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 *(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)*
☐	Demographic Survey

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

Completed	*Recommended for Representative's Records – available by request from PICS*
☐	Employment Application
☐	Job Description
☐	Training as Identified by Representative

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**

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 **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 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.

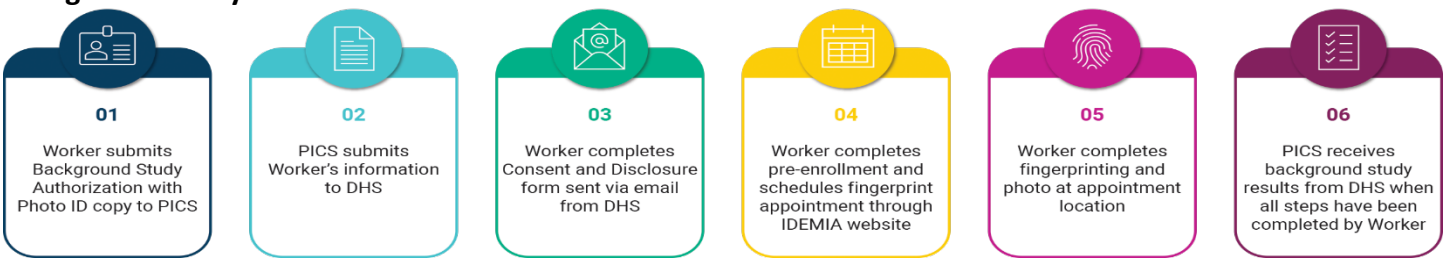
By signing this agreement, you are agreeing to be legally bound by all of its terms. If you have questions about it, you should get answers to them before signing this agreement. If you need or want legal advice, you should contact your own attorney. For more information, call 651-431-2700.

Background Study Authorization

***Please Note**:*

- *Background study results must be complete and in accordance with Minnesota Statute 245c.14 before providing direct support.*
- *Processed through MN Department of Human Services and fingerpringing is required.*

Background Study Instructions



Worker Information *(submit form with copy of photo ID)*

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 (Required)		
RACE		PLACE OF BIRTH *(U.S. STATE OR COUNTRY if outside the U.S.)*		
SOCIAL SECURITY NUMBER		PRIOR NAMES AND ALIASES USED		

Required if you have lived in another U.S. state that is outside of Minnesota in the last 5 years.		
U.S. CITY	U.S. STATE	YEAR – YEAR AT ADDRESS

Required if photo ID doesn't include eye color, hair color, height, and weight.			
EYE COLOR	HAIR COLOR	HEIGHT	WEIGHT

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*

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

Acceptable Forms of Identification
For DHS Background Studies

Entities that initiate background studies are required by law to verify the background study subject's identity in NETStudy 2.0. This is a summary of acceptable forms of identification to be used for DHS background studies.

Primary Identification Document
When a background study subject has a valid* picture identification listed below use this document for identity verification:

- State-Issued Driver's License – the issuing authority must be a US state or territory
- State-Issued Identification Card – the issuing authority must be a US state or territory
- US Passport or US Passport Card

***Valid Documentation:** Only unexpired, original documentation is acceptable, except when a background study subject presents an acceptable receipt for a primary or secondary identification document. There are three types of acceptable receipts:

- A receipt showing that the subject has applied to replace the primary or secondary identification document;
- The arrival portion of Form I-94/I-94A with a temporary I-551 stamp and photograph of the individual;
- The departure portion of Form I-94/I-94A with a refugee admission stamp.

