1650 West End Blvd. Suite 100
St. Louis Park, MN 55416
Phone: 612-868-3270
Fax: 612-395-5593
Web: AbilityCare.com

PCA Hiring Forms
Cover Sheet & Guidelines

The following documents are NOT a job application and should only be completed when a job has been offered by a Consumer partner. Incomplete forms will result in your forms being rejected and you will have to start over.

New hires that do not work within 60 days after receiving a "PCA Welcome Letter" email will be considered a "no hire" and will need to complete forms in the future.

PCA	First Name	Middle Initial	Middle Name	Last Name

Consumer	First Name	Last Name	Job Type	
Responsible Party				

Ability Care Partners is a PCA Choice Provider (not a full service traditional agency). We do not place or assign PCAs. Our Consumers are responsible for finding and scheduling their own PCAs. We do not have regular in-person open office hours (our staff works remotely). Your Consumer is your first point of contact. If you need further assistance, please contact us. We check email and voicemails regularly, and this is the most effective way to communicate with us!

Overview of Common Roles & Terminology			
PCA Candidate	**Consumer**	**Responsible Party (RP)**	**Agency**
Person intending to work for a Consumer.	Also referred to as a client or care recipient.	When necessary and identified by the agency or the county. A person who directs care of the recipient who is unable to direct their care or has opted not to. The RP cannot be a PCA..	Ability Care Partners (ACP) PCA Choice Provider, Joint employer.

Before you begin:

- Review the **PCA Job Description** and **Company Policies** available in our Employee Resource Center (ERC).
- Complete the free Online **PCA/CFSS Support Worker Certification** at http://abilitycare.com/pcatraining/
  ⇒ *If you have previously completed the test, you can lookup your certificate with your name and email address at **http://abilitycare.com/certificatelookup/** or repeat the test.*
- **If you have been a PCA before** and were assigned a **UMPI #** from another agency, please have it ready to list on your forms. If you do not have one, no worries! We will obtain one from MN DHS for you.
- **Use your smartphone or a scanner to capture and include photo proof of:**
  I-9 Acceptable Documents (Photo I.D.)
  Direct Deposit Account Proof (Voided Check or Bank Letter)
- **Carefully review all requested data entries**
- **Your electronic signature and initials are legally binding per state and federal law.**
- **You CANNOT report to work for your consumer until we have sent you a "*PCA Welcome Letter" email*. You will NOT be paid by us for any services / hours before this clearance email. No exceptions.**

PCA Signature: ______________________________ **Date:** ______________

AbilityCarePartners

1650 West End Blvd. Suite 100
St. Louis Park, MN 55416
Phone: 612-868-3270
Fax: 612-395-5593
Web: AbilityCare.com

Conditional Hire Employee Personal Data Form

Our policy is to provide equal opportunity to applicants regardless of age, color, gender, disability, national origin, race, religion or any other classification in accordance with federal, state, and local statutes, regulations and ordinances. Any answers to questions on this form will not be used to discriminate against anyone.

First Name	Middle Initial	Middle Name	Last Name

Email Address: (Required for hiring instructions and employee notices only)	Primary Phone Number	Type of Phone	Permission to contact by TXT?

Physical Address: Address Line 1	Address Line 2 (Apt #, Unit #, etc.)

City	County	State	Zip Code

Mailing Address: *Address Line 1* *(ONLY if different from Physical Address)* ***Same as above?***	*Address Line 2 (Apt #, Unit #, etc.)*

City	*County*	*State*	*Zip Code*

MN DHS NETStudy 2.0 Background Study: *(Info must match I.D.)* ***You MUST pass a NETStudy 2.0 initiated by ACP before working. Review the policy and privacy notice.***

Social Security Number	Date of Birth *(MM/DD/YYYY)*	Place of Birth / State *(Country - if not in U.S.)*	**U.S. I-9 EMPLOYMENT ELIGIBILITY STATUS** I am a...

Gender:	Race:	Height: ft. in.	Weight: lbs.	Hair Color:	Eye Color:

Photo ID #	Photo ID Type	State of Issue	Expiration Date *(MM/DD/YYYY)*

Have you lived outside of Minnesota in the last five (5) years?
If **Yes**, list any below (If extra space is needed, type in notes section.)

	City	State	Year From	Year To
☐				
☐				
☐				
☐				

List any previous names or aliases
(ie. maiden or married names, nicknames, etc.)

	Full Name / Alias Used
☐	
☐	
☐	
☐	

EMERGENCY CONTACT ***(You will need to provide a current emergency contact to the Consumer at all times)***

Name	Primary Phone #	Relationship

MN PCA Online Training Certificate #: **Date of Training:** *(MM/DD/YYYY)*

Other Applicable Education / Training / Certification(s): (CNA, LPN, RN, CPR, Medication, MN Vulnerable Adult Training, etc.)

Optional Information / Notes:

PCA Signature: ▷ ______________________________ **Date:** ______________

DEPARTMENT OF HUMAN SERVICES

DHS-4469-ENG 11-21

MINNESOTA HEALTH CARE PROGRAMS (MHCP)

Individual Personal Care Assistant (PCA) Enrollment Application

Complete all fields to enroll an individual personal care assistant or complete your request using the Minnesota Provider Screening and Enrollment (MPSE) portal. If submitting by fax, complete this form online, print and then fax 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 and completion of PCA training)

◯ Rehire (requires new background study and completion of PCA training) – PREVIOUS EMPLOYMENT END DATE: ______

◯ Previous background study conducted for managed care organizations (MCO) (new background study not required)

Individual PCA Information

PROVIDER TYPE **38 - INDIVIDUAL**	**SOCIAL SECURITY NUMBER**	**UMPI** (if requesting reinstatement)
LEGAL NAME (FIRST)	**FULL MIDDLE NAME**	**LAST NAME**
DATE OF BIRTH	**Is the person 18 years old or older?** ◯ Yes ◯ No* *May affiliate with only one agency	PHONE NUMBER
Has this person continued to be employed by your agency or MCO without a break in employment? ◯ Yes ◯ No		

