Lifelong Advocacy, Inc.
43970 N Gratiot Ave – Clinton Twp, MI 48036
586-846-2457
www.lifelongadvocacy.org

New Hire Packet - **PLEASE READ**

- Employee must submit a copy of current driver's license and social security card with packet
- DO NOT email or fax new hire packet. We must have the original packet
- Packets must be printed on one side only
- We have up to 5 business days to process a completed packet, we will contact the consumer when processing is complete
- Do not schedule the new employee to work until you have received a call from Lifelong confirming they are approved and can begin working

Please go to www.lifelongadvocacy.org to access the MCCMH Training Guide which is under the *Training* tab. Follow links in training guide to the websites to complete training.

- Staff must meet minimum training requirements in order to be paid.
- The trainings on the MCCMH Training Guide MUST be followed.

Training required by MCCMH prior to approval of new hire packet:

- Bloodborne Pathogens
- IPOS – Individual Plan of Service Training Verification Form

Training required by MCCMH within 30 days of hire:

- Basic First Aid – can be taken online through American Heart or American Red Cross
- Recipient Rights – must be taken through Macomb County Office of Recipient Rights
- Emergency Preparedness – Only required if consumer is enrolled in SED or Children's waiver programs
- Behaviorist Treatment Plan specific to person –if a plan is in place

Training Strongly Encouraged by MCCMH, only required if employer wants staff to take training

- Corporate Compliance/HIPAA
- CPR-Cardiopulmonary Resuscitation
- Cultural Competency
- Grievances and Appeals
- Limited English Proficiency
- Trauma Informed Care

Please read!

Please keep these sheets for future reference.

Answers to some common questions

REGARDING TIME SHEETS AND PAYROLL

Time sheets are LEGAL documents. According to Medicaid Rules, LifeLong Advocacy CANNOT ALTER TIME SHEETS IN ANY WAY EXCEPT TO CORRECT A MATHEMATICAL ERROR. We cannot check off a box, change a time or even a date. We cannot sign paperwork for the employer or employee. If any of these are missing or incorrect we/LifeLong (by Medicaid Policy) must send the timesheets back to the employer for corrections.

Per Medicaid Policy, we cannot pay for two services on the same date and time.

Example: January 1, 2023 – the time sheet shows from 3-5 o'clock the consumer had physical therapy and they also billed for CLS services. This is an "overlap" and we cannot pay for that time!

When are my time sheets due?
Your time sheets are due on the 16th and the 1st of each month.

What happens if I turn in my time sheets late?
Chances are you will not be paid on the scheduled pay date, and if you have Direct Deposit, it will not be put into your account. You will receive a paycheck, by mail, as soon as possible.

When do we get paid?
Pay dates are on the 10th and 25th of each month.

If I have Direct Deposit when will my funds be in the bank?
They will be posted to your account on the 10th and the 25th of each month. Please do NOT call our office the day before, asking if we are going to post your check sooner.

Do I get paid if any of my certifications expire?
NO, you will not be paid if you are not in compliance. We are not allowed to pay for the hours worked when you are non-compliant with the Medicaid Guidelines. When you finally get your updated certifications we cannot back pay you for the hours worked.

It is up to both you and your employer to make sure that you are tracking when your certifications expire. LifeLong tries to assist in this process, but the responsibility is yours to maintain records. We do offer an auto-generated email reminder from "First Voice" that will remind the employer in advance of certifications expiring. Please call our office for more information if needed. MCCMH also has a training tracking guide to help you track your employees training.

REGARDING REIMBURSEMENT FOR CLASSES

Do we get reimbursed for the cost of a class?
You may be reimbursed for the cost of a class not offered by the county such as First Aid CPR if the consumer's budget allows. Have your employer speak to the FI here at Lifelong to see if there is room in their budget to compensate you for the costs.

Do you pay for the time while I am taking the class?
We will reimburse you for the hours spent in the classroom (at minimum wage).