Secondary Identification Document
If a background study subject does not have a valid picture identification listed above, the following secondary identification documents (consistent with federal employment requirements and the I9 form) may be used for identity verification:

- School ID card that includes a photograph
- Voter's registration card
- US military card or draft record
- Military dependent's ID card
- US Coast Guard Merchant Mariners Document (MMD) Card
- Native American tribal document
- Driver's License issued by a Canadian government authority
- Permanent Resident Card or Alien Registration Receipt Card (Form I-551)
- Foreign passport containing temporary I-551 stamp/printed notation on a machine-readable immigrant visa (MRIV)
- Employment Authorization Document (Card) that contains a photograph (Form I-766)
- Foreign passport with Form I-94/I-94A, Arrival/Departure Report bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status that authorizes such alien to work for a specific employer incident to this status. This document may only be used if the period of endorsement has not yet expired.
- Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94/I-94A showing nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI.
- Foreign passport with special documents issued by the Commonwealth of Northern Mariana Islands (CNMI)
- Foreign passport that contains a temporary I-551 stamp/printed notation on a machine-readable immigrant visa (MRIV)

Exceptions – People Under Age 18
People under 18 who are unable to present a picture identification document listed in the Primary Identification Document section may present the following acceptable secondary identification documents:

- School report or report card
- Clinic, doctor, or hospital record
- Day-care, or nursery school record

Legal References

- Information required to be provided by background study subjects; See Minnesota Statutes, section 245C.05, subd. 1.
- Information required to be verified by the entity initiating the background study; See Minnesota – the issuing authority must be a US state or territory; See Minnesota Statutes, section 245C.05, subd. 2 (a).

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

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

Updated: 02/12/2015

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*

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2024

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
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, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

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

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

Step 3: Claim Dependent and Other Credits

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

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

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 2024 if you meet both of the following conditions: you had no federal income tax liability in 2023 **and** you expect to have no federal income tax liability in 2024. You had no federal income tax liability in 2023 if (1) your total tax on line 24 on your 2023 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 2024 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, 2025.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

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

1. Expect to work only part of the year;

2. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

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

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

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

Specific Instructions

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

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

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

Instead, if you (and your spouse) have a total of only two jobs, you may check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount 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 2024 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; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

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

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

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

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

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

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

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

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

1 Enter an estimate of your 2024 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:
- $29,200 if you're married filing jointly or a qualifying surviving spouse
- $21,900 if you're head of household
- $14,600 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	$780	$850	$940	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,370
$10,000 - 19,999	0	780	1,780	1,940	2,140	2,220	2,220	2,220	2,220	2,220	2,570	3,570
$20,000 - 29,999	780	1,780	2,870	3,140	3,340	3,420	3,420	3,420	3,420	3,770	4,770	5,770
$30,000 - 39,999	850	1,940	3,140	3,410	3,610	3,690	3,690	3,690	4,040	5,040	6,040	7,040
$40,000 - 49,999	940	2,140	3,340	3,610	3,810	3,890	3,890	4,240	5,240	6,240	7,240	8,240
$50,000 - 59,999	1,020	2,220	3,420	3,690	3,890	3,970	4,320	5,320	6,320	7,320	8,320	9,320
$60,000 - 69,999	1,020	2,220	3,420	3,690	3,890	4,320	5,320	6,320	7,320	8,320	9,320	10,320
$70,000 - 79,999	1,020	2,220	3,420	3,690	4,240	5,320	6,320	7,320	8,320	9,320	10,320	11,320
$80,000 - 99,999	1,020	2,220	3,620	4,890	6,090	7,170	8,170	9,170	10,170	11,170	12,170	13,170
$100,000 - 149,999	1,870	4,070	6,270	7,540	8,740	9,820	10,820	11,820	12,830	14,030	15,230	16,430
$150,000 - 239,999	1,960	4,360	6,760	8,230	9,630	10,910	12,110	13,310	14,510	15,710	16,910	18,110
$240,000 - 259,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$260,000 - 279,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$280,000 - 299,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,380
$300,000 - 319,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,980	17,980	19,980
$320,000 - 364,999	2,040	4,440	6,840	8,310	9,710	11,280	13,280	15,280	17,280	19,280	21,280	23,280
$365,000 - 524,999	2,720	6,010	9,510	12,080	14,580	16,950	19,250	21,550	23,850	26,150	28,450	30,750
$525,000 and over	3,140	6,840	10,540	13,310	16,010	18,590	21,090	23,590	26,090	28,590	31,090	33,590