Individual PCA Address

ADDRESS (RESIDENTIAL ADDRESS ONLY – DO NOT ENTER A P.O. BOX)			
CITY	**STATE**	**ZIP CODE**	COUNTY OF RESIDENCE

Individual PCA Training Information

INDIVIDUAL PCA TRAINING COMPLETION DATE	INDIVIDUAL PCA TRAINING CERTIFICATION NUMBER

Individual PCA Background Study Information

BACKGROUND STUDY NUMBER	APPLICATION NUMBER	FACILITY ID

Individual PCA 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 the 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 MCHP 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 PCA (print or type)	**SIGNATURE OF INDIVIDUAL PCA**	**DATE SIGNED**

Organization Affiliation Information

You may affiliate or enroll the individual PCA named on this form if he or she is 18 years old or older with other agencies you directly own without completing another application and agreement. Do you want to affiliate this individual PCA with any other agencies you own? ◯ Yes ◯ No

Organization Information

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 OR AGENCY NAME		FACILITY NPI OR UMPI
ORGANIZATION FAX NUMBER	ORGANIZATION PERSONNEL COMPLETING FORM	ORGANIZATION PERSONNEL SIGNATURE

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 Minnesota Provider Screening and Enrollment (MPSE) portal or fax to 651-431-7465. MHCP will process only complete requests.

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	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
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.

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

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

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

1. Alien Registration Number/USCIS Number: ____________

OR

2. Form I-94 Admission Number: ____________

OR

3. Foreign Passport Number: ____________

Country of Issuance: ____________

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

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

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

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

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

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

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

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

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

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

Section 2. Employer or Authorized Representative Review and Verification

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

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

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

Additional Information

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

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

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

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

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

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

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

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

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

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

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

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

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

2022

Step 1: Enter Personal Information

(a) First name and middle initial | Last name | (b) Social security number

Address

City or town, state, and ZIP code

► **Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.

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

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the estimator at *www.irs.gov/W4App*, and privacy.

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . ► ☐

TIP: To be accurate, submit a 2022 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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

Step 3: Claim Dependents

If your 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 and enter the total here . . . . **3** $

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

General Instructions

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 2022 if you meet both of the following conditions: you had no federal income tax liability in 2021 **and** you expect to have no federal income tax liability in 2022. You had no federal income tax liability in 2021 if (1) your total tax on line 24 on your 2021 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), 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 2022 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, 2023.

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

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

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

1. Expect to work only part of the year;

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

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

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

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

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

Specific Instructions

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

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

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

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

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

Step 3. 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 2022 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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

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

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

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

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

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

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

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

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

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

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

1 Enter an estimate of your 2022 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:
- $25,900 if you're married filing jointly or qualifying widow(er)
- $19,400 if you're head of household
- $12,950 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 possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

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

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

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

Married Filing Jointly or Qualifying Widow(er)

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$110	$850	$860	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,770	$1,870
$10,000 - 19,999	110	1,110	1,860	2,060	2,220	2,220	2,220	2,220	2,220	2,970	3,970	4,070
$20,000 - 29,999	850	1,860	2,800	3,000	3,160	3,160	3,160	3,160	3,910	4,910	5,910	6,010
$30,000 - 39,999	860	2,060	3,000	3,200	3,360	3,360	3,360	4,110	5,110	6,110	7,110	7,210
$40,000 - 49,999	1,020	2,220	3,160	3,360	3,520	3,520	4,270	5,270	6,270	7,270	8,270	8,370
$50,000 - 59,999	1,020	2,220	3,160	3,360	3,520	4,270	5,270	6,270	7,270	8,270	9,270	9,370
$60,000 - 69,999	1,020	2,220	3,160	3,360	4,270	5,270	6,270	7,270	8,270	9,270	10,270	10,370
$70,000 - 79,999	1,020	2,220	3,160	4,110	5,270	6,270	7,270	8,270	9,270	10,270	11,270	11,370
$80,000 - 99,999	1,020	2,820	4,760	5,960	7,120	8,120	9,120	10,120	11,120	12,120	13,150	13,450
$100,000 - 149,999	1,870	4,070	6,010	7,210	8,370	9,370	10,510	11,710	12,910	14,110	15,310	15,600
$150,000 - 239,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	15,340	16,540	16,830
$240,000 - 259,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	15,340	16,540	17,590
$260,000 - 279,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	16,100	18,100	19,190
$280,000 - 299,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	13,700	15,700	17,700	19,700	20,790
$300,000 - 319,999	2,040	4,440	6,580	7,980	9,340	11,300	13,300	15,300	17,300	19,300	21,300	22,390
$320,000 - 364,999	2,100	5,300	8,240	10,440	12,600	14,600	16,600	18,600	20,600	22,600	24,870	26,260
$365,000 - 524,999	2,970	6,470	9,710	12,210	14,670	16,970	19,270	21,570	23,870	26,170	28,470	29,870
$525,000 and over	3,140	6,840	10,280	12,980	15,640	18,140	20,640	23,140	25,640	28,140	30,640	32,240

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	$400	$930	$1,020	$1,020	$1,250	$1,870	$1,870	$1,870	$1,870	$1,970	$2,040	$2,040
$10,000 - 19,999	930	1,570	1,660	1,890	2,890	3,510	3,510	3,510	3,610	3,810	3,880	3,880
$20,000 - 29,999	1,020	1,660	1,990	2,990	3,990	4,610	4,610	4,710	4,910	5,110	5,180	5,180
$30,000 - 39,999	1,020	1,890	2,990	3,990	4,990	5,610	5,710	5,910	6,110	6,310	6,380	6,380
$40,000 - 59,999	1,870	3,510	4,610	5,610	6,680	7,500	7,700	7,900	8,100	8,300	8,370	8,370
$60,000 - 79,999	1,870	3,510	4,680	5,880	7,080	7,900	8,100	8,300	8,500	8,700	8,970	9,770
$80,000 - 99,999	1,940	3,780	5,080	6,280	7,480	8,300	8,500	8,700	9,100	10,100	10,970	11,770
$100,000 - 124,999	2,040	3,880	5,180	6,380	7,580	8,400	9,140	10,140	11,140	12,140	13,040	14,140
$125,000 - 149,999	2,040	3,880	5,180	6,520	8,520	10,140	11,140	12,140	13,320	14,620	15,790	16,890
$150,000 - 174,999	2,040	4,420	6,520	8,520	10,520	12,170	13,470	14,770	16,070	17,370	18,540	19,640
$175,000 - 199,999	2,720	5,360	7,460	9,630	11,930	13,860	15,160	16,460	17,760	19,060	20,230	21,330
$200,000 - 249,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,310
$250,000 - 399,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,310
$400,000 - 449,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,470
$450,000 and over	3,140	6,290	8,880	11,380	13,880	16,010	17,510	19,010	20,510	22,010	23,380	24,680