When and how do I get reimbursed?
Keep the reimbursement sheet from the New Hire Packet and make copies. The Reimbursement Sheet must have EACH SECTION filled out entirely and it must be signed by the employer and employee. The Reimbursement sheet must be turned in immediately (upon taking the class) with the certifications ATTACED. If staff is completing the form to be reimbursed for cost of First Aid and/or CPR-if required by employer, we will need a copy of the receipt. We will process it within 30 days of receiving the properly filled out paperwork with certs or class costs receipt.

Can I take online classes?
Bloodborne Pathogens is taken online. Training information for the Bloodborne Pathogens is on page 1 of the MCCMH Training guide. There are 3 websites listed, only 1 needs to be completed. The MCCMH Training guide is on our website lifelongadvocacy.org under the training tab an on mccmh.net/training.

Macomb County Office of Recipient Rights is no longer offering virtual training. We have the updated training memos on our website lifelongadcvocacy.org under the training tab. Classes are first come first serve with a capacity of 100. Employees will need their date of hire and name of employer or Fiscal Intermediary.

- Virtual training can be taken from another CMH Rights Office, it must be a LIVE virtual class.

First Aid can be taken online at this time if it is taken through American Heart or American Red Cross. CPR is only required if the employer wants you to take it. CPR training must be face to face or taken as a blended class with First Aid or in a classroom. We have the MCCMH First Aid CPR flier on our website.

As of January 20, 2021 MCCMH has made Bloodborne Pathogens, IPOS Universal Training Verification Form, First Aid and Recipient Rights required for all staff. If the consumer is in a waiver program the Emergency Preparedness is also required. The remaining training's are Strongly Encouraged. This means it is up to the employer (consumer/guardian) to decide if staff needs to take these trainings. We have the MCCMH training guide on website with this training information.

NEW HIRE PACKET CHECKLIST

All documents must be received to begin processing the packet.

** New Hire Packets **cannot** be emailed or faxed. They can be turned in to the office or mailed in. We must have the original documents.

New Hire packets that have not been approved are kept for 90 days and will be destroyed after that.

_____ Copy of employee's drivers license and social security card MUST be submitted

_____ Background Check page must be completed and signed by the employee.
***Consumers phone number and email must be on this page, this is the number we will call regarding the new hire packet. Email address may be used to send missing document information and will go in our system for training notifications.**

_____ Employment Eligibility Checklist must have a box checked and signed by employee

_____ Tax forms, state and federal must be completed and signed by employee

_____ Employment Agreement is completed by consumer/guardian and employee. Must be completed and signed by employer and employee.

_____ Authorization to Release Recipient Rights Information needs to be completed by employee.

_____ Medicaid Provider Agreement needs to be completed by the employee, they must sign and date the very last line

_____ DHS-1929 Central Registry Clearance Request must be completed if the consumer is a minor.

_____ Employment Eligibility Verification form from Homeland Security must have top section completed by and signed the employee only. We will complete section 2 at the bottom.

_____ MCCMH Individual Plan of Service Training Log (IPOS) must be completed by case manager or trained guardian and employee. We must have a copy of the completed form to approve the new hire packet.

_____ Direct Deposit form must be completed and legible if the employee is going to want direct deposit.

_____ Reimbursement Form must be completed and signed by employer and employee so the employee can be reimbursed for training as long as it is in the budget. Cost of training First Aid and Bloodborne) must have a receipt submitted with reimbursement form as well.

_____ MCCMH Training Tracking form is for the guardian/employee to keep and track employee's training and date of hire, we do not need this form.

_____ Bloodborne training must be completed and we must have a copy of the training certificate to approve the packet.

Do you work (or have you worked) for ANOTHER CONSUMER thru LifeLong? YES or NO
CONSUMER'S NAME: _____

BACKGROUND CHECK INFORMATION REQUIRED

PLEASE NOTE THAT BOTH **STATE** AND **FEDERAL** BACKGROUND CHECKS WILL BE PERFORMED.

If you have a Felony on your record, we cannot hire you.
This New Hire Packet will be destroyed in 90 days if it is not activated.

1. FULL NAME _____
2. Drivers License Number _____
3. Social Security Number _____
4. Birth Date _____
5. Phone Number (H)_____ (C)_____
6. Email Address _____
7. Sex (required by State of Michigan) _____
8. Race (required by State of Michigan) _____
9. Consumer (person receiving your services) _____
10. IMPORTANT! **CONSUMER'S** EMAIL ADDRESS? _____
    (This is for the auto-generated email program to notify you about certifications about to expire)

I authorize investigation of all statements contained in this application for employment as may be necessary in arriving at an employment decision.

SIGN AND DATE BELOW

_____**(Name)** _____ **(Date)**

*** The above signature must match signatures used on ALL data provided to this office.**

If you have any questions and/or to mail in New Hire Packet: Lifelong Advocacy, Inc.
43970 N Gratiot Ave – Clinton Twp 48036 Call: 586-846-2457

CONSUMER'S NAME:_____ ***TELEPHONE #*** _____

OFFICE USE ONLY – do not write below

CALLED _____ I-CHAT _____ MEDICARE/MEDICAID EXCLUSIONS _____ SANCTIONED PROVIDER _____
RRR _____ MEDICAID _____ CROSSREFERENCE _____ I-9 _____

MCCMH/IPOS ENT'D (A) _____ I-CHAT ENT'D (A) _____ M&M ENT'D (A) _____ SANCTIONED ENT'D (A) _____

ALERTS: PG _____ CONSUMER _____ OTHER _____

A-NEW CONSUMER ____ CREATED IN FIRST VOICE _____

NHP STATUS_____

EMPLOYMENT ELIGIBILITY CHECKLIST

Per a "Compliance Alert" sent to LifeLong Advocacy by MCCMH (11/25/13), we are to include a checklist for you to fill out and sign; so that MCCMH can be assured there is no conflict of interest based on MCCMH's requirements.

PLEASE CHECK IF ANY APPLY TO YOU. If you do check any of the items below, you are NOT qualified to work for the Consumer. If you have any questions pertaining to this, please call your Supports Coordinator/Case Manager.

DO NOT CALL LIFELONG ADVOCACY. This is a policy set forth by MCCMH.

COMMUNITY LIVING SUPPORTS (CLS) MAY NOT BE PROVIDED BY THE FOLLOWING INDIVIDUALS, so if you check one listed below you cannot provide services to this consumer.

- ☐ A spouse of an individual receiving services
- ☐ Parents of minor children receiving services
- ☐ The guardians of persons receiving services, including co-guardians and alternate/standby guardians
- ☐ Individuals designated by the person receiving services as attorney-in-fact, under power of attorney, including alternate attorney-in-fact

Respite Care may not be provided by the following:

- ☐ Any of the persons listed above
- ☐ Unpaid primary caregiver of the person receiving services
- ☐ If none of the above pertain to you, PLEASE CHECK HERE

_____ _____

Employee Signature Date

Please note: If at a later date MCCMH should become aware that a conflict of interest exists between the employee and the person served (consumer), the employee will be liable to MCCMH to pay back ALL amounts received under the employment arrangement while a conflict of interest was in existence.

NHP - ELIGIBILITY

MI-W4

(Rev. 12-20)

EMPLOYEE'S MICHIGAN WITHHOLDING EXEMPTION CERTIFICATE
STATE OF MICHIGAN - DEPARTMENT OF TREASURY

This certificate is for Michigan income tax withholding purposes only. Read instructions on page 2 before completing this form.

Issued under P.A. 281 of 1967.

▶ 1. Full Social Security Number			▶ 2. Date of Birth	
▶ 3. Name (First, Middle Initial, Last)			4. Driver's License Number or State ID	
Home Address (No., Street, P.O. Box or Rural Route)			▶ 5. Are you a new employee? ☐ Yes If Yes, enter date of hire..... ☐ No	(mm/dd/yyyy)
City or Town	State	ZIP Code		

6. Enter the number of personal and dependent exemptions (see instructions).....	▶ 6.	
7. Additional amount you want deducted from each pay (if employer agrees).....	7.	$ .00

8. I claim exemption from withholding because (see instructions):

a. ☐ A Michigan income tax liability is not expected this year.

b. ☐ Wages are exempt from withholding. Explain: _____

c. ☐ Permanent home (domicile) is located in the following Renaissance Zone: _____

EMPLOYEE: If you fail or refuse to file this form, your employer must withhold Michigan income tax from your wages without allowance for any exemptions. Keep a copy of this form for your records. See additional instructions on page 2.