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	$240	$870	$1,020	$1,020	$1,020	$1,540	$1,870	$1,870	$1,870	$1,870	$1,910	$2,040
$10,000 - 19,999	870	1,680	1,830	1,830	2,350	3,350	3,680	3,680	3,680	3,720	3,920	4,050
$20,000 - 29,999	1,020	1,830	1,980	2,510	3,510	4,510	4,830	4,830	4,870	5,070	5,270	5,400
$30,000 - 39,999	1,020	1,830	2,510	3,510	4,510	5,510	5,830	5,870	6,070	6,270	6,470	6,600
$40,000 - 59,999	1,390	3,200	4,360	5,360	6,360	7,370	7,890	8,090	8,290	8,490	8,690	8,820
$60,000 - 79,999	1,870	3,680	4,830	5,840	7,040	8,240	8,770	8,970	9,170	9,370	9,570	9,700
$80,000 - 99,999	1,870	3,690	5,040	6,240	7,440	8,640	9,170	9,370	9,570	9,770	9,970	10,810
$100,000 - 124,999	2,040	4,050	5,400	6,600	7,800	9,000	9,530	9,730	10,180	11,180	12,180	13,120
$125,000 - 149,999	2,040	4,050	5,400	6,600	7,800	9,000	10,180	11,180	12,180	13,180	14,180	15,310
$150,000 - 174,999	2,040	4,050	5,400	6,860	8,860	10,860	12,180	13,180	14,230	15,530	16,830	18,060
$175,000 - 199,999	2,040	4,710	6,860	8,860	10,860	12,860	14,380	15,680	16,980	18,280	19,580	20,810
$200,000 - 249,999	2,720	5,610	8,060	10,360	12,660	14,960	16,590	17,890	19,190	20,490	21,790	23,020
$250,000 - 399,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$400,000 - 449,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$450,000 and over	3,140	6,450	9,110	11,610	14,110	16,610	18,430	19,930	21,430	22,930	24,430	25,870

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	$510	$850	$1,020	$1,020	$1,020	$1,020	$1,220	$1,870	$1,870	$1,870	$1,960
$10,000 - 19,999	510	1,510	2,020	2,220	2,220	2,220	2,420	3,420	4,070	4,070	4,160	4,360
$20,000 - 29,999	850	2,020	2,560	2,760	2,760	2,960	3,960	4,960	5,610	5,700	5,900	6,100
$30,000 - 39,999	1,020	2,220	2,760	2,960	3,160	4,160	5,160	6,160	6,900	7,100	7,300	7,500
$40,000 - 59,999	1,020	2,220	2,810	4,010	5,010	6,010	7,070	8,270	9,120	9,320	9,520	9,720
$60,000 - 79,999	1,070	3,270	4,810	6,010	7,070	8,270	9,470	10,670	11,520	11,720	11,920	12,120
$80,000 - 99,999	1,870	4,070	5,670	7,070	8,270	9,470	10,670	11,870	12,720	12,920	13,120	13,450
$100,000 - 124,999	2,020	4,420	6,160	7,560	8,760	9,960	11,160	12,360	13,210	13,880	14,880	15,880
$125,000 - 149,999	2,040	4,440	6,180	7,580	8,780	9,980	11,250	13,250	14,900	15,900	16,900	17,900
$150,000 - 174,999	2,040	4,440	6,180	7,580	9,250	11,250	13,250	15,250	16,900	18,030	19,330	20,630
$175,000 - 199,999	2,040	4,510	7,050	9,250	11,250	13,250	15,250	17,530	19,480	20,780	22,080	23,380
$200,000 - 249,999	2,720	5,920	8,620	11,120	13,420	15,720	18,020	20,320	22,270	23,570	24,870	26,170
$250,000 - 449,999	2,970	6,470	9,310	11,810	14,110	16,410	18,710	21,010	22,960	24,260	25,560	26,860
$450,000 and over	3,140	6,840	9,880	12,580	15,080	17,580	20,080	22,580	24,730	26,230	27,730	29,230

DEPARTMENT OF REVENUE

2024 W-4MN, Minnesota Withholding Allowance/Exemption Certificate

* 2 4 2 4 6 1 *

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

City | State | ZIP Code

Marital Status *(Check one):*

- ☐ 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 2024 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 2024 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 2024 Minnesota itemized deductions. For 2024, you may have to reduce your itemized deductions if your income is over $232,500 ($116,250 for Married Filing Separately). . . . . _____

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

a. $29,150 if Married Filing Jointly

b. $21,900 if Head of Household

c. $14,575 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 2024 additional standard deduction (from page 11 of the Form M1 instructions) . . . . . _____

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

6 Enter an estimate of your 2024 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 $5,050. 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.

Form W-4MN Employer Instructions

Form W-4MN Requirement

Federal Form W-4 will not determine withholding allowances used to determine the amount of Minnesota withholding. Employees completing a 2024 Form W-4 will need to complete 2024 Form W-4MN to determine the appropriate amount of Minnesota withholding.

Lock-In Letters

IRS Letter 2800C tells you when the IRS believes your employee may have filed an incorrect federal Form W-4. If you receive this letter, you must provide the Minnesota Department of Revenue with a copy of the employee's Form W-4MN. We will verify the number of allowances that the employee may claim for Minnesota purposes. Continue using the Form W-4MN you were using at the time you received Letter 2800C from the IRS, until we notify you to change the amount of allowances on the employee's Form W-4MN. If the employee has not completed a Form W-4MN, have them complete the form and use the allowances calculated on that form until notified by the department.

Use the amount on line 1 of page 1 for calculating the withholding tax for your employees.

When does an employee complete Form W-4MN?

Employees complete Form W-4MN no later than when they begin employment or when their personal or financial situation changes.

How should I determine Minnesota withholding for an employee that does not complete Form W-4MN?

If an employee does not complete Form W-4MN and they have a federal Form W-4 (from 2019 or prior years) on file, use the allowances on their federal Form W-4. Otherwise, withhold Minnesota tax as if the employee is single with zero withholding allowances.

What if my employee claims to be exempt from Minnesota withholding?

If your employee claims exempt from Minnesota withholding, they must complete Section 2 of Form W-4MN. They must provide you with a new Form W-4MN by February 15 of each year. If you are paying an employee for wages that are exempt from withholding, such as Medicaid Waiver Payments or wages to H-2A visa workers, do not send us Form W-4MN.

When do I need to submit copies of a Form W-4MN to the department?

You must send copies of Form W-4MN to us if any of these apply:

- The employee claims more than 10 Minnesota withholding allowances
- The employee checked box A or B under Section 2, and you reasonably expect the employee's wages to exceed $200 per week
- You believe the employee is not entitled to the number of allowances claimed

You do not need to submit Form W-4MN to us if the employee is asking to have additional Minnesota withholding deducted from their pay.

We may assess a $50 penalty for each Form W-4MN you do not file with us when required.

Mail Forms W-4MN to:

Minnesota Department of Revenue
Mail Station 6501
600 N. Robert St.
St. Paul, MN 55146-6501

What if my employee is a resident of a state that has a reciprocity agreement with Minnesota?

Your employee must complete Form MWR, Reciprocity Exemption/Affidavit of Residency if both of these apply:

- They are a resident of North Dakota or Michigan, and
- They do not want you to withhold Minnesota tax from their wages

Your employee must complete a Form MWR by February 28 of each year, or within 30 days after they begin working or change their permanent residence. See Withholding Fact Sheet 20, *Reciprocity - Employee Withholding*, for more information.

What is an invalid Form W-4MN?

A Form W-4MN is considered invalid if any of these apply:

- There is any unauthorized change or addition to the form, including any change to the language certifying the form is correct
- The employee indicates in any way the form is false by the date they provide you with the form
- The form is incomplete or lacks the necessary signatures
- Both Section 1 and Section 2 were completed
- The employer information is incomplete

What if I receive an invalid form?

Do not use the invalid form to calculate Minnesota income tax withholding. Have the employee complete and submit a new Form W-4MN. If the employee does not give you a valid form, and you have an earlier Form W-4MN from them, use the earlier form to calculate their withholding.