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	$760	$910	$1,020	$1,020	$1,020	$1,190	$1,870	$1,870	$1,870	$2,040	$2,040
$10,000 - 19,999	760	1,820	2,110	2,220	2,220	2,390	3,390	4,070	4,070	4,240	4,440	4,440
$20,000 - 29,999	910	2,110	2,400	2,510	2,680	3,680	4,680	5,360	5,530	5,730	5,930	5,930
$30,000 - 39,999	1,020	2,220	2,510	2,790	3,790	4,790	5,790	6,640	6,840	7,040	7,240	7,240
$40,000 - 59,999	1,020	2,240	3,530	4,640	5,640	6,780	7,980	8,860	9,060	9,260	9,460	9,460
$60,000 - 79,999	1,870	4,070	5,360	6,610	7,810	9,010	10,210	11,090	11,290	11,490	11,690	12,170
$80,000 - 99,999	1,870	4,210	5,700	7,010	8,210	9,410	10,610	11,490	11,690	12,380	13,370	14,170
$100,000 - 124,999	2,040	4,440	5,930	7,240	8,440	9,640	10,860	12,540	13,540	14,540	15,540	16,480
$125,000 - 149,999	2,040	4,440	5,930	7,240	8,860	10,860	12,860	14,540	15,540	16,830	18,130	19,230
$150,000 - 174,999	2,040	4,460	6,750	8,860	10,860	12,860	15,000	16,980	18,280	19,580	20,880	21,980
$175,000 - 199,999	2,720	5,920	8,210	10,320	12,600	14,900	17,200	19,180	20,480	21,780	23,080	24,180
$200,000 - 449,999	2,970	6,470	9,060	11,480	13,780	16,080	18,380	20,360	21,660	22,960	24,250	25,360
$450,000 and over	3,140	6,840	9,630	12,250	14,750	17,250	19,750	21,930	23,430	24,930	26,420	27,730

2022 W-4MN, Minnesota Withholding Allowance/Exemption Certificate

Employees

Complete Form W-4MN so that 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.

First Name and Initial	Last Name			Social Security Number
Permanent Address				**Marital Status** ***(Check one):*** ☐ Single; Married, but legally separated; or Spouse is a nonresident alien
City		State	ZIP Code	☐ 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 2022 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.
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 and Pension/Annuity Recipients

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

When should 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)
- You receive distributions from an annuity or pension

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 2022 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. Enter zero on steps B, C, and E.

If you are resident of Canada, Mexico, South Korea, or India, and are allowed to claim dependents, you may 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, your dependents, and other qualifying individuals. 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 2022 Minnesota itemized deductions. For 2022, you may have to reduce your itemized deductions if your income is over $206,050 ($103,025 for Married Filing Separately). . . . . ._________

2 Enter one of the following based on your filing status: . . . . ._________
- a. $25,800 if Married Filing Jointly
- b. $19,400 if Head of Household
- c. $12,900 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 2022 additional standard deduction (from page 11 of the Form M1 instructions) . . . . ._________

5 Add steps 3 and 4 . . . . ._________

6 Enter an estimate of your 2022 taxable nonwage income . . . . ._________

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

8 Divide the amount on step 7 by $4,450. 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-G

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.
- **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.

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 Internal Revenue Service, to 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.

1650 West End Blvd. Suite 100
St. Louis Park, MN 55416
Phone: 612-868-3270
Fax: 612-395-5593
Web: AbilityCare.com

PCA Choice
Employment & Wage Agreement

Agreement between	Party	First Name	Last Name
	Consumer (Recipient)		
	Responsible Party (RP) ****If required***		
	Ability Care Partners Inc. (*ACP*)	Joshua	Holler
	Personal Care Assistant (PCA)		

Term: This agreement is entered into effective on ________________________ by and between the parties named above. We enter into this employment agreement to provide Personal Care Assistant (PCA) services for the Consumer/Recipient.

Consumer (or Responsible Party) Roles and Responsibilities

As a consumer using *ACP* as my PCA Choice provider, I, (or my RP - if applicable), agree to the following responsibilities:

