

I/DD – SLEEP CYCLE SUPPORT

DSW PACKET

ADDITIONAL DOCUMENTS NEEDED

YOU **MUST** PROVIDE COPIES OF THE REQUIRED ITEMS TO PROVE YOUR ELIGIBILITY TO WORK FROM THE LIST OF ACCEPTABLE DOCUMENTS ON I-9 FORM PAGE 2.

- ONE SELECTION FROM LIST A

~ OR ~

- ONE SELECTION FROM LIST B
- ~ AND ~
- ONE SELECTION FROM LIST C



SOUTHEAST KANSAS INDEPENDENT LIVING

1801 Main
P.O. Box 957
Parsons, KS 67357

Phone: (620) 421-5502
Fax: (620) 421-2096
Toll Free: (800) 688-5616

SLEEP CYCLE REQUIREMENT

All Sleep Cycle Support workers must work a minimum of 8 hours per shift.

Failure to comply will result in not being paid for the time worked while on that shift.

**Working 7 hours and 59 minutes will not be paid out.
(ie: To guarantee pay, work 8 hours and 1 minute).**

DSW Signature: _____

Date: _____

AUTHENTICARE REQUIRED INFORMATION

1. Are you bilingual? (circle one) → Yes No

a. If so, what languages? _____

2. Do you know Sign Language? (circle one) → Yes No

3. Are you related to the employer? (circle one) → Yes No

a. If so, how are you related? _____

4. Is a language accommodation required? (circle one) → Yes No

DSWs are **required** to use of AuthentiCare®KS for reporting of time and attendance; and

The employer / participants who choose to participant-direct his/her services must comply with the required use of the IVR system for DSWs to submit time worked, including having the ability and equipment needed to utilize the system.

Guidelines for Requesting an Exception to the use of Interactive Voice Response (IVR) System

Direct service providers of Kansas Department for Aging and Disability Services-Home and Community Based Services (KDADS-HCBS) (FE, I/DD, PD, TBI, TA) and MFP (FE, I/DD, PD and TBI) are required to utilize the IVR system to document time worked and activities relating to service delivery. The utilization of the IVR is necessary to meet documentation requirements in order to support claims submitted for reimbursement of services rendered.

In the event every attempt to utilize the IVR was unsuccessful and all documented training efforts have been exhausted, the employing agency may submit a formal request via for an "exception to the required use of the IVR system" via the Request for Exception to use of KS AuthentiCare-IVR form. The form must be submitted to the KDADS HCBS-ks@kdads.ks.gov. The following information must be included in the request:

Name of the individual receiving HCBS services

Medicaid number of the individual receiving

HCBS services Number of unsuccessful attempts to utilize IVR

Copy of translated resources available to accommodate the language barrier Include DSW's primary language

An exception will not be granted for language barrier reasons when a translated language is provided by the system. Copy of the training policy/process for the use of IVR system

Dates and types of additional training provided to direct service worker following unsuccessful attempts.

Following documented unsuccessful attempts to train the DSW, the managing employer must determine the worker is not qualified provider due to inability to perform required job functions. It is a program requirement that the DSW must be able to perform all tasks related to the duties of the DSW, including required use of IVR system for the purpose of documentation of time and attendance.

An administrative committee will review the request within 10 business days of receipt of the request, and approve or deny the request for an exception to submit paper documentations in lieu of the IVR system. If additional documentation is requested of the provider, KDADS clock stops and the provider must submit the documentation to KDADS within 10 business days. If the additional requested documentation is not submitted within 10 business of KDADS request, a decision will be made based on the documentation that KDADS received with the initial request. If the "exception" is granted, the direct service worker may as an alternative to the IVR submit a paper documentation of time worked and activities relating to service delivery. It is the responsibility of the provider to notify KDADS of a worker who has been granted an exception.

DIRECT SUPPORT WORKER AGREEMENT

Employer Name: _____

Direct Support Worker Name: _____

The employer contracts with Southeast Kansas Independent Living (SKIL) to provide payroll services. The employer is responsible for all functions of an employer which includes but is not limited to: selecting, training, scheduling, managing, selecting a wage and terminating their Direct Support Worker (DSW). The DSWs are under the complete control and direction of the employer. Southeast Kansas Independent Living (SKIL) **is not** the employer, but rather works under a contractual arrangement with the employer to act as a fiscal management agency. DSWs are responsible for directing all employment disputes and issues to their employer.

The DSW must complete all documentation in the employment packet and return to Southeast Kansas Independent Living (SKIL) **prior to** the first day of working any hours.

DSWs will consider all information regarding an employer to be completely confidential and will not discuss this information without the employer's consent.

TIME KEEPING

Authenticare:

Direct Support Workers **are required** to use the Kansas Authenticare System (also known as electronic visit verification or EVV) for all waiver services including Personal Services and Sleep Cycle Support. Detailed instructions have been mailed to all DSWs. Please review the information. Authenticare does not apply to the following: Choices/Private Pay, Senior Care Act or IDD-Licensed.

Enclosed in your DSW packet is an Exception Form. In **rare** occurrences, you might need to utilize this form to submit time worked (*). Please keep in mind Authenticare notifies Southeast Kansas Independent Living (SKIL) of any outages or updates when the system is not available. Those occurrences are uncommon.

DSW will receive their Authenticare ID number once the completed DSW packet has been received and processed for payroll. Expect to receive the ID number via mail. In order to ensure you receive your Authenticare ID number timely, please make certain that you complete your entire packet along with the requested documents.

Pay Periods:

- 1st - 15th of the month; payable on last day of same month.
- 16th - End of Month; payable on 15th of the following month.

Employer and DSW acknowledge:

- Providing Medicaid funded services to 2 employers at the same time is against Medicaid regulations.
- Under no circumstances will DSWs be authorized to either provide services or submit hours for the time that an employer is hospitalized or receiving any other institutional care.

(*) The Exception Form can be utilized until the DSW receives their AuthentiCare ID number.

Federal, State and FICA taxes are withheld from your wages and are done in accordance to Federal and State law. All other benefits are provided in accordance to Federal and State law.

Pay checks are direct deposited on the 15th and last day of the month. If the pay period fall on a weekend, direct deposits will be received on the Friday before.

Change of Address or any other employment related information must be submitted in writing to Southeast Kansas Independent Living (SKIL).

This agreement shall remain in effect until one of the following happens: the denial of the employer's Medicaid eligibility; the termination/closure of the employer's HCBS case; the termination of the DSW as the customer's self- directed worker; or the termination of the customer/employer's right to self-direct his/her care.

The DSW agrees to cooperate with the customer/Kansas Department for Children and Families (DCF) or any other state designated entity (such as a Managed Care Organization) regarding any questions and/or inquiries regarding the customer/employer's HCBS case.

DSW Signature: _____ Date: _____

Customer/Employer Signature: _____ Date: _____

SKIL Rep Signature: _____ Date: _____

I have read and understand the information provided in the Direct Support Worker Acknowledgement and I agree to perform my duties as a Direct Support Worker accordingly. I further understand my responsibility to record accurate and timely information in correlation to the information provided.

All parties agree that services provided will follow the plan of care that was developed by the employer and their Managed Care Organization. **No services outside the scope of the plan of care will be payable.**

Any falsification of documents and/or services or failure to comply by Medicaid regulations may result in a determination against you. If action is taken against you, you may be held financially accountable. Southeast Kansas Independent Living (SKIL) is responsible for working with the State Attorney General's office and other State entities on suspected Medicaid Fraud cases.

The DSW agrees to follow the policies and procedures as the Southeast Kansas Independent Living (SKIL) sets forth.

SMS OPT-IN RELEASE

Direct Support Worker Name: _____

The purpose of this release is so that Southeast Kansas Independent Living (SKIL) can contact you through text messages for important matters, such as: issues affecting your employer's home and community-based services; changes in your payroll; messages Southeast Kansas Independent Living (SKIL) or your employer have not been able to relay to you by phone call or mail; important legislative updates and announcements; invitations to Southeast Kansas Independent Living (SKIL) sponsored events (picnics, advocacy groups, commodities, vaccine clinics and other events); due dates for having paperwork updated or renewed; training opportunities; and other matters that impact your employment.

Southeast Kansas Independent Living (SKIL) **will not** be sending third party advertisements or SPAM of any kind. We simply want to be able to maintain communication with our valued direct service workers, their employers and community partners, and we believe this will be the best way to keep you informed in a timely manner.

I, _____, give Southeast Kansas Independent Living (SKIL) permission to send SMS text messages to my cell phone number for the reasons stated above. I have been made aware of the online privacy policy on the Southeast Kansas Independent Living (SKIL) website. I am also aware that I can opt-out of receiving messages at any time by replying "**STOP**", if I wish to unsubscribe.

This release is applicable unless otherwise revoked.

DSW Signature: _____ Date: _____

Cell Phone #: _____

SKIL Rep Signature: _____ Date: _____

WISELY ENROLLMENT FORM

First Name: _____

Middle Initial: _____

Last Name: _____

Social Security Number: _____

Physical Address (required): _____

P.O. Box (if applicable): _____

City: _____ State: _____ Zip: _____

Date of Birth: _____

Phone Number: _____

Email Address: _____

DSW Signature: _____ Date: _____

Office Use Only

Routing Number: _____

Account Number: _____

SKIL Rep Signature: _____ Date: _____

Southeast Kansas Independent Living (SKIL) is a paperless payroll. Failing to submit a completed direct deposit form will result in enrollment in the payroll card program currently being used by Southeast Kansas Independent Living (SKIL). This program is through Wisely.

For more information visit www.mywisely.com.

AUTHORIZATION FOR DIRECT DEPOSIT

Payroll Agent: Southeast Kansas Independent Living (SKIL)
 1801 Main
 Parsons, Kansas 67357

Phone: (620) 421-5502
Fax: (620) 421-0997

I hereby authorize Southeast Kansas Independent Living (SKIL) hereinafter call Company, to initiate credit entries and, if necessary, debit entries for the purpose of correcting an erroneous credit previously initiated to my account indicated below. I further authorize the Financial Institution named below to accept such entries and to credit or debit the amount thereof to such account.

You can have your check deposited into more than one account. Please be sure to indicate the percentage of your check you want deposited to each account. Attach a voided check for checking account(s) or contact your bank for the routing number on savings accounts. Please note: when depositing to multiple accounts, the percentage total must be 100%. Any changes to your account(s) must be submitted immediately.

<input type="checkbox"/> New Account		<input type="checkbox"/> Change of Account		<input type="checkbox"/> Cancellation	
<input type="checkbox"/> Checking Account (attach a voided check)					
<input type="checkbox"/> Savings Account (please contact your bank for the routing number. Do not use a deposit slip)					
_____		_____		_____	
Financial Institution Name		Branch Name		Phone Number	
_____		_____		_____	
Address		City	State	Zip Code	
_____		_____	_____	_____	
Account Routing Number		Account Number		_____ % of Check to be Deposited	

<input type="checkbox"/> New Account		<input type="checkbox"/> Change of Account		<input type="checkbox"/> Cancellation	
<input type="checkbox"/> Checking Account (attach a voided check)					
<input type="checkbox"/> Savings Account (please contact your bank for the routing number. Do not use a deposit slip)					
_____		_____		_____	
Financial Institution Name		Branch Name		Phone Number	
_____		_____		_____	
Address		City	State	Zip Code	
_____		_____	_____	_____	
Account Routing Number		Account Number		_____ % of Check to be Deposited	

This authority is to remain in full force and effect until Company and Financial Institution have received written notification from me of its termination in such time and manner as to afford Company and Financial Institution a reasonable opportunity to act upon it.

 DSW – Print Name

 Social Security Number

 DSW – Signature

 Date

 Phone Number

Authorization will take effect not less than 10 days after acceptance by Financial Institution.

Southeast Kansas Independent Living (SKIL) is a paperless payroll. Failing to submit a completed direct deposit form will result in enrollment in the payroll card program currently being used by Southeast Kansas Independent Living (SKIL). This program is through Wisely.

For more information visit www.mywisely.com.

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.

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov .
City or town, state, and ZIP code		
(c) <input type="checkbox"/> Single or Married filing separately		
<input type="checkbox"/> Married filing jointly or Qualifying surviving spouse		
<input type="checkbox"/> 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.)		

TIP: Consider using the estimator at www.irs.gov/W4App to determine the most accurate withholding for the rest of the year if: you are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

- (a) Use the estimator at www.irs.gov/W4App for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**
- (b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**
- (c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate

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

Step 3: Claim Dependent and Other Credits	If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly):		
	Multiply the number of qualifying children under age 17 by \$2,000 \$ _____		
	Multiply the number of other dependents by \$500 \$ _____		
	Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here	3	\$ _____
Step 4 (optional): Other Adjustments	(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income	4(a)	\$ _____
	(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here	4(b)	\$ _____
	(c) Extra withholding. Enter any additional tax you want withheld each pay period	4(c)	\$ _____

Step 5: Sign Here	Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.		
	Employee's signature (This form is not valid unless you sign it.)		Date

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

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

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 2025 if you meet both of the following conditions: you had no federal income tax liability in 2024 and you expect to have no federal income tax liability in 2025. You had no federal income tax liability in 2024 if (1) your total tax on line 24 on your 2024 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2025 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 17, 2026.

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

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

1. Are submitting this form after the beginning of the year;
2. Expect to work only part of the year;
3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;
4. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or
5. Prefer the most accurate withholding for multiple job situations.

TIP: Have your most recent pay stub(s) from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

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. Submit a separate Form W-4 for each job.

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

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



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

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

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2025 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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



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

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

- 1 Two jobs. If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, skip to line 3.
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.
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.
c Add the amounts from lines 2a and 2b and enter the result on line 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.
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).

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



- 1 Enter an estimate of your 2025 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.
2 Enter: { \$30,000 if you're married filing jointly or a qualifying surviving spouse; \$22,500 if you're head of household; \$15,000 if you're single or married filing separately }
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-".
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.
5 Add lines 3 and 4. Enter the result here and in Step 4(b) of Form W-4.

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$0	\$700	\$850	\$910	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020
\$10,000 - 19,999	0	700	1,700	1,910	2,110	2,220	2,220	2,220	2,220	2,220	2,220	3,220
\$20,000 - 29,999	700	1,700	2,760	3,110	3,310	3,420	3,420	3,420	3,420	3,420	4,420	5,420
\$30,000 - 39,999	850	1,910	3,110	3,460	3,660	3,770	3,770	3,770	3,770	4,770	5,770	6,770
\$40,000 - 49,999	910	2,110	3,310	3,660	3,860	3,970	3,970	3,970	4,970	5,970	6,970	7,970
\$50,000 - 59,999	1,020	2,220	3,420	3,770	3,970	4,080	4,080	5,080	6,080	7,080	8,080	9,080
\$60,000 - 69,999	1,020	2,220	3,420	3,770	3,970	4,080	5,080	6,080	7,080	8,080	9,080	10,080
\$70,000 - 79,999	1,020	2,220	3,420	3,770	3,970	5,080	6,080	7,080	8,080	9,080	10,080	11,080
\$80,000 - 99,999	1,020	2,220	3,420	4,620	5,820	6,930	7,930	8,930	9,930	10,930	11,930	12,930
\$100,000 - 149,999	1,870	4,070	6,270	7,620	8,820	9,930	10,930	11,930	12,930	14,010	15,210	16,410
\$150,000 - 239,999	1,870	4,240	6,640	8,190	9,590	10,890	12,090	13,290	14,490	15,690	16,890	18,090
\$240,000 - 259,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
\$260,000 - 279,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
\$280,000 - 299,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
\$300,000 - 319,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,170	19,170
\$320,000 - 364,999	2,040	4,440	6,840	8,390	9,790	11,100	12,470	14,470	16,470	18,470	20,470	22,470
\$365,000 - 524,999	2,790	6,290	9,790	12,440	14,940	17,350	19,650	21,950	24,250	26,550	28,850	31,150
\$525,000 and over	3,140	6,840	10,540	13,390	16,090	18,700	21,200	23,700	26,200	28,700	31,200	33,700

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	\$200	\$850	\$1,020	\$1,020	\$1,020	\$1,370	\$1,870	\$1,870	\$1,870	\$1,870	\$1,870	\$2,040
\$10,000 - 19,999	850	1,700	1,870	1,870	2,220	3,220	3,720	3,720	3,720	3,720	3,890	4,090
\$20,000 - 29,999	1,020	1,870	2,040	2,390	3,390	4,390	4,890	4,890	4,890	5,060	5,260	5,460
\$30,000 - 39,999	1,020	1,870	2,390	3,390	4,390	5,390	5,890	5,890	6,060	6,260	6,460	6,660
\$40,000 - 59,999	1,220	3,070	4,240	5,240	6,240	7,240	7,880	8,080	8,280	8,480	8,680	8,880
\$60,000 - 79,999	1,870	3,720	4,890	5,890	7,030	8,230	8,930	9,130	9,330	9,530	9,730	9,930
\$80,000 - 99,999	1,870	3,720	5,030	6,230	7,430	8,630	9,330	9,530	9,730	9,930	10,130	10,580
\$100,000 - 124,999	2,040	4,090	5,460	6,660	7,860	9,060	9,760	9,960	10,160	10,950	11,950	12,950
\$125,000 - 149,999	2,040	4,090	5,460	6,660	7,860	9,060	9,950	10,950	11,950	12,950	13,950	14,950
\$150,000 - 174,999	2,040	4,090	5,460	6,660	8,450	10,450	11,950	12,950	13,950	15,080	16,380	17,680
\$175,000 - 199,999	2,040	4,290	6,450	8,450	10,450	12,450	13,950	15,230	16,530	17,830	19,130	20,430
\$200,000 - 249,999	2,720	5,570	7,900	10,200	12,500	14,800	16,600	17,900	19,200	20,500	21,800	23,100
\$250,000 - 399,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
\$400,000 - 449,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
\$450,000 and over	3,140	6,490	9,160	11,660	14,160	16,660	18,660	20,160	21,660	23,160	24,660	26,160

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	\$450	\$850	\$1,000	\$1,020	\$1,020	\$1,020	\$1,020	\$1,870	\$1,870	\$1,870	\$1,890
\$10,000 - 19,999	450	1,450	2,000	2,200	2,220	2,220	2,220	3,180	4,070	4,070	4,090	4,290
\$20,000 - 29,999	850	2,000	2,600	2,800	2,820	2,820	3,780	4,780	5,670	5,690	5,890	6,090
\$30,000 - 39,999	1,000	2,200	2,800	3,000	3,020	3,980	4,980	5,980	6,890	7,090	7,290	7,490
\$40,000 - 59,999	1,020	2,220	2,820	3,830	4,850	5,850	6,850	8,050	9,130	9,330	9,530	9,730
\$60,000 - 79,999	1,020	3,030	4,630	5,830	6,850	8,050	9,250	10,450	11,530	11,730	11,930	12,130
\$80,000 - 99,999	1,870	4,070	5,670	7,060	8,280	9,480	10,680	11,880	12,970	13,170	13,370	13,570
\$100,000 - 124,999	1,950	4,350	6,150	7,550	8,770	9,970	11,170	12,370	13,450	13,650	14,650	15,650
\$125,000 - 149,999	2,040	4,440	6,240	7,640	8,860	10,060	11,260	12,860	14,740	15,740	16,740	17,740
\$150,000 - 174,999	2,040	4,440	6,240	7,640	8,860	10,860	12,860	14,860	16,740	17,740	18,940	20,240
\$175,000 - 199,999	2,040	4,440	6,640	8,840	10,860	12,860	14,860	16,910	19,090	20,390	21,690	22,990
\$200,000 - 249,999	2,720	5,920	8,520	10,960	13,280	15,580	17,880	20,180	22,360	23,660	24,960	26,260
\$250,000 - 449,999	2,970	6,470	9,370	11,870	14,190	16,490	18,790	21,090	23,280	24,580	25,880	27,180
\$450,000 and over	3,140	6,840	9,940	12,640	15,160	17,660	20,160	22,660	25,050	26,550	28,050	29,550

K-4

(Rev. 7-24)

KANSAS

EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

K-4
Attach
500524



Use the following instructions to accurately complete your K-4 form, then detach the lower portion and give it to your employer. For assistance, call the Kansas Department of Revenue at 785-368-8222.

Purpose of the K-4 form: A completed withholding allowance certificate will let your employer know how much *Kansas* income tax should be withheld from your pay on income you earn from *Kansas* sources. Because your tax situation may change, you may want to re-figure your withholding each year.

Exemption from Kansas withholding: To qualify for exempt status you must verify with the Kansas Department of Revenue that: **1)** last year you had the right to a refund of **all**

STATE income tax withheld because you had **no** tax liability; and **2)** this year you will receive a full refund of **all** STATE income tax withheld because you will have **no** tax liability.

Basic Instructions: If you are not exempt, complete the **Personal Allowance Worksheet** that follows. The total on line F should **not** exceed the total exemptions you claim under "Exemptions and Dependents" on your *Kansas* income tax return.

NOTE: Your status of "Single" or "Joint" may differ from your status claimed on your federal form W-4).

Using the information from your **Personal Allowance Worksheet**, complete the **K-4** form below, sign it and provide it to your

employer. If your employer does not receive a K-4 form from you, they must withhold *Kansas* income tax from your wages without exemption at the "Single" allowance rate.

Head of household: Generally, you may claim head of household filing status on your tax return only if you are **unmarried and pay more than 50% of the cost of keeping up a home for yourself and for your dependent(s).**

Non-wage income: If you have a large amount of non-wage *Kansas* source income, such as interest or dividends, consider making *Kansas* estimated tax payments on Form K-40ES. Without these payments, you may owe additional *Kansas* tax when you file your state income tax return.

Personal Allowance Worksheet (Keep for your records)

- A Allowance Rate: If you are a single filer mark "Single" A Single
 If you are married and your spouse has income mark "Single" Joint
 If you are married and your spouse does not have income mark "Joint"
- B Enter "0" or "1" if you are married or single (entering "0" may help you avoid having too little tax withheld) B _____
- C Enter "0" or "1" if you are married and only have one job, and your spouse does not work (entering "0" may help you avoid having too little tax withheld) C _____
- D. Enter "2" if you will file head of household on your tax return (see conditions under Head of Household above)..... D _____
- E Enter the number of dependents you will claim on your tax return. **Do not** claim yourself or your spouse or dependents that your spouse has already claimed on their form K-4 E _____
- F **Add lines B through E** and enter the total here F _____

▼ Cut here and give the lower portion to your employer. Keep the top portion for your records. ▼

K-4

(Rev. 7-24)

Kansas Employee's Withholding Allowance Certificate

Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the Kansas Department of Revenue. Your employer may be required to send a copy of this form to the Department of Revenue.

1 Print your First Name and Middle Initial	Last Name	2 Social Security Number
Mailing address		3 Allowance Rate Mark the allowance rate selected in Line A above. <input type="checkbox"/> Single <input type="checkbox"/> Joint
4 Total number of allowances you are claiming (from Line F above).....	4	
5 Enter any additional amount you want withheld from each paycheck (this is optional).....	5	\$
6 I claim exemption from withholding. (You must meet the conditions explained in the "Exemption from withholding" instructions above.) If you meet the conditions above, write "Exempt" on this line..... Note: The Kansas Department of Revenue will receive your federal W-2 forms for all years claimed Exempt.		6
Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief it is true, correct, and complete.		
SIGN HERE		Date
7 Employer's Name and Address		8 EIN (Employer ID Number)



Employment Eligibility Verification

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

USCIS
Form I-9

OMB No. 1615-0047
Expires 05/31/2027

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

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

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

Last Name (Family Name)		First Name (Given Name)		Middle Initial (if any)	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number (if any)	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number		Employee's Email Address			Employee's Telephone Number
<p>I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.</p>	Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):					
	<input type="checkbox"/> 1. A citizen of the United States					
	<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)					
	<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)					
<input type="checkbox"/> 4. A noncitizen (other than Item Numbers 2. and 3. above) authorized to work until (exp. date, if any)						
If you check Item Number 4. , enter one of these:						
USCIS A-Number		OR	Form I-94 Admission Number		OR	Foreign Passport Number and Country of Issuance
Signature of Employee					Today's Date (mm/dd/yyyy)	

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

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

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)	Additional Information				
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)	<input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.				
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

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

Last Name, First Name and Title of Employer or Authorized Representative		Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)
Employer's Business or Organization Name		Employer's Business or Organization Address, City or Town, State, ZIP Code	

For reverification or rehire, complete [Supplement B, Reverification and Rehire](#) on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.

* Documents extended by the issuing authority are considered unexpired.

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

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (2) An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 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 	OR	<ol style="list-style-type: none"> 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 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 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <li style="text-align: center;">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 	AND	<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 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. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security <p style="margin-left: 20px;">For examples, see Section 7 and Section 13 of the M-274 on uscis.gov/i-9-central.</p> <p style="margin-left: 20px;">The Form I-766, Employment Authorization Document, is a List A, Item Number 4. document, not a List C document.</p>
<p>Acceptable Receipts</p> <p>May be presented in lieu of a document listed above for a temporary period.</p> <p>For receipt validity dates, see the M-274.</p>				
<ul style="list-style-type: none"> • Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee. 	OR	<ul style="list-style-type: none"> • Receipt for a replacement of a lost, stolen, or damaged List B document. 	AND	<ul style="list-style-type: none"> • Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on [I-9 Central](#) for more information.

ABUSE, NEGLECT & EXPLOITATION

Abuse

Any act or failure to act performed intentionally or recklessly that causes or is likely to cause harm, including: infliction of physical or mental injury; sexual abuse; unreasonable use of physical or chemical restraint, isolation or medication; threat or menacing conduct; fiduciary abuse; and omission or deprivation by a caretaker or another person of goods or services which are necessary to avoid physical or mental harm or illness.

Neglect

Failure or omission by one's self, caretaker or another person with a duty to supply, or provide goods or services which are reasonably necessary to ensure safety and well-being, and to avoid physical or mental harm or illness.

Exploitation

Misappropriation of an adult's property or intentionally taking unfair advantage of an adult's physical or financial resources.

Fiduciary Abuse

A situation in which a person who is the caretaker of or who stands in a position of trust to an adult, takes, secretes, or appropriates their money or property for any use or purpose not in the due and lawful execution of the adult's trust or benefit.

Who Should Report

Kansas law (KSA-39-143 1) requires persons in specific professions to report suspected abuse, neglect, exploitation or fiduciary abuse of adults residing in the community to the Department for Children and Family Services.

Confidentiality

The names of persons who report suspected abuse, neglect, exploitation or fiduciary abuse are confidential and cannot be disclosed without the written consent of the person making the report or through a court order.

What To Report

1. Name and location of the person who is alleged to be abused, neglected, exploited or fiducially abused.
2. Information regarding the nature of the abuse, neglect, exploitation or fiduciary abuse including:
 - a. What the person saw.
 - b. Why the reporter considers it to be abuse, neglect, exploitation or fiduciary abuse.
 - c. Whether the reporter considers the person to be in immediate danger.
 - d. Specific addresses and/or phone numbers, if known, for caretakers, next of kin, collateral contacts and alleged perpetrators.

When To Report

A report should be made when:

1. The person is in a harmful situation or is in danger of being harmed.
2. A specific incident or pattern suggests abuse, neglect, exploitation or fiduciary abuse is occurring.
3. The person is unable to provide for or obtain the services necessary to ensure safety and well-being, and to avoid physical and mental harm or illness.

Where And How To Report

1. During normal working week days and hours of operation, call any DCF office or local law enforcement.
2. Call law enforcement when DCF offices are closed or call the Adult Protective Services toll-free hotline at 1-800-922-5330.

What DCF Will Do

1. Initiate a personal visit within 24 hours to five working days depending on the risk of imminent danger to the individual.
2. Contact collateral sources. (relatives, neighbors, services providers, etc.)
3. With the consent of the adult, interview the alleged perpetrator if one has been named.
4. Discuss with the adult, guardian, conservator and/or caretaker what actions are needed and develop service plans or corrective action plans with recommendations to prevent further harm.
5. Assist in locating services which are necessary to maintain physical or mental health such as legal services, medical care, appropriate living arrangements, assistance in personal hygiene, food, clothing, adequately heated and ventilated shelter, protection from maltreatment and transportation.
6. Involuntary intervention. (i.e. guardianship or conservatorship)
7. Provide advocacy to assure protection of personal rights.
8. Services provided will include only those that are determined to be needed to protect the adult in the least restrictive manner.
9. After due process, the names of confirmed perpetrators of abuse, neglect, exploitation or fiduciary abuse are entered on a central registry. The registry is available to any individual who wishes to learn if his/her name is on the registry or to any agency/organization doing background checks on their employees, volunteers or other persons who provide services to adults age 18 or above. DCF must have a signed release of information before the registry check can be processed.
10. KSA 39-1433 requires DCF upon receiving a report that an adult is being or has been abused, neglected or exploited, or is in need of protective services to immediately notify the appropriate enforcement agency when a criminal act has occurred or has appeared to have occurred.

DSW Signature: _____ Date: _____

BLOOD BORNE PATHOGEN TRAINING

BLOOD BORNE PATHOGENS

In accordance with the revised OSHA Blood Borne Pathogens Standard, 29 CFT 9110.1030, the following Exposure Control Plan has been developed.

1. Exposure Determination

OSHA requires an exposure determination concerning occupational exposure to blood or other potentially infectious materials, without regard to the use of personal protective equipment. Occupational exposure may affect attendants.

2. Methods of Compliance (Training, Post-Exposure Evaluation and Follow-Up)

- A. All attendants will be informed of the Blood Borne Pathogens Exposure Control Plan at the time they complete their necessary employment forms and before they begin work.
- B. All exposure incidents will be reported to Southeast Kansas Independent Living (SKIL) before the end of the work shift or as soon as possible.

** Reports shall include documentation of the route of exposure and the circumstances related to the incident. **
- C. All attendants who have incurred an exposure incident while on duty and have reported it to Southeast Kansas Independent Living (SKIL) for post-exposure evaluation and follow-up will be offered the Hepatitis B vaccination at no charge, in accordance with the OSHA standard.

DSW Signature: _____ Date: _____



KANSAS DEPARTMENT FOR CHILDREN AND FAMILIES
 Child Abuse and Neglect Central Registry
 P.O. Box 2637 • Topeka, KS 66601 • DCF.CentralRegistry@ks.gov
Release of Information

Complete form by printing legibly in ink. Fee of \$10.00 per Release of Information form may be required prior to processing.

All releases and fees are to be sent to the address or email listed above (see below for specifics)

CONFIDENTIALITY: *Kansas Department for Children and Family records are confidential. No individual, association, partnership, corporation, