature** on the I-9 form.

**Worker (steps 1 – 9)**

① Print your full legal name: Last, First and Middle Initial. Provide any other names you've used (such as maiden name). Enter "N/A" if you have never used any other name.

② Print your physical address. Entering a PO Box is not allowed. Enter "N/A" if you have no apartment number.

③ Print your Date of Birth (mm/dd/yyyy).

④ Print your Social Security number.

⑤ Print your email address or print "N/A" if you choose not to provide it.

⑥ Print your telephone number or print "N/A" if you choose not to provide it.

⑦ Check the one box that best describes your citizenship or immigration status in the United States.

⑧ Sign and print the date you completed the form. **No later than first day of work for pay.**

⑨ Check the box that indicates whether or not you were assisted by a preparer or translator.

Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

▸ 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) |
|---|---|---|---|
| ① SMITH | JANE | A | DOE |

| Address (Street Number and Name) | Apt. Number | City or Town | State | ZIP Code |
|---|---|---|---|---|
| ② 123 MAIN STREET | B | ANYTOWN | MN | 12345 |

| Date of Birth (mm/dd/yyyy) | U.S. Social Security Number | Employee's E-mail Address | Employee's Telephone Number |
|---|---|---|---|
| ③ 01/01/1960 | ④ 123-45-6789 | ⑤ JSMITH@EMAIL.COM | ⑥ 123-456-7890 |

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.

⑦ I attest, under penalty of perjury, that I am (check one of the following boxes):

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

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

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

QR Code - Section 1 Do Not Write In This Space

| ⑧ Signature of Employee | Jane Smith | Today's Date (mm/dd/yyyy) | 05/25/2021 |
|---|---|---|---|

**Preparer and/or Translator Certification (check one):**

⑨ ☐ 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 |
|---|---|---|---|
| | | | |

SAMPLE



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**Back Page:** Representative or Authorized Representative will complete steps 1 - 9 on the back page. The Authorized Representative can be a non-relative or notary. The Employer Business Name will be the FEIN Holder's Name and the Employer's Business Address will be the FEIN Holder's home address. Please note that you **cannot use an electronic signature** on the I-9 form.

**The Worker **CANNOT** complete the back page of their own I-9 form.**

**Authorized Representative (steps 1 – 9)**

① Print Worker's name from Section 1: Last, First, and Middle Initial.

② Print the Worker's citizenship status as selected in Section 1.

③ Examine each document and note the details in the appropriate List column.

One document from List A

**OR**

One from List B *and* one from List C

Only unexpired, original documents (no photocopies) are acceptable.

④ Sign the form.

⑤ Print the date you signed the form. **Must be completed and signed within 3 days of Worker's first day of employment.**

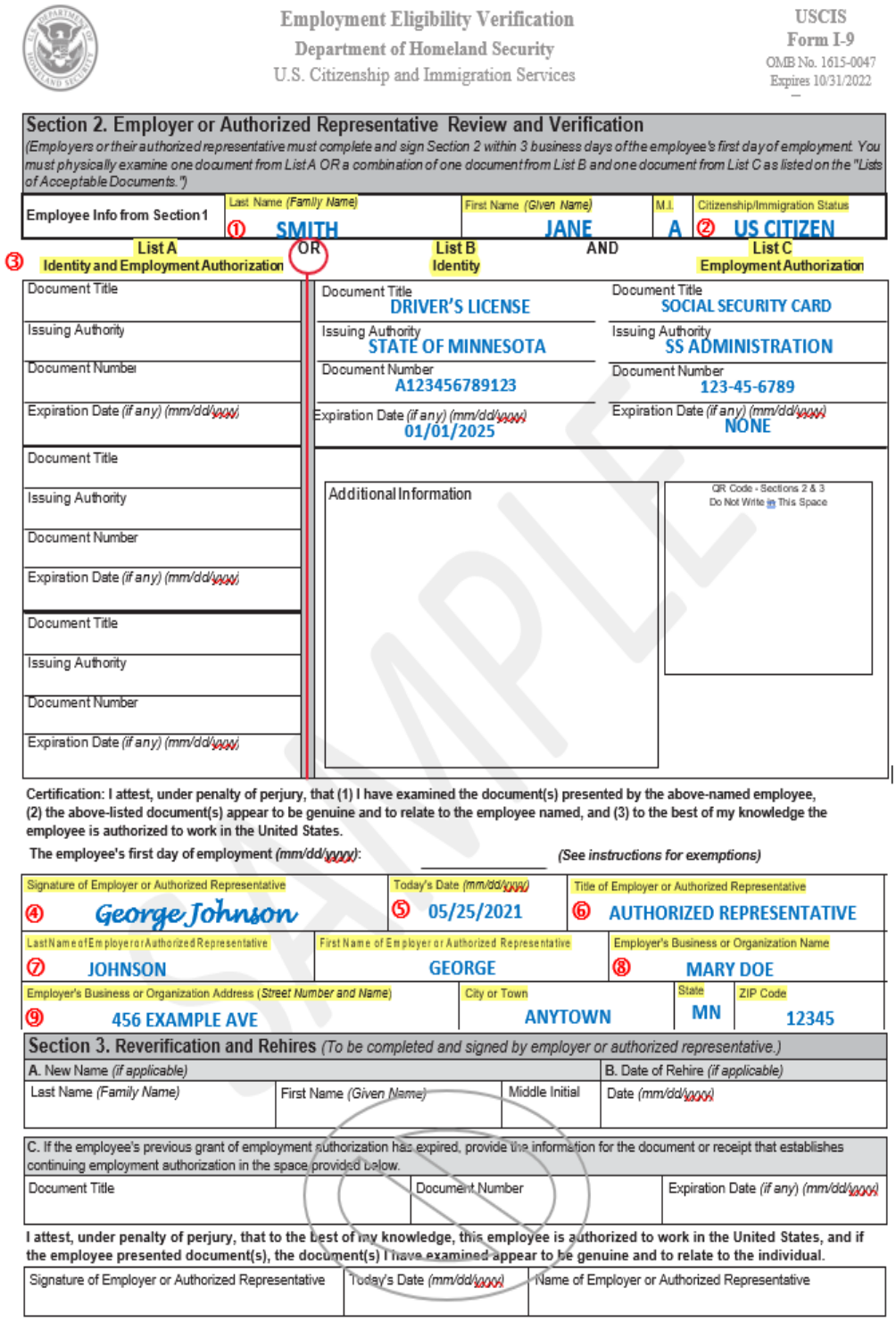
⑥ Print your title as "Authorized Representative."

⑦ Print your last then first name.

⑧ Print the FEIN Holder's first and last name.

⑨ Print FEIN Holder's home address.

****Do not complete Section 3 of this page. Doing so makes this form invalid.***



Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS Form I-9
OMB No. 1615-0047
Expires 10/31/2022

**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 |
|---|---|---|---|---|
| | ① SMITH | JANE | A | ② US CITIZEN |

| ③ List A Identity and Employment Authorization | OR | List B Identity | AND | List C Employment Authorization |
|---|---|---|---|---|
| Document Title | | DRIVER'S LICENSE | | SOCIAL SECURITY CARD |
| Issuing Authority | | STATE OF MINNESOTA | | SS ADMINISTRATION |
| Document Number | | A123456789123 | | 123-45-6789 |
| Expiration Date (if any) (mm/dd/yyyy) | | 01/01/2025 | | NONE |
| Document Title | | | | |
| Issuing Authority | | | | |
| Document Number | | | | |
| Expiration Date (if any) (mm/dd/yyyy) | | | | |
| Document Title | | | | |
| Issuing Authority | | | | |
| Document Number | | | | |
| Expiration Date (if any) (mm/dd/yyyy) | | | | |

Additional Information

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

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

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

| Signature of Employer or Authorized Representative | Today's Date (mm/dd/yyyy) | Title of Employer or Authorized Representative |
|---|---|---|
| ④ George Johnson | ⑤ 05/25/2021 | ⑥ AUTHORIZED REPRESENTATIVE |

| Last Name of Employer or Authorized Representative | First Name of Employer or Authorized Representative | Employer's Business or Organization Name |
|---|---|---|
| ⑦ JOHNSON | GEORGE | ⑧ MARY DOE |

| Employer's Business or Organization Address (Street Number and Name) | City or Town | State | ZIP Code |
|---|---|---|---|
| ⑨ 456 EXAMPLE AVE | ANYTOWN | MN | 12345 |

**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 |
|---|---|---|
| | | |

SAMPLE



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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 10/31/2022

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

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

QR Code - Section 1
Do Not Write In This Space

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

## Preparer and/or Translator Certification (check one):

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

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

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

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

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

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

STOP *Employer Completes Next Page* STOP

## Section 2. Employer or Authorized Representative Review and Verification

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

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

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

Additional Information

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

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

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

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

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

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

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

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

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

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

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

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

## LISTS OF ACCEPTABLE DOCUMENTS
## All documents must be UNEXPIRED

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

| LIST A<br>Documents that Establish Both Identity and Employment Authorization | OR | LIST B<br>Documents that Establish Identity | AND | LIST C<br>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:<br>(1) NOT VALID FOR EMPLOYMENT<br>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION<br>(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:<br>**a.** Foreign passport; and<br>**b.** Form I-94 or Form I-94A that has the following:<br>(1) The same name as the passport; and<br>(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:** | | |
| **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 | | **10.** School record or report card | | |
| | | **11.** Clinic, doctor, or hospital record | | |
| | | **12.** Day-care or nursery school record | | |

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

**Refer to the instructions for more information about acceptable receipts.**

# FEA Program Employment Agreement

| | |
|---|---|
| **Worker Name:** | **Date of Agreement:** |
| **Representative Name:** | **Participant Name:** |
| **Participant Employer / FEIN Holder:** | **FEIN #:** |

**Job Title:** ☐ Direct Support Professional ☐ Homemaker

**Work Schedule:** ☐ Part-Time *(29 hours or less per week)* ☐ Full-Time *(30 hours or more per week)*

**Relationship to Participant Employer / FEIN Holder:**

**If I am the Parent of Minor or Spouse of the Participant, I understand that by entering into employment with PICS, I am:*

- *Agreeing to obtain County-approved work schedule, obey wage restrictions, and pay all employment related taxes and expenses.*
- *Agreeing that no overtime will be worked by/paid to me and no mileage reimbursement will be submitted by/paid to me.*
- *Agreeing that only hours conforming to the approved work schedule will be paid.*

| **Relation to FEIN Holder** | **Income Tax** Federal/State | **FICA** Medicare & Social Security | **FUTA** Federal Unemployment | **SUTA** State Unemployment | **Workers Compensation** |
|---|---|---|---|---|---|
| ☐ Parent/Stepparent of FEIN Holder | Based on W-4 | EXEMPT | EXEMPT | EXEMPT | Not Required |
| ☐ Spouse of FEIN Holder | | EXEMPT | EXEMPT | EXEMPT | Not Required |
| ☐ Legal Guardian (Non-Parental) | | TAXABLE | TAXABLE | TAXABLE | Required |
| ☐ Child of FEIN Holder: Age 14-21 | | EXEMPT | EXEMPT | TAXABLE | Required |
| ☐ General Household Workers: *Other Relation to FEIN Holder (including adult children over age 21) & No Relation to FEIN Holder* | | EXEMPT Age: 14-18<br>TAXABLE Age: 18+ | TAXABLE | TAXABLE | Required |

*If General Household Worker, please select relationship to FEIN Holder: ☐ Sibling ☐ No Relation ☐ Other:_____
*Please select relationship to Participant (*if different from relationship to FEIN Holder*): ☐ Sibling ☐ No Relation ☐ Other:_____

**Compensation**

Worker is paid on a bi-weekly basis. Payment is issued following the submission of accurate time records, signed by the Representative and Worker, by 12 p.m. on Monday of each payroll week. Pay period dates, timesheet due dates, and pay dates are listed on the Payroll Schedule.

a. Representative agrees to pay Worker:

b. $_____ per hour as compensation for normal services rendered, as described in the job description.

$_____ per hour for ☐ respite ☐ housekeeping ☐ other: _____ services rendered, as described in job description

c. Worker position is classified as a non-exempt position according to federal wage-hour law, meaning worker will be eligible for overtime pay. Overtime must be approved in advanced by PICS. If approved, Worker will receive overtime pay for any hours worked in excess of 40 in a work week. Overtime pay that includes both normal and respite hours will be calculated at a weighted average hourly rate.

d. Worker will receive $ _____ per mile for transportation services if transportation reimbursement is approved in Participants budget.

e. Any of the above listed pay rates may be changed at the discretion of the Representative provided such rates are within the approved budget and services plan for the Participant. Pay changes will only be effective after written notification has been received by PICS from the Representative. A confirmation of any pay rate change will be communicated in writing to the Worker by PICS.


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## Employment Agreement

As the Worker, I acknowledge that my employment is dependent upon the Participant's enrollment in a qualified program, with Partners in Community Supports (PICS). PICS has agreed to provide administrative, including payroll and human resources, support to the Representative by being the employer of record for the Worker. If the Participant is no longer eligible for this program, I will no longer be employed by PICS. In order to acknowledge the terms of my employment, I agree to the following:

1. I acknowledge that my employment is dependent upon the Participant's enrollment in a qualified program administered by PICS. If the Participant is no longer eligible or no longer utilizing PICS' services, I will no longer be employed.
2. I acknowledge that if my employment requires a criminal background check, successful completion of the appropriate background check (Minnesota Department of Human Services or BackgroundChecks.com) will be required. I understand that the results of my background check will be made available to PICS and Representative.
3. Job Assignment. The Representative shall employ the Worker to assist the Representative by performing the duties specified in this Agreement. The Representative is responsible for training, managing and supervising the Worker and controlling workplace activities. The Worker accepts such employment in accordance with the terms and conditions of this Agreement.
    a. Representative has developed a written job description, and provided a copy to the Worker. Worker agrees to perform his or her duties in accordance with the terms of the job description. The job description may be amended periodically by the Representative and any revised job description will be provided to the Worker.
    b. Specific job duties, working conditions and location of work will be established by the Representative, based on the needs of the Participant, and communicated to the Worker.
    c. The Worker is required to perform his or her duties in an ethical manner, preserving and respecting the rights and dignity of the Participant, in compliance with the Minnesota Vulnerable Adults and Maltreatment of Minors Acts.
    d. Hours of work may vary from week to week and will be established by Representative. Worker is not authorized and agrees not to work in excess of 40 hours per week (or a lesser number established by Representative) without prior written permission from both PICS and the Representative.
    e. The Worker will utilize all appropriate safeguards and universal health precautions, assuming at all times the possible presence of communicable disease.
    f. Worker represents and warrants that he or she is able to perform the essential functions of the job with or without reasonable accommodation and that he or she will advise the Representative if accommodation is needed.
4. I understand that I cannot begin providing services in this program before I have successfully cleared the required background checked, completed all of the required employment paperwork including proof that you are eligible to work in the United States, and the participant has been approved for services.
5. I understand that I may not submit time records and will not be paid for any time while the participant is admitted to the hospital or other type of rehabilitation facility. I understand I cannot be paid for any period for which the participant is not eligible for or receiving services.
6. I understand that not being absent from providing direct support for more than 1 year is a requirement for continued employment.
7. I understand that any false claims (including reporting hours not worked) or untruthful submission of documents, in an attempt to obtain improper payment, is reportable as Medicaid Fraud and subject to investigation. Medicaid Fraud is a felony and can lead to penalties. It is a federal crime to provide materially false information on service billings for medical assistance or services provided under a federally approved waiver plan as authorized under Minnesota Statutes, sections 256B.0913, 256B.0915, 256B.092 and 256B.49.
8. I agree to report work injuries to my Representative and to PICS Human Resources at 651-967-5060 or hr@picsmn.org. I agree to report any work injuries within 24 hours and I acknowledge that reporting incidents or accidents is critical for processing worker's compensation claims.
9. Benefits: All benefits are outlined in the SEIU collective bargaining agreement. Health insurance, dental insurance, life insurance, disability insurance, or retirement is not offered to workers in this program. PTO: Workers accrue 1 hour of PTO for every 40 hours worked. Workers also have the option to waive their right to accrue PTO. SICK: Sick and Safe leave are administered per the applicable city ordinance rules. Other: In accordance with Minnesota Law and PICS policy, if relationship requires, the Worker will be covered under workers' compensation and unemployment compensation insurances.
10. Deductions: Before you receive your paycheck, various deductions will be made. By law, deductions for federal income tax, federal Social Security, Medicare and state income tax will be taken. Your paycheck will include a statement of all earnings, deductions and PTO balance.
11. Training: I acknowledge that I will receive on the job training from the Representative.
12. Transportation: If, while performing services under this Agreement, I understand that while working if a vehicle is used to transport the Participant for any reason, the Representative will certify that only a vehicle in good working order owned by either the Representative or the Worker will be used and will be Fully Insured. "Fully Insured" means that the insurance coverage on the vehicle is at least $500,000 single limit liability, $500,000 uninsured motorist coverage and $500,000 underinsured motorist coverage.
13. Employment-At-Will. Employment with the Representative, with administrative duties by PICS, will be employment-at-will, meaning that either the Representative or Worker may terminate the employment relationship at any time, for any legal reason, with or without notice. However, where possible, the Representative will attempt to give the Worker up to two weeks' advance written notice of termination. The Representative requests that the Worker also attempt to give two weeks' advance written notice of resignation. Nothing in this provision is intended to nor does it alter the at-will employment relationship.


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14. Policy and Employment Information: On behalf of the Representative, PICS will provide the Worker with an employment handbook that contains important information regarding employment in self-directed services, diversity, ADA and reasonable accommodation, code of ethics, anti-harassment stance, worker expectation requirements, and benefits and payroll information.
15. I agree to make a report if I suspect that abuse, neglect or exploitation or a vulnerable person has occurred. For reports involving a vulnerable adult, go to www.mn.gov/dhs/reportadultabuse/ or call (24/7) 844-880-1574. For reports involving maltreatment of a child, contact the participants case manager or contact PICS at 651-967-5060.
16. I hereby agree to abide by the security and confidentiality of protected data of the client and others, including protected health information (PHI) under the Health Insurance Portability and Accountability Act (HIPAA).
17. Contact Person. The Worker has been recruited and hired by and will receive orientation and direction from the Representative, who shall control the Worker's workplace activities. In addition to acting as payroll administrator on behalf of the Representative, PICS acts as a consultant to the Representative in connection with a number of services that are intended to ensure compliance with applicable laws and regulations. Both the Worker and the Representative have access to PICS staff for information and clarification.
18. Agreement: This Agreement constitutes the entire agreement between the parties, and that there are no other oral or written agreements, understandings, or other representations between the parties relating to the terms of employment of the Worker. This Agreement supersedes all prior agreements, understandings, discussions, or negotiations relating to this subject matter. This Agreement may be modified or amended if the amendment is made in writing and is signed by the parties to this Agreement. Failure of either party to enforce any provision of this Agreement shall not be construed as a waiver or limitation of that party's right to subsequently enforce and compel strict compliance with every provision of this Agreement. This Agreement, the construction of its terms and the interpretation of the parties' rights and duties, shall be governed by and construed under the laws of the State of Minnesota unless federal law controls the issue in question.

By signing below, I attest that I have read this agreement in its entirety. I understand what is being requested of me, and agree to abide by these terms and conditions. I further understand and agree that violation of any of these terms and/or conditions of this agreement may result in my termination. I understand that this employment agreement may be terminated by any party at any time without advance notice or cause.

**IN WITNESS WHEREOF**, the parties have executed this Agreement.

_____ _____

*Worker Signature* *Date*

_____ _____

*Representative Signature* *Date*


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# False Claims Act Notice

**A. Prevention and Detection of Fraud, Abuse, and Waste**

Partners in Community Supports (PICS) has a longstanding practice of fair and truthful dealing with its participants, their families, the government, health professionals and other business associates. No PICS Associate shall engage in any act of fraud, abuse or waste, such as knowingly making false statements of material fact, in the preparation or submission of any claim for reimbursement under the Medicaid program. A PICS Associate is any PICS worker, Representative, Representative worker, contractor or other agent hired by PICS. Compliance with this Policy is a condition of employment or business relationship with PICS. Violation of this policy is grounds for immediate termination of employment or agency relationship.

The federal Deficit Reduction Act of 2005 ("DRA"), effective January 1, 2007, was enacted to bring entitlement spending under control by increasing the detection and prevention of fraud, waste and abuse. DRA requires Medicaid providers like PICS to implement formal written policies to combat such fraud, abuse and waste. DRA imposes liability on any person who knowingly, directly or indirectly, is involved in presenting a false or fraudulent claim to the U.S. government for payment. DRA also provides special protections for workers who report any such suspected or actual wrongdoing. This Appendix will describe PICS' anti-fraud policies and procedures and the specific federal and Minnesota laws relating to fraud, abuse and waste.

Fraud is an intentional misrepresentation that, when relied on by a payer or other person, deceives that person to his or her detriment. Abusive tactics are broader than fraud, and may include submitting deceptive or misleading claims to a government program like Medicaid, or using a false statement to support a claim. Waste may include other deceptive tactics, such as over-utilization of otherwise necessary services.

*Types of fraud, abuse, or waste which may lead to liability are:*

1. Knowingly filing a false or fraudulent claim for payments to Medicare, Medicaid or another governmentally funded health care program, such as billing for services not actually provided;
2. Knowingly making or using a false record or statement to obtain payment on a false or fraudulent claim from Medicare, Medicaid or other governmental program, such as documenting clinical care not actually provided;
3. Conspiring to defraud Medicare, Medicaid or other governmentally funded health care program by attempting to have a false or fraudulent claim paid; or
4. Knowingly making or using, or causing to be made or used, a false record to statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the government.

   *Examples of the above include but are not limited to:*

   a. Billing for services not actually provided;
   b. Making payments to a phantom vendor or phantom worker;
   c. Paying a vendor or worker for services not actually provided;
   d. Paying an invoice known to be false;
   e. Accepting or soliciting kickbacks or illegal inducements from vendors of services, or offering or paying kickbacks or illegal inducements to vendors of services;
   f. Paying, offering gifts, money, remuneration or free services to entice a Medicaid recipient to use a particular vendor;
   g. Using Medicaid reimbursement to pay a personal expense;
   h. Embezzling; and
   i. Ordering and charging for medical services not necessary for the participant.

   "Knowingly" means that a person (i) has actual knowledge of the information, (ii) acts in deliberate ignorance of the truth or falsity of the information, or (iii) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

**B. Mandatory Reporting Requirement.**

If any PICS Associate has reason to believe that anyone associated with PICS has engaged in any fraud, abuse or waste, the Associate has a duty to report any such observations and concerns immediately to the Executive Director. PICS shall not retaliate against anyone submitting a timely report pursuant to this policy.

All reports shall be investigated under the supervision of the Executive Director. All Associates have a duty to cooperate with any investigation conducted by PICS under this requirement, including but not limited to providing information upon request and meeting with PICS' legal, accounting or other authorized representatives, if directed to do so by the Executive Director.

PICS will take any necessary action to respond appropriately to any substantiated offense and to prevent any further offenses, including but not limited to terminating PICS workers, Representative relationships and contractor or agency contracts. Offenses will be evaluated for voluntary self-disclosure under applicable federal laws, and when warranted, they will be referred to federal and state authorities. PICS will cooperate with government officials investigating or prosecuting any individual referred by PICS.

**C. Federal and State Laws.**

***(i) False Claims Act.***



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Federal law requires Medicaid providers like PICS to provide you with detailed information about the administrative remedies under the federal False Claims Act, 31 U.S.C. §§ 3729-3733 and 3801-3812. These laws are important to you and PICS because they not only provide severe sanctions for submitting false claims to the federal Medicaid program, they also provide whistleblower protections to individuals who alert federal and state officials to offenses.

Under the False Claims Act, individuals or organizations that are found to have knowingly submitted false claims to the federal government, including the Medicaid program, are subject to civil liability in the amount of $5,500 to $11,000 per claim, plus three times the amount of damages the government sustained because of the illegal act. Offenders also face exclusion from the Medicaid and Medicare programs. Penalties may be reduced for providers who promptly self-disclose suspected False Claims Act violations if the information is submitted within 30 days of learning of it, if the organization fully cooperates with the government's investigation of the violation and depending on whether the government has already begun its own investigation of the reported violation.

***(ii) Program Fraud Civil Remedies Act.***

Under the Program Fraud Civil Remedies Act of 1986, a separate law similar to the False Claims Act, a civil money penalty of up to $5,500 per false claim or false statement relating to a claim may be imposed, as well as damages equal to twice the amount of any reimbursed false claim. Investigations may be commenced by the Secretary of Health and Human Services for claims submitted that a person knows are false, that include any written statement that includes a material misstatement of fact or omits a material fact that the person has a duty to disclose or that is in payment for property or services not provided.

***(iii) Minnesota Medical Assistance Fraud Laws.***

In addition to the sanctions levied by federal law, Minnesota law contains criminal and civil penalties for Medical Assistance fraud. Under Minn. Stat. § 609.466, any person who, with the intent to defraud, presents a claim for reimbursement which is false in whole or in part is guilty of an attempt to commit theft of public funds and may be sentenced accordingly. Under Minn. Stat. § 256B.121, any vendor of medical care who willfully submits a claim for reimbursement that is known to be a false claim is also subject to a civil action by the State of Minnesota for three times the payments which result from the false representation, costs and attorneys' fees.

***(iv) Minnesota Vulnerable Adult Law***.

Subjecting a vulnerable adult to unnecessary and over-utilized services for the profit or advantage of another may also constitute financial exploitation under the Minnesota Vulnerable Adults Act, Minn. Stat. §§626.5572, subd. 9 and 609.2335.

***(v) Whistleblower Protections under federal and Minnesota Law.***

The federal False Claims Act, at 31 U.S.C. §3730(h), provides anti-retaliation protections for whistle-blowing workers. If an worker participates in the investigation for, initiation of, testimony for, or assistance in an action filed under the False Claims Act, the employer may not discharge, demote, suspend, threaten, harass or in any other manner discriminate against the worker in the terms and conditions of employment, in retaliation for the worker's protected action.

Relief for an worker who is retaliated against in violation of 31 U.S.C. §3730(h) may include reinstatement, double back pay with interest, and compensation for any special damages, including litigation costs and reasonable attorneys' fees.

In addition, the False Claims Act enables private individuals to initiate lawsuits on behalf of the federal government against any party who submitted false claims for payment from the Medicaid program. Known as *qui tam* actions, the suing private plaintiff, if successful, may be rewarded part of any penalty recovered and the remainder goes to the government. Depending upon the circumstances of each case, the government may intervene. In cases where the government declines to intervene and the private plaintiff pursues the action on his or her own, the plaintiff's recovery share may be as great as 25 to 30% of the penalty. In cases where the government elects to intervene, the court may award between 15 and 25% of the recovery to the private plaintiff. Individuals who initiate *qui tam* cases may not be discriminated or retaliated against in any manner by their employers. Employer violations of the *qui tam* anti-retaliation provisions could result in reinstatement and damages of double the amount of lost wages if the worker is fired and any other damages sustained if the worker is otherwise discriminated against.

The Minnesota Whistleblower Law, Minn. Stat. §181.932, prohibits employers from discharging, disciplining, threatening or otherwise discriminating against or penalizing an worker for good faith reporting of suspected violations of any state or federal law or rule, or for participating in a government investigation. The law allows workers to refuse an employer's order to perform an act that violates federal or state law. The Minnesota law expressly authorizes a worker to report in good faith violations of federal or state health care standards that put the public at risk.

**D. PICS Fraud Prevention and Detection Policy.**

PICS has adopted Policies and Procedures for Maintaining Program Integrity by Preventing Fraud, Abuse and Other Wasteful Financial Practices (Attachment 1). These Policies and Procedures describe PICS' internal efforts to maintain the integrity of our billing and reimbursement policies, as well as the process for reporting and investigation of fraud, waste and abuse. It is a condition of every Associate's employment or agency relationship with PICS that both this Policy and the False Claims Policy be read, understand and complied with. Anyone with questions about this policy or who desires to report a suspected False Claims Act or other fraud-related violation should immediately contact the Executive Director. Anyone who feels retaliated against under the whistleblower and *qui tam* protections of the laws, as described above, should immediately contact the Executive Director or any member of the Board. PICS reserves the right to amend or terminate this Policy as applicable laws or circumstances require.



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