1. Accept responsibility for my health and safety by finding staff or supports that ensure my needs are met.
2. Develop and maintain a care plan with the QP that details my cares and health/safety needs based on the PHN PCA assessment.
3. Recruit, interview, hire and provide training for my own PCA staff.
4. Review, sign and submit the employment application for my PCAs to *ACP*. I will verify the PCA's employment eligibility on form I-9 by reviewing their "acceptable documents" (i.e. ID, SSN, Passport, Work Authorization).
5. Not allow my PCA to work any shifts until they have passed a MN DHS NETStudy criminal background study, facilitated by *ACP* to ensure they have no prior criminal record that disqualifies them from being employed as a PCA. *ACP* will notify the consumer and PCA via email with the approved start date. No exceptions.
6. As a joint employer with *ACP*, sign a written agreement with each of my PCAs before I receive their services.
7. Schedule my PCA staff to meet the needs specified in my care plan and develop a Back-up Support Plan that I will follow in case a regularly scheduled PCA is unable to fulfill their duties as scheduled. **The recipient (or RP) is responsible for ensuring all cares are covered in the event of a PCA absence.**
8. Provide information, orientation and training to my PCA staff including safety and emergency procedures.
9. Provide and maintain my emergency contact information and any Health Care Directives (if applicable), to my PCA staff for my own safety.
10. **Manage the use of my PCA allocated hours to ensure I do not use more than allocated in my Service Authorization (SA).** I will monitor my use of flexible PCA units, and if I run out of units before my SA expires, I understand my services will be suspended until the new SA starts. If I exhaust all of my SA units I will be personally responsible to pay for my continued care. *ACP* will provide "Service Hours Used" reports upon request.
11. **Communicate with my PCA about their total hours worked with ALL PCA agencies, to ensure they do not go over the 310 hours per month rule.**
12. **I agree to personally pay *ACP* for any services that are not paid for by my insurance, including but not limited to: co-pays, out-of-pocket deductibles and denied claims due to MA ineligibility, non-covered services, over-use of hours, unauthorized use of services or fraud.**
13. Abide by Department of Labor regulations and *ACP* policies regarding overtime.
14. Review, sign and submit PCA timesheets (including EVV) as outlined in the company policies and procedures.
15. Notify *ACP* of my in-patient treatment or hospitalization dates throughout our service agreement.
16. Notify the county public health nurse, waiver caseworker or other appropriate individual when it is time for a reassessment of my need for PCA services or if there is a change in condition or change in the level of services that I need. I will inform them of my intent to use a PCA Choice provider.
17. I will notify *ACP* prior to terminating any PCAs and inform them of the effective date. I will notify *ACP* if assistance is needed in terminating an employee.
18. Comply with company policies and procedures and make sure all of my PCAs receive any updated policies.

Provider Roles and Responsibilities

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

1. Enroll and meet all standards as a PCA Choice Provider with MN DHS, including passing NetStudy.
2. As a joint employer with the consumer (or RP), enter into a written agreement with each PCA before services are provided to the consumer.
3. Process a MN DHS NetStudy criminal background study for all PCA and QP applicants.
4. Submit billing to DHS / MA or other applicable health insurance plan for PCA services rendered.
5. Pay the PCAs at the rate(s) specified in this agreement.

6. Issue paychecks, withhold and remit all applicable state and federal taxes from PCAs paychecks.
7. Arrange for and pay the employers share of payroll taxes, unemployment insurance, worker's compensation insurance and liability insurance for all staff.
8. Keep records of the hours worked by PCAs as submitted by the consumer or responsible party.
9. Assist consumer in terminating PCAs, if requested to do so by the consumer.
10. Assess an administrative fee for PCA provider services in each consumer's "PCA Service Rate Agreement"
11. Ensure arm's length transactions without undue influence or coercion with the consumer, PCA or qualified professional.

Personal Care Assistant (PCA) Responsibilities

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

1. **I have completed and passed the required Individualized Personal Care Assistant Training** offered through the MN DHS. I will send *ACP* a copy of my certificate of completion before working as a PCA.
2. **I am not:** a recipient of PCA services myself, the responsible party of the consumer; spouse of the consumer, paid guardian of the consumer, parent or step parent of a minor child consumer (under 18 years old)
3. I will enter into a written agreement with the consumer and *ACP*, as joint employers.
4. I understand and agree that all employment with *ACP* and the consumer is "at-will" and can be ended by any of the parties, at any time, with or without reason.
5. I will fully and accurately complete all required employment hiring information and DHS enrollment forms.
6. **I must complete and clear a MN-DHS NetStudy Criminal Background Study submitted through *ACP* before working any shifts and submitting a timesheet for payroll.**
7. **I must work at least every 120 days (or communicate my anticipated return) to remain on the active roster with *ACP*. I must be re-hired and process a new NetStudy 2.0 after 120 days without working for *ACP*.**
8. Until *ACP* notifies me (and the consumer) with my official start date, I understand I CANNOT report to work for the consumer under any circumstances. No exceptions. I will not be paid wages for any shifts in violation of this rule. **ACP will email me a "PCA Welcome Letter" when I am cleared to work.**
9. I will obtain training and orientation instructions from the consumer, RP or QP to ensure I can satisfactorily perform all responsibilities in the consumer's care plan and follow emergency procedures listed. I agree to communicate with the consumer (or RP) directly, regarding any safety, health or training concerns.
10. I will provide and maintain my personal emergency contact information to the consumer (or RP).
11. I must work at scheduled times as determined by the consumer (or RP) I will notify them of planned absences or emergency absences as early as possible so they can enact their Back-Up Staffing Plan.
12. I will provide PCA services to only the consumer as specified in their care plan.
13. I will inform the consumer about all visible bodily changes that may need medical attention.
14. I will not violate the Home Care Bill of Rights, Minnesota Vulnerable Adults Act, Maltreatment of Minors Act, nor engage in any other unsafe acts or illegal conduct including PCA service fraud. I am a Mandated Reporter of any abuse or neglect and will report it to *ACP* and the county's Common Entry Point. *(See Policies & Procedures)*
15. I will focus on my job duties, maintain professional boundaries and respect the rights and dignity of the consumer.
16. I will keep the consumer's personal life as confidential, respect their property and adhere to data privacy policies.
17. I agree to not bring any children or friends to work. I will not provide care to *anyone* other than the consumer.
18. I agree to be present when working with the consumer and leave only when the shift is completed.
19. I understand and will follow safety and emergency procedures in my applicable service environment and work to identify my safety needs and along with those of the consumer.
20. I agree to accurately document time worked with my consumer, initial cares and sign my timesheet before submitting for payroll.
21. I will communicate with the consumer to ensure submission of my timesheet to *ACP* by the deadline and follow policies for completing timesheets. I may also elect to submit my own timesheet (completed and signed by all parties) to *ACP*.
22. **I understand that the consumer's Medical Assistance (MA) funding pays for their PCA services and that if the consumer becomes ineligible for MA, all PCA services and my employment will be suspended until the consumer is eligible.** *ACP* will notify the consumer of any lapses in MA eligibility and the consumer will notify me.
23. **I understand that MN-DHS issues a Service Authorization (SA) that determines the dates and amount of PCA hours the consumer receives. If my consumer's SA ends or is exhausted early (run out of hours), PCA services and my employment will be suspended effective on the date of ineligibility or exhaustion of hours and I will not be allowed to work as a result of this.**
24. I understand that I cannot work and be paid wages for PCA services when the consumer is receiving any type of in-patient treatment, in-patient hospitalization or nursing home services.

25. **I agree to notify *ACP* in writing or via email when I work for another PCA agency and monitor my total hours worked with all agencies/consumers actively I am employed with.**
26. **I fully understand that PCAs cannot work more than 310 hours per month.** If working for multiple consumers or agencies I understand my combined totals cannot exceed these limits. If I am found to have violated this policy, I will be required to promptly return wages paid due to exceeding the 310-hour rule.
27. **I agree to not work over 40 hours per week (Sun-Sat). Overtime (OT) is not authorized and I will not be paid OT without prior approval from *ACP* administration.**
28. **I agree that *ACP* reserves the right to collect (take-back) wages of any PCA due to ineligibility, erroneous payment or overpayment.** This includes: PCA being over 310 hours per month, consumer being out of service hours authorized, consumer not being eligible for services, PCA disqualifications, non-covered cares, fraudulent activity, payroll error or over-payment (regardless of who is at fault).
29. **I agree that *ACP* can bill me for any wages deemed ineligible, erroneous or over-paid, and will notify me in writing of the ineligible service hours or over-payment amount to be collected.** I agree to promptly return the wages owed to ACP either via check or electronic payment within 3 business days or via a payroll deduction (full amount) from my next payroll. Any non-repayment over 30 days past due will accrue interest charges (as allowed by law) and may result in suspension, termination, civil lawsuit and reporting to a collections agency.
30. **I will report any service/work related injuries or accidents to the consumer (or RP) AND *ACP* within 24 hours of the incident**.
31. I agree that when necessary or requested, I will meet with the Qualified Professional (QP) within a maximum of 14 calendar days from the date the QP requested or be subject to suspension until the meeting is conducted.
32. **I agree that if my employment is resigned by myself or that if I am terminated, I will submit my fully completed timesheet to *ACP* and will be paid on the next scheduled payroll date.**
33. **I have read, understood and will comply with current *ACP* Policies & Procedures. *(ACP will publish any changes to the Policies & Procedures which are available on our website.)***

PCA Wage Agreement

PCA Starting Wage: $______________/hr. Enhanced Rate PCA Wage (if eligible per DHS requirements): $_____________/hr.

Wage Changes & Raises - *ACP* determines the rate of pay for all PCAs, in accordance with DHS policy regarding reimbursement rates and the current MN DHS / SEIU PCA Collective Bargaining Agreement (posted on our website).

Agency Fee for Administrative Expenses - Per agreement with the Consumer, *ACP* retains an administrative fee which covers fiscal intermediary and PCA program services that meet the state criteria. This fee is deducted from the current program reimbursement rates set by MN DHS.

Grievance Procedures

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

Regulatory Compliance

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

Cancellation and Amendments

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

Signature Acknowledgements

All parties agree to honor any documents that are signed electronically or by handwriting.

Personal Care Assistant (PCA)	Consumer or Responsible Party (RP)	Ability Care Partners Inc. (*ACP*)
Date Signed:	Date Signed:	Date Signed:

1650 West End Blvd. Suite 100
St. Louis Park, MN 55416
Phone: 612-868-3270
Fax: 612-395-5593
Web: AbilityCare.com

EMPLOYMENT STATUS & WAGE NOTICE

Employee Name:		**Hire Date:**	

Employer Legal Name:	ABILITY CARE PARTNERS, INC.	**Phone:**	(612) 868-3270
Main Office Address:	1650 West End Blvd. Suite 100 St. Louis Park, MN 55428	**Email:**	staff@abilitycare.com

Employment Status:	*Non-Exempt: Entitled to overtime after 40 hours (paid at time and a half), minimum wage, other protections under Minn. Stat. 177.		
Pay Type:	Hourly, no tips.	**Pay Rate (Determined by MN DHS & SEIU CBA):**	**$**
Allowances:	None. (Example: meals, uniforms, equipment, lodging, cash, mileage, etc.). Hourly pay ONLY.		
Overtime (OT) Policy:	***Not authorized** to work more than 40 hours per calendar week (Sun. - Sat.) without prior documented (written or email) approval by Ability Care Partners Inc. management.		
Paid Time-Off (PTO) Description:	PTO may be used for: Employee Sick & Safe Time, Paid Vacation or other Paid Leave. Employees are eligible after working 600+ hours or 6-months (whichever comes first).		
PTO Accrual Rate:	● 1 hour for every 30 hours worked (0.0333 accrual rate).		
PTO Redemption Terms:	● Available for use / redemption once eligible per CBA or local labor laws. ● End of Employment Cash-Out option available for employees who have worked 600+ hours or 6-months (whichever comes first) per MN DHS & SEIU PCA CBA.		
Deductions that may be made from employee's pay:	● Employment taxes and withholdings. ● Garnishments/Attachments (if applicable). ● Union dues and contributions (SEIU Healthcare Minnesota members only). ● Amounts permitted under Minn. Stat. 181.79. ● Any other amount the Company is permitted by law to withhold from your wages.		
Pay Details: Length of Pay Period: 14 days. Regularly scheduled payday: Every other Friday (see Payroll Calendar) Date employee will receive first payment of wages: **Scheduled pay date in accordance with the first shift worked.**			
Acknowledgments: By signing below, all parties acknowledge receiving a copy of this Employment Status Notice; and nothing in this notice alters any employment agreement terms or the "at-will" nature of your employment.			
Employee Signature:		**Date:**	
Employer Signature:		**Date:**	

Notice: The following statement is being translated and will be provided in the languages below: "This document contains important information about your employment agreement. Check the box at left to receive this information in this language."

1650 West End Blvd. Suite 100
St. Louis Park, MN 55416
Phone: 612-868-3270
Fax: 612-395-5593
Web: AbilityCare.com

EMPLOYMENT STATUS & WAGE NOTICE

	Language	Notice
	Spanish / Español	Este documento contiene información importante sobre su acuerdo de empleo. Marque la casilla a la izquierda para recibir esta información en este idioma.
	Hmong / Hmoob	Daim ntawv no muaj cov xov tseem ceeb txog koj txoj cog lus ua hauj lwm. Khij lub npauv ntawm sab laug kom tau txais cov xov tseem ceeb no yam siv hom lus no.
	Vietnamese / Việt ngữ	Tài liệu này chứa thông tin quan trọng về thỏa thuận việc làm của quý vị. Đánh dấu vào ô bên trái để nhận thông tin này bằng Việt ngữ.
	Simp. Chinese / 简体中文	本文件包含与您的雇用协议相关的重要信息。勾选左边的方框将接收以这种语言提供的信息。
	Russian / русский	Данный документ содержит важную информацию о вашем трудовом договоре. Отметьте галочкой квадрат слева для получения этой информации на данном языке.
	Somali / Soomaali	Dukumentigan waxaa ku qoran macluumaad muhiim ah oo ku saabsan heshiiska shaqadaada. Calaamadi sanduuqan haddii aad rabto inaad macluumaadkan ku hesho luqaddan.
	Laotian / ພາສາລາວ	ເອກະສານນີ້ມີຂໍ້ມູນທີ່ສຳຄັນກ່ຽວກັບສັນຍາການຈ້າງງານຂອງທ່ານ. ກວດເບິ່ງກ່ອງທີ່ຢູ່ເບື້ອງຊ້າຍເພື່ອຮັບຂໍ້ມູນນີ້ໃນພາສານີ້.
	Korean /한국어	이 문서에는 귀하의 고용 계약 조건에 대한 중요한 정보가 담겨있습니다. 이 언어로 이 정보를 받기를 원하시면 왼쪽 상자에 체크하여 주세요.
	Tagalog / Tagalog	Ang dokumentong ito ay nagtataglay ng mahalagang impormasyon tungkol sa kasaunduan sa iyong pagtatrabaho. Lagyan ng tsek ang kahon sa kaliwa upang matanggap ang impormasyong ito sa wikang ito.
	Oromo / Oromoo	Waraqaan kun waayee waliigaltee hojii keetii odeeffannoo barbaachisoo ta'an qabatee jira. Saaxinnii karaa bitaatti argamu kana irratti mallattoo godhi yoo afaan Kanaan barreeffama argachuu barbaadde.
	Amharic/ አማርኛ	ይህ ዶኩመንት አቀጣጠሮን በሚመለከት ስለተደረሰው ስምምነት አስፈላጊ መረጃ የያዘ ነው። ይህንን ዶኩመንት በስተግራ በኩል ባለው ቋንቋ ተተርጉሞ እንዲሰጦት ከፈለጉ በዛው በስተግራ በኩል ባለው ሳጥን ውስጥ ምልክት ያድርጉ።
	Karen / ကညီကျိာ်	လံာ်တီလံာ်မီတခါအံၤဟ်ဃုာ်တၢ်ဂ့ၢ်တၢ်ကျိၤလၢအရှ့ဒိၣ်ဘၣ်ဃးန့တၢ်ဖံးတၢ်မၤအတၢ်အၢၣ်လီၤအီလီၤန့ၣ်လီၤ. တၢ်နီၣ်တၢ်ဒၢဖိလၢအအိၣ်လၢအစ့ၣ်လၢတၢ်ကဒိးန့ၢ်တၢ်ဂ့ၢ်တၢ်ကျိၤလၢကျိာ်တခါအံၤအဂီၢ်န့ၣ်တက့ၢ်.

1650 West End Blvd. Suite 100
St. Louis Park, MN 55416
Phone: 612-868-3270
Fax: 612-395-5593
Web: AbilityCare.com

PAYROLL DIRECT DEPOSIT FORM

Ability Care Partners (ACP) offers payment for wages by either Direct Deposit or ADP Wisely Pay card. We issue payroll bi-weekly as listed on our Payroll Calendar. We cannot issue direct deposits on any other dates or in emergency situations. Paystubs are available through ADP online or the ADP mobile app. PCAs are responsible for reviewing paystubs regularly to verify hours worked, wages paid, tax and other payroll deductions, PTO balance and pay rate.

Employee Information

Full Name:		**Social Security #:**
Email:		**Phone:**

I choose to receive payment for wages by:

☐ **ADP Wisely Pay Card** - ***Direct deposit to an ADP Wisely Pay Visa debit card. Free of charge. No direct deposit fee. Access your funds 24/7 everywhere Visa debit cards are accepted or via ATM (fees may apply at ATM locations). A temporary card will be mailed to you via U.S. mail on your first payroll (Pay cards are not available for pick up). You must activate your pay card. For more info, visit: https://info.mywisely.com/pay/***
Notice: Ability Care Partners is not responsible for lost Wisely Pay cards. We do not issue replacement cards. If lost, call Wisely Pay at 1-866-313-6901.

Or

☐ **Direct Deposit Enrollment** - **The bank account must be in your legal name as the sole or joint account holder.**

List your Direct Deposit account information for the bank account(s) to be used for your wages:

Bank Name	Routing #	Account #	Account Type	Deposit Instructions

Proof of account(s):* *Please attach photo proof of your bank account details. Deposit tickets are not accepted. We accept a voided check, bank letter or bank issued direct deposit form that shows your legal name along with account type (checking or savings), bank routing number and your account number.

☐ ***No proof submitted.*** I acknowledge any errors are my responsibility and may result in payroll delays of 30 days.

Payroll Errors & Overpayments: If a mistake is made resulting in erroneous payment or overpayment to my account or pay card; I agree that Ability Care Partners will proceed with the following steps (as time permits):

- The funds transfer will be cancelled (when possible) and a new deposit will be issued to my account or pay card. If unsuccessful, ACP will notify me and request the return of the funds within three (3) business days.
- Funds not voluntarily returned by me will be deducted in full from my next scheduled direct deposit(s).

Acknowledgements: I authorize ACP to deposit my wages into the account(s) specified above. I agree that direct deposit transactions I authorize comply with all applicable laws. I understand that under no circumstances will ACP be responsible for overdraft fees. I understand that in the event my financial institution is not able to complete an electronic transfer to my account due to any action I take, I am responsible for ALL resulting bank fees incurred and that the Agency cannot issue the payroll funds to me until the funds are returned to ACP by my financial institution. This authorization will remain in effect until I have cancelled it in writing or by completing a new direct deposit form.

Employee Signature:____ **Date:**____________________

1650 West End Blvd. Suite 100
St. Louis Park, MN 55416
Phone: 612-868-3270
Fax: 612-395-5593
Web: AbilityCare.com

Payroll & Benefits Information

Payroll is done by direct deposit to your bank account or a free ADP Wisely Pay Card. For more information on the ADP Wisely Pay Card, visit: https://info.mywisely.com/pay/

If you do not have a bank account, we will automatically issue you a free **ADP Wisely Pay Card**. On your first payroll we will mail you a temporary debit card that you can use to access your payroll funds at no charge. A permanent ADP Wisely Pay Card with your name will be sent to you from the card issuer. If you have any questions or concerns, contact us via email or telephone.

Online Paystubs & PTO Balance Verification

All employees may access their paystubs and current PTO balance online 24/7 via computer or smartphone through ADP. Accessing paystubs is very easy on the ADP mobile app and website! On the day of your first payroll deposit, you will be able to register for an ADP account using the "Find Me" feature where you'll verify your identity. We cannot create usernames or passwords for employees. For additional assistance, visit our Payroll Support page.

If you need a copy of your paystub and do not have internet access, please contact us to make arrangements to obtain copies (allow 3-5 business days).

Employee Benefits

A. Paid Time-Off - *ACP* **PCA Choice employees accrue Paid Time-Off (PTO) as required by the 2021-2023 Collective Bargaining Agreement (CBA) between the State of Minnesota and SEIU Healthcare Minnesota (PCA Union)**.

- PCA Choice employees will earn 1 hour of PTO for every 30 hours worked (accrual rate of 0.0333).
- Once an employee has worked 600 hours (after July 1, 2019) they will be eligible to redeem PTO pay by submitting a **PTO Request Form** (with consent from the Consumer/RP) for approval and eventual processing on the next applicable payroll.
- *Eligible PCAs that resign or are terminated will have the option to cash-out PTO providing they have met the required 600 hours as a PCA criteria in the CBA.*
- *PCAs must have submitted a signed final timesheet and returned any keys or consumer property before final payroll and any PTO will be issued.*

B. Holiday Pay – Per the CBA, we will pay at 1.5 times hourly wage for PCAs that work on the holidays below:

- **Labor Day, Thanksgiving Day, New Year's Day, Martin Luther King Day and Memorial Day.**

C. Floating Holiday Pay (Effective October 1st, 2021)

- Each PCA has two (2) floating holidays of their choice to use between Oct. 1, 2021 to June 30, 2022, and two (2) floating holidays to use between July 1, 2022, and June 30, 2023.
- A floating holiday is a day chosen by the PCA and will be paid at 1.5 times their regular hourly wage for hours worked. The floating holidays do not need to be recognized state or federal holidays and are in addition to the five holidays (above) listed in the CBA.
- A worker must obtain the consent of the consumer (or the Responsible Party) to use a floating holiday. Workers must obtain the Floating Holiday Request Form posted on abilitycare.com and submit the completed form *with* their timesheets for the corresponding date. **No exceptions.**
- All floating holiday shifts are limited to up to an 8 hour maximum or the number of hours the recipient is assessed for on a daily basis (whichever is less). If there is a need for the worker to work additional hours on a floating holiday, it must be pre-approved by *ACP*.
- ACP and the consumer are not responsible to remind PCAs to use their floating holidays available each state fiscal year.

D. Health & Dental Insurance - *ACP* currently does not offer health insurance.

AbilityCarePartners

1650 West End Blvd. Suite 100
St. Louis Park, MN 55416
Phone: 612-868-3270
Fax: 612-395-5593
Web: AbilityCare.com

PCA Training, Certification, Enrollment & Union Information

All PCAs are required to complete the free **Individualized Personal Care Assistant Training** offered through MN-DHS before working and enrolling as a PCA. ***We require all PCAs to send proof of completion as outlined below, or the PCA will be prohibited from working until the training is passed.*** You may take the test as many times as needed (no required wait between attempts).
The online training covers the followng subjects:

Free PCA Training & Certification:
http://abilitycare.com
(No access to a computer? Check with a local public library or workforce center for free computer lab access.)

- PCA Program Overview
- Emergency Preparedness
- Infection Control & Standard Precautions
- Body Mechanics
- Understanding Behaviors
- Child & Vulnerable Adult Maltreatment
- Time cards and Documentation
- Fraud
- Stress, Self-care & Support for the PCA

PCA Certification Test Instructions

- Go to **http://registrations.dhs.state.mn.us**
- Click **"Training"** to review the training materials
- Under Event, select: **"PCA/CFSS support workers"**
- Click the **"Next - Register"** button to proceed.

Send Us Your PCA Certificate

Once you have passed the online test you will receive a certificate emailed by MN-DHS and we ask that you forward it to us at staff@abilitycare.com or fax to 612-395-5593. If you previously completed the test, we require you to send a copy of the certificate to us (or take the test again). If you have any questions regarding the training, call MN-DHS at (651) 431-2400 or email us.

Additional Required PCA Training, Orientation & Information

We value our PCAs greatly and want you to be confident and safe while serving Consumers. Because of the unqiue dynamics of working as a PCA under the MN PCA Choice program, you will be working directly for your Consumer and you must communicate with them regarding your training, orientation and saftey on the job. If you need to report saftey concerns or an injury, you may file a report through our web site. Because we do not have a central work site or input over your work schedule, we designate our web site as the Employee Resource Center for training materials and publishing notices. We strive to comply with industry standards set by our workers compensation insurance provider. We offer additional free training materials and videos on our web site. All PCAs are required to review the training materials on our web site as part of the orientation for their Consumer. You will be verifying your completion of all training materials with your signature on your hiring paperwork. If you do not have access to our web site, speak with your Consumer to review materials with them or call us at 612-868-3270 to request printed copies.

Individual PCA Provider ID Number (UMPI #) Enrollment Information

MN-DHS requires that all PCAs enroll to receive an Individual PCA Provider ID (UMPI) Number. The enrollment forms are included with your hiring forms. Please do not send in your forms directly to DHS, we need to complete the forms with your background study number. MN-DHS will process UMPI # forms as soon as possible (it can take up to 120 days). After passing the NETStudy 2.0 and completing the online PCA Training Certification, PCAs are eligible to work while their UMPI # is being processed. Once we receive your UMPI #, it will be listed on your payroll account as your 10-character Employee ID #. We will also send your UMPI # via email to you and your Consumer. You will be required to list your UMPI # on your timesheets.

SEIU Healthcare Minnesota - PCA Union Information

SEIU Healthcare Minnesota serves as the union organization for PCAs who work in the consumer directed PCA/CFSS programs (PCA Choice, CDCS & CSG). PCAs in these programs are covered under the Collective Bargaining Agreement (CBA) between the State of Minnesota. Union membership information and enrollment materials are available on our website at http://www.abilitycare.com. If you would like a copy mailed to you, please email or call us or contact the SEIU directly.

You are not required to be a union member to work for ACP. Any wages, benefits, PTO, etc. set forth in the CBA will be given to all union or non-union PCAs. Union members will have dues automatically withheld from their ACP payroll at the dues rate set by the SEIU (currently set at 3% of wages earned). As stated in the CBA, PCAs do not have the right to strike and agencies do not have any direct bargaining with the SEIU. ACP maintains a neutral position with regard to union membership.

Any questions about union membership, benefits, dues, events or other information should be directed to:
SEIU Healthcare Minnesota • http://www.SEIUhealthcaremn.org • Email: mac@seiuhealthcaremn.org
345 Randolph Ave, Suite 100, St. Paul, MN 55102 • Phone: 651-294-8100 • Toll- Free 800-828-0206 • Fax: 651-294-8200

IMPORTANT REMINDER: PCAs are not allowed to work until we have notified both the Consumer and PCA by email.

1650 West End Blvd. Suite 100
St. Louis Park, MN 55416
Phone: 612-868-3270
Fax: 612-395-5593
Web: AbilityCare.com

PCA JOB DESCRIPTION

Ability Care Partners is a **PCA Choice Provider** which means we are not a full service traditional PCA agency. Our Consumers are responsible for finding and scheduling their own PCAs (we do not assign PCA positions). We handle the administrative, payroll and billing responsibilities. Most of our operations staff work remotely. We conduct in-person office hours on a limited basis by appointment only. The most effective way to communicate with us is via email.

PCAs provide direct care services to Consumers with disabilities in the home and community. Each Consumer has a Care Plan created by the RN Qualified Professional that outlines what services are needed. The Consumer (or Responsible Party) hires, trains, schedules and directs all PCA staff.

PCA Requirements:

- Must be at least 18 (or 16-17 with QP supervision), eligible to work in the U.S., free of drugs or illegal substances, and pass a DHS NETStudy 2.0 background study before working.
- Complete MN PCA Certification training online (free of charge).
- Complete individualized training and orientation on the needs of the Consumer they are working with.
- Be capable of providing all services in the Consumer's Care Plan.
- Must NOT be a Consumer of PCA services and not be the Consumer's Spouse, Parent (of minor child Consumer), Corporate/Paid Guardian or Responsible Party.

General Overview of PCA Responsibilities:

- Provide for the care and safety of the Consumer and report any abuse or neglect.
- Maintain daily written records including, but not limited to, timesheets.
- Communicate openly regularly with the Consumer, Responsible Party and the Qualified Professional regarding progress/changes in condition(s).
- Assist with the Activities of Daily Living, Instrumental Activities of Daily Living (for Consumers 18+), Health Related Functions*, Behaviors* (*if applicable).
- Demonstrate good communication, dependability, ability to follow orders with little direct supervision and make appropriate judgments.

Essential PCA Job Duties:

Bowel/Bladder Care • Skin Care • Range Of Motion • Respiratory Assistance • Transfers (with or without the use of belts, sliding boards, Hoyer lifts, etc.) • Bathing • Grooming • Turning/Positioning • Assist with medications that are self-administered by Consumer • Application/Maintenance of Prosthetics, Assistive/Medical Devices • Dressing • Meal Preparation/Plans • Eating/Feeding • Accompanying a Consumer to obtain Medical Treatment and other out-of-home activities • Incidental Household Services • Practice Universal Safety Precautions • Other personal cares as specified in the Care Plan.

Any duties or tasks that are not outlined above are considered non-covered services that may not be provided by our PCA employees (unless prior approved in writing by the company).

If you are a PCA employee that also is licensed as a CNA, this job description outlines the general duties of a Personal Care Assistant (PCA) in Minnesota. Many duties of a PCA may be considered for CNA renewal, we are only able to verify the name and dates of employment. Our Consumers act as the direct supervisor and may be able to write a more detailed letter with descriptions of the exact cares performed on the job. We may be able to include their letter with any verification request.

Questions? Please email staff@abilitycare.com

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. 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, as required by law .

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 for your job or position.

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;
- MNSure, 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. If an FBI check is required for your background study, the Federal Bureau of Investigation (FBI) may keep your fingerprints and may use them for other purposes in accordance with state and federal law.

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) for 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, 524.5-118; and 626.559 subdivision 1b.

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

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) so that you are represented on the claim 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 serves. It also allows the Department 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 client.

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 the Department 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, please call 651-431-2700.

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

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

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

Refer to the instructions for more information about acceptable receipts.