If a valid Form W-4MN is not completed by the employee, withhold taxes as if the employee is single and claiming zero withholding allowances.

What if my employee is a nonresident alien of the United States?

If the wages to this employee are subject to income tax withholding, you will use Table 1 and the procedure under **Withholding Adjustment for Nonresident Alien Employees** in IRS Publication 15-T to determine the correct Minnesota withholding tax. Do not use this procedure for nonresident alien students from India and business apprentices from India. Also do not use this procedure for certain nonresident aliens who are residents of South Korea. See IRS Notice 1392 for special instructions and withholding exceptions.

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)*

EMPLOYEE FULL NAME or BUSINESS NAME		EMAIL
FULL MAILING ADDRESS		
PHONE NUMBER	DATE OF BIRTH	SSN (LAST 4 DIGITS) or EIN (EMPLOYER IDENTIFICATION NUMBER)

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 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 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*

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*

Money Network™ Visa® Debit Card

To receive a Money Network 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 Money Network Debit Card.

The 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 Money Network™ Check Program Account ("Account") every payday so you have immediate access to your money.

Advantages to Money Network™

- Check account balance for free online or by phone
- Pay bills online with *Money Network*™ 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 Money Network pay card option, I hereby authorize PICS to assign me a 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.*

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.

FEA I-9 Sample

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

Section 1: Worker will complete Steps 1 - 9. Please note that an **electronic signature cannot be used 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. 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 here.

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

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

8. Provide your handwritten signature. **Electronic signature cannot be used.**

9. Print the date you completed the I-9 form. **No later than your first day of work for pay.**

Employment Eligibility Verification

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

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

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

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

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

Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	Other Last Names Used (if any)
1 SMITH	JANE	M	DOE

Address (Street Number and Name)	Apt. Number (if any)	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 Email Address	Employee's Telephone Number
3 01/01/1960	4 1 2 3 4 5 6 7 8 9	5 JSMITH@EMAIL.COM	6 123-456-6789

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

7 Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

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

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

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

Signature of Employee	Today's Date (mm/dd/yyyy)
8 *Jane Smith*	9 10/01/2023

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

SAMPLE

**If a preparer or translator assisted the Worker in completing Section 1, please refer to pg. 3 of this Sample on how to complete Supplement A, Preparer and/or Translator Certification.*

Section 2: Representative or Authorized Representative will complete Steps 1 - 6. 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 an **electronic signature cannot be used on the I-9 form**.

The Worker **CANNOT complete Section 2 of their own I-9 form.**

Authorized Representative (Steps 1- 6)

1. 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.

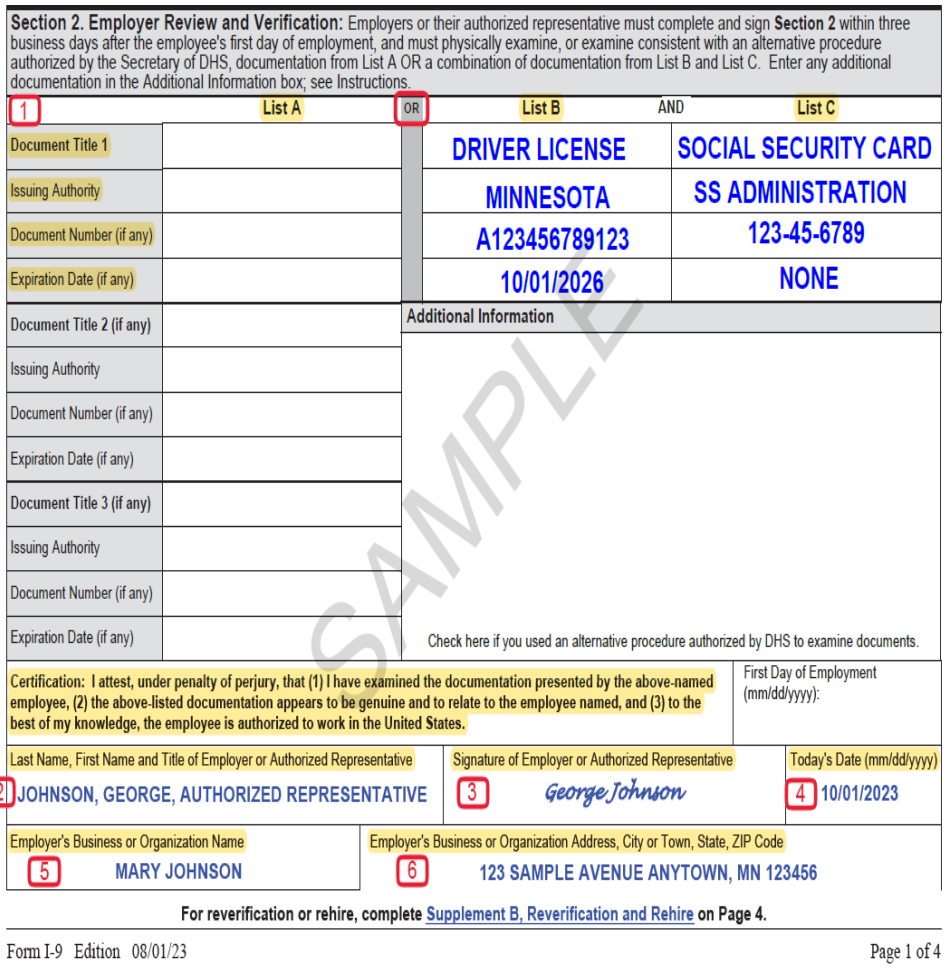
2. Print your Last Name, First Name, and print your title as "Authorized Representative".

3. Provide your handwritten signature. **Electronic signature cannot be used.**

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

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

6. Print the FEIN Holder's entire home address. A PO Box is not allowed.



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

1	List A	OR	List B	AND	List C
Document Title 1			DRIVER LICENSE		SOCIAL SECURITY CARD
Issuing Authority			MINNESOTA		SS ADMINISTRATION
Document Number (if any)			A123456789123		123-45-6789
Expiration Date (if any)			10/01/2026		NONE
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

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

SAMPLE

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

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

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)
2 JOHNSON, GEORGE, AUTHORIZED REPRESENTATIVE	3 George Johnson	4 10/01/2023

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
5 MARY JOHNSON	6 123 SAMPLE AVENUE ANYTOWN, MN 123456

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

Form I-9 Edition 08/01/23 Page 1 of 4

Partners in Community Supports

Please only complete Supplement A, Preparer and/or Translator Certification, if a preparer or translator assisted in completion of Section 1 of the I-9 form.

Supplement A: Preparer and/or Translator will complete Steps 1 - 5. Please note that an **electronic signature cannot be used on the I-9 form**.

Preparer/Translator (Steps 1- 5)

1. Print the Worker's Last Name, First Name, and Middle Initial matching Section 1.

2. Provide your handwritten signature. **Electronic signature cannot be used.**

3. Print the date you signed the form. This should match the date Section 1 was completed.

4. Print your Last Name, First Name, and Middle Initial.

5. Print your entire address. A PO Box is not allowed.

If more than one preparer and/or translator was used to assist a Worker in completion of Section 1, repeat Steps 2 – 5 on subsequent fields on Supplement A per preparer/translator.

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

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

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

Last Name *(Family Name)* from Section 1.	First Name *(Given Name)* from Section 1.	Middle initial *(if any)* from Section 1.
1 SMITH	JANE	M

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
2 *John Translator*			3 10/01/2023
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
4 TRANSLATOR	JOHN		D
Address *(Street Number and Name)* 5	City or Town	State	ZIP Code
123 TRANSLATION ST	ANYTOWN	MN	12345

SAMPLE

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

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

SAMPLE

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

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 07/31/2026

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

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

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

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

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

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

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

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

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

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

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

Additional Information

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS

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

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

Acceptable Receipts

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

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

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

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

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

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

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

FEA Program Employment Agreement

Worker Name:	**Representative Name:**
Participant Name:	**Participant Employer/FEIN Holder:**

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 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.

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.

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*

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.

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.