Under penalty of perjury, I certify that the number of withholding exemptions claimed on this certificate does not exceed the number I am allowed to claim. If claiming exemption from withholding, I certify that I do not anticipate a Michigan income tax liability this year.

9. Employee's Signature	▶ Date

EMPLOYER: Complete the below section.

10. Employer's Name	▶ 11. Federal Employer Identification Number		
Address (No., Street, P.O. Box or Rural Route)	City or Town	State	ZIP Code
Name of Contact Person	Contact Phone Number		

INSTRUCTIONS TO EMPLOYER: Keep a copy of this certificate with your records. All new hires must be reported to the State of Michigan. See: www.mi-newhire.com for information.

In addition, a copy of this form must be sent to the Michigan Department of Treasury if the employee claims 10 or more exemptions or claims they are exempt from withholding. Send a copy to:

Michigan Department of Treasury
Tax Technical Section
P.O. Box 30477
Lansing, MI 48909

INSTRUCTIONS TO *EMPLOYEE'S MICHIGAN WITHHOLDING EXEMPTION CERTIFICATE* (Form MI-W4)

You must submit a Michigan withholding exemption certificate (form MI-W4) to your employer on or before the date that employment begins. If you fail or refuse to submit this certificate, your employer must withhold tax from your compensation without allowance for any exemptions. Your employer is required to notify the Michigan Department of Treasury if you have claimed 10 or more personal or dependency exemptions or claimed that you are exempt from withholding.

You MUST provide a new MI-W4 to your employer within 10 days if your residency status changes or if your exemptions decrease because: a) your spouse, for whom you have been claiming an exemption, is divorced or legally separated from you or claims his/her own exemption(s) on a separate certificate, or b) a dependent no longer qualifies under the Internal Revenue Code.

Line 5: If you check "Yes," enter your date of hire.

Line 6: Personal and dependency exemptions. The number of exemptions claimed here may not exceed the number of exemptions you are entitled to claim on a *Michigan Individual Income Tax Return* (Form MI-1040). Dependents include qualifying children and qualifying relatives under the Internal Revenue Code, even if your AGI exceeds the limits to claim federal tax credits for them.

Do not claim the same exemptions more than once or tax will be under-withheld. Specifically, **do not claim:**

- Your personal exemption if someone else will claim you as their dependent.
- Your personal exemption with more than one employer at a time.
- Your spouse's personal exemption if they claim it with their employer.
- Your dependency exemptions if someone else (for example, your spouse) is claiming them with their employer.

Line 7: You may designate additional withholding if you expect to owe more than the amount withheld.

Line 8a: You may claim exemption from Michigan income tax withholding if all of the following conditions are met:

i) Your employment is intermittent, temporary, or less than full time;

ii) Your personal and dependency exemptions exceed your annual taxable compensation;

iii) You claimed exemption from federal withholding; and

iv) You did not incur a Michigan income tax liability for the previous year.

Line 8b: Reasons wages might be exempt from withholding include:

- You are a nonresident spouse of military personnel stationed in Michigan.
- You are a resident of one of the following reciprocal states while working in Michigan: Illinois, Indiana, Kentucky, Minnesota, Ohio, or Wisconsin.
- You are an enrolled member of a federally-recognized tribe that does not have a tax agreement with the state of Michigan, you reside within that tribe's Indian Country (as defined in 18 USC 1151), and compensation from this job will be earned within that Indian Country.

Line 8c: For questions about Renaissance Zones, contact your local assessor's office.

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

EMPLOYMENT AGREEMENT

This agreement is made on ____/____/____ (date) between _____ *(employer)* and _____ *(employee)* to describe the supports that the employee will provide to the employer and the terms and conditions of employment.

Article I
EMPLOYEE RESPONSIBILITIES

I, _____ *(employee's name)* acknowledge and agree that employment is conditioned on my employer's participation in the Choice Voucher System administered by Macomb County Community Mental Services (MCCMH). If my employer ends participation in the Choice Voucher System, my employment may end. I agree to the following terms of employment:

1. During the term of this Agreement, I shall provide support to my employer by performing the duties outlined in this agreement and any attachments to it.

2. I agree to assist my employer in maintaining the documentation and records required by my employer or MCCMH. I agree to complete all necessary paperwork to secure mandatory payroll deductions from my pay. All records I may have or assist in maintaining are the property of my employer. I will keep these records confidential, release them only with the consent of my employer, and return them to my employer if my employment ends. In addition, I will complete illness and incident reports when necessary as required or requested by MCCMH or my employer.

3. I agree that if I become aware of or witness my employer suffer a physical injury, illness, or other adverse event that I will provide immediate comfort and protection, and assure immediate medical treatment for my employer.

4. I agree to participate in any meetings if requested to do so by my employer.

5. I agree to abide by all of my employer's rules and MCCMHS regulations (described below) regarding my employment duties to the employer through the Choice Voucher System, and I acknowledge receipt of the following rules and regulations.

   a. Attachment A to this Agreement, which outlines the goals and outcomes of my employer's individual plan of service and the services and supports that I will be providing.

   b. Attachment B to this agreement, Recipient Rights Protection Requirements. I will also receive a copy of the Recipient Rights Booklet, a copy of Chapter 7 of the Michigan Mental Health Code, and copy of Chapter 7 of the MDCH Administrative Rules. I agree to complete Recipient Rights training and all other required training prior to my first day of work. I agree to assist my employer in filing Right's complaints upon request. I also understand that I have a responsibility to report Rights violations of which I am aware or any potential abusive or neglectful situations I observe. I understand that I may be required to cooperate wit a recipient rights investigation and/or assist my employer with exercising his or her rights.

   c. Attachment C to the Agreement which outlines Employer's House Rules. Additional changes to the House Rules shall be provided to me by my Employer in writing, and a copy shall be attached to the original Employment Agreement.

d. Attachment D, outlining the reporting and documentation requirements for verifying my hours worked. The Fiscal Intermediary will provide this to me.

e. The Chapter 9 policies of the MCCMH MCO Policy Manual (Recipient Rights). These policies may be accessed from the MCCMH Policy website at the following address:
http://www.mccmh.net/MCCMH Policies/tabid/80/Default.aspx

6. I understand that this is an employment at will relationship, which can be terminated by me or by my employer at any time. However, my employer cannot terminate my employment on the basis of my race, religion, sex, disability or other protected status under Federal or Michigan law. In addition, I agree to give _____ ***days*** written notice to my employer if I terminate my employment.

7. I understand and acknowledge that my employer is my sole employer and that I am not an employee of MCCMHS, which authorizes the supports I provide, or the fiscal intermediary, which is the financial administrator of the Choice Voucher System funds used to pay me.

8. I agree not to sue the fiscal intermediary for its role as the financial administrator of my employer's Choice Voucher System funds and MCCMHS for its role in administering the Choice Voucher System.

9. I agree to the following compensation for the services I shall perform: $_____/hour. Benefits: ***NONE.***

10. I agree to execute a Medicaid Provider Agreement with MCCMHS and acknowledge that this agreement does not alter the fact that MCCMHS is only the project administrator of the Choice Voucher System, and that my employer is _____ ***(person you are caregiver for).*** I understand that my employment is contingent on completing this agreement.

11. My **initials** below attest to the fact that:

I am not a legally responsible person (e.g. guardian, agent, etc.) for my employer...

I am at least 18 years of age...

I am able to prevent transmission of any communicable disease from self to others in the environment in which I will be providing support...

I am able to communicate expressively and receptively in order to follow individual plan requirements and participant-specified emergency procedures, and report on activities performed...

I am in good standing with the law (i.e. not a fugitive from justice, a convicted felon, or an illegal alien) and...

I am able to perform basic first aid procedures.

_____ (initials) I understand that my employer will check my truthfulness of my attestation, above, by conducting a background check on me to assure I meet these minimum requirements. I further understand that my employment is conditioned on meeting these minimum requirements.

Article II
EMPLOYER RESPONSIBILITIES

I, _____ ("employer") agree to the following:

1. I will provide my Fiscal Intermediary with the necessary documentation to assure timely compensation of my employee.
2. I will compensate my employee in the following manner: $ _____/hr. Benefits my employee shall receive include: NONE. Payroll will be handled by my fiscal intermediary, **LifeLong Advocacy**, which will withhold all necessary tax, social security , employment and other withholding from the employee's paychecks.
3. I will assure my employee receives appropriate training, including but not limited to Recipient Rights training according to the provisions of Attachment B to this agreement.
4. I will evaluate the performance of my employee and provide appropriate feedback to assure that I am receiving quality supports. My employee shall be evaluated on an annual basis. Continuation of the Agreement is conditioned upon the employee's satisfactory performance under this Agreement.
5. I will assure that my employee executes a Medicaid Provider Agreement with MCCMHS, and I shall forward executed agreement to MCCMHS prior to my employee's start of employment.

_____ _____
Employee Signature Date

_____ _____
Employer Signature Date

Please submit this Agreement along with the New Hire Packet to LifeLong Advocacy.

MACOMB COUNTY
COMMUNITY MENTAL HEALTH

Office of Recipient Rights
19800 Hall Road
Clinton Township, MI 48038

Phone: 586-469-8528
Fax: 586-466-4131
info@mccmh.net
www.mccmh.net

AUTHORIZATION TO RELEASE RECIPIENT RIGHTS INFORMATION

I _____ hereby authorize Macomb County Community Mental Health Services, Office of Recipient Rights, to release to the following

corporation/provider: Lifelong Advocacy at the following

address: 43970 N. Gratiot, Clinton Twp, MI 48036 and/or to the following

FAX NUMBER: (586) 846-2460, any written reports or records regarding substantiated violations of recipient rights against me.

I release the Macomb County Community Mental Health Services, Office of Recipient Rights (ORR), from any and all claims, liability and damages that may result from the release of these reports or records. I also understand that because of the nature of my job and licensing requirements, the information provided pursuant to this authorization may be provided to representatives of the Department of Consumer and Industry Services and/or other community health agencies. I hereby consent to the release of information to these agencies.

_____
***Applicant's Name (please print clearly)

_____
Applicant's Signature Date
(Electronic Signature Verification Acceptable)

_____
Applicant's Maiden Name (please print clearly)

Last 4 digits of
Social Security Number: _____

_____ _____
Witness's Signature Date

Note: If an applicant disagrees with our findings, please contact this office prior to any dismissal to ensure we have the correct person and prevent a possible mix up in identities

FAX BACK TO ORR: 586-466-4131

PLEASE PROVIDE COMPLETE MAILING ADDRESS AND/OR FAX NUMBER ON ALL RELEASE FORMS

*****If this form indicates the ***Applicant "DOES" have a substantiated Recipient Rights**

FOR MCCMH ORR OFFICE USE ONLY

The individual named above ***DOES _____ DOES NOT _____ have a written report or record regarding a substantiated Recipient Rights violation of Abuse and/or Neglect against them.

_____ _____
Authorized Signature of the Office of Recipient Rights Date

Employer Name: _____Case #_____ CW __SEDW __(check as applicable)

MEDICAID PROVIDER AGREEMENT

This agreement is made on _____ between Macomb County Community Mental Health Services (MCCMHS) and _____ ("Medicaid Provider"). The purpose of this agreement is to define the roles and responsibilities of the above named parties. This agreement shall remain in effect until such time as it is terminated or modified. Any party can initiate a termination or modification by providing written notice to the other of the desire to terminate or modify this agreement.

Upon receipt of this agreement, MCCMHS will certify the Medicaid Provider as available to provide services to individuals who receive services and/or supports in accordance with their individual plans of services and supports developed in a person-centered planning process, authorized by MCCMHS or one of its contractors, and financed through Michigan's Medicaid Specialty Pre-paid Mental Health Plan.

The Medicaid Provider stipulates that it agrees to the following:

1. To keep any records required by the participant or MCCMHS regarding the services provided to participants and to provide such information and any related invoices or billings, upon request, to the participant, MCCMHS, the state Medicaid Agency, the Secretary of the Department of Health and Human Services or the state Medicaid fraud control unit.

2. To comply with the ownership disclosure requirements specified in 42 CFR 455, subpart B, as applicable.

3. To comply with intent of the advance directive requirements specified in 42 CFR 489, Subpart I and 42 CFR 417.436 (d), as applicable, by finding out if a participant has an advance directive to refuse life-sustaining medical treatment, and informing the participant, before the provider starts work, whether or not the provider will carry out that advance directive so the participant can make an informed choice during the hiring process.

Both parties expressly acknowledge that the sole purpose of this agreement is to assure compliance with 42 USC 1902 (a) 27. Further, both parties recognize and reaffirm that MCCMHS is not the employer of the Medicaid Provider, and that the participant is the sole employer of the Medicaid Provider.

This agreement sets forth the entire understanding between the parties with respect to the subject matters, and supersedes any and all other agreements, either oral or in writing between the parties pertaining to these matters. No change or modification of the terms of this agreement is valid unless it is in writing and signed by the parties.

_____ _____

MCCMHS Chief Executive Officer Date

_____ _____

Medicaid Provider Agency/Individual Date

DHS-1929, CENTRAL REGISTRY CLEARANCE REQUEST

Michigan Department of Health and Human Services
(Revised 5-23)

COPY PHOTO ID HERE

OR

ATTACH A SEPARATE PAGE

SECTION 1 – INFORMATION ON PERSON BEING CLEARED

Name, (First, Middle, Last)

Maiden Name, Aliases, also known as (A.K.A) | Social Security Number | Date of Birth

Address | City | State | Zip Code

Phone Number | Email

☐ I would like to pick up my results in County (For Michigan Residents Only).

Signature Required for Individual Being Cleared | Date

SECTION 2 – REQUESTER INFORMATION

Check Appropriate Box

☐ Employer
☐ Volunteer Agency
☐ Out-of-State Child Caring Institution
☐ Out-of-State Adoption/Foster Care Home Screening
☐ Michigan Court/Law Enforcement/Department of Corrections/Prosecuting Attorney
☐ Individual Self-Request

Name of Agency or Organization | Name of Requester

Address | City | State | Zip Code

Email | Fax | Phone Number

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)

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. If any, enter additional documentation in the Additional Information box. See instructions.

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

☐ 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.

MACOMB COUNTY
COMMUNITY MENTAL HEALTH

Individual Plan of Service Training Log

The Individual Plan of Service Training Log serves as a training record to evidence Aide-Level Staff's ability to implement the supports and services identified in the Individual Plan of Service (IPOS). A copy of the completed IPOS Training Log must be retained in the person's served electronic medical record (FOCUS).

Section 1 of the form is to be completed by the Primary Case Holder each time there is a new or existing staff who must be trained on the person's served Initial IPOS, Amendment, Periodic Review, Crisis Plan or other change to the Plan that impacts the delivery of a service being provided. *Staff documented as trained in this section of the form are considered "Certified Trained Staff" and can use the Train-the-Trainer Approach in Section 2.*

Section 2 of the form only needs to be completed upon receipt of an inter-agency training using the Train-the-Trainer Approach. Staff members who conduct the training must be listed in Section 1 as "Certified Trained Staff".

The following staff were trained by the Primary Case Holder on this Person Served Treatment Plan on the training date(s) listed below. These Staff are now Certified to use the Train the Trainer Approach to train additional Staff.	
Today's Date:	**Location:**
Person Served Name:	**Primary Case Holder Name:**
Case#:	**Primary Case Holder Agency:**
Plan Effective Date:	**Plan Expiration Date:**
Reason for Training ***(Please check all training categories that apply)*****:** ☐ Annual IPOS ☐ IPOS Amendment ☐ Period Review ☐ Crisis Plan ☐ Other _____	

Certified Trained Staff Name & Signature	Signature Date	Primary Case Holder Name, Credentials & Signature	Training Date

The following staff were trained by Certified Staff on this Person Served Treatment Plan on the training date(s) listed below.			
Aide-Level Staff Name & Signature	Signature Date	Certified Trained Staff Name & Signature	Training Date

CIRCLE ONE BELOW
Is this a <u>new account</u> or are you <u>changing DD information</u>?

AUTHORIZATION FOR DIRECT DEPOSIT - EMPLOYEE FORM

This authorizes Lifelong Advocacy (the "Company") to send credit entries (and appropriate debit and adjustment entries), electronically or by any other commercially accepted method, to my (our) account(s) I (we) identify in the future (the "Account"). This authorizes the financial institution holding the Account to post all such entries.

Your check will be posted to your account on the 10th and 25th of each month that you turn in time sheets (by their due date). Your bank processes them exactly on the day as specified above.

ACCOUNT (check one) Checking or Debit _____ Savings _____

_____
Employee Bank Name

_____ _____
Bank Routing # (ABA#) *Account #*

Percentage or Dollar Amount to be deposited to This Account - 100%

If you do not print legibly, <u>we will not be able to process this request</u>.

This authorization will be in effect until the Company receives a written termination notice (from myself) and has a reasonable opportunity to act on it.

Signature _____

Printed Name
_____

Consumer's Name: (Person you work for) _____ *Date:* _____

For Office Use Only: Information Posted to the Account on: _____

Notes :
_____
_____
_____
_____
_____

IMPORTANT! Make copies of your certifications for your records! Do NOT turn in this sheet unless you have **ATTACHED** a copy of the class certification or a receipt for the cost of the class!

(Make copies of this form for future use)

REIMBURSEMENT FORM

Employee's Name: _____ Consumer's Name: _____

Do you work for other Consumers? YES / NO (circle one).

This form must be submitted within 30 days of take a class. This form must have a copy of the certifications attached.

REQUIRED TRAINING (class): Reimbursement for the cost of a training class can only be reimbursed if there is room in the budget. Please have your employer check with their Fiscal Intermediary BEFORE taking the class.

*This form must be filled out **ENTIRELY AND SIGNED BY BOTH THE EMPLOYER AND EMPLOYEE TO BE VALID.** We cannot reimburse for any costs if this form is not filled out properly or if there is not a signed receipt along with the name and phone number of the training site.*

Training	Cost	Hours Attended	Receipt Included	Notes
1 – Recipient Rights	$0			Trained by the County
2 – First Aid*				*Must be American Heart or Red Cross sponsored
3 – CPR*				*Must be American Heart or Red Cross sponsored
4 – Bloodborne	$0			plp.mivu.org
5 –				
6 –				
7 –				
8 –				
9 –				
10 –				
Total Cost of Classes				
Total Amount of Hours				

Employer Signature: _____ Employee Signature: _____

For Office Use Only

Reimbursed on: _____ Date: _____

FI Initials: _____ App'd by: _____

Macomb County Community Mental Health
Self-Determination Employee Training Tracking

Refer to SD Direct Employment Training Grid for training details

Staff Name: _____

Date of Hire: _____

REQUIRED TRAINING:	INITIAL TRAINING DUE BY:	DATE OF INITIAL TRAINING:	REPEAT TRAINING DUE BY:	DATE OF REPEAT TRAINING:
Bloodborne Pathogens / Universal Precautions/ Infection Control * *Required* (RAPID TRAINING)				
Person-Centered Planning-IPOS Plan Goals and Objectives *Required (RAPID TRAINING)				
Emergency Preparedness *Required if working w/SED or CW W (RAPID TRAINING)				
Basic First Aid *Required				
Recipient Rights *Required				
Behavior Treatment Plan Specific to Person * (Required if plan exists)				
Corporate Compliance/ HIPAA (Strongly Encouraged)				
CPR (Strongly Encouraged)				
Cultural Competency (Strongly Encouraged)				
Grievances and Appeals (Strongly Encouraged)				
Limited English Proficiency (Strongly Encouraged)				
Trauma-Informed Care (Strongly Encouraged)				
Other per IPOS (if any): _____ _____				

*Required Trainings within 30 days of hire. RAPID TRAINING completed prior to billable services delivered. Employers are responsible for ensuring that hired staff remain compliant with initial and repeat training timeframes. Staff missing training risk not being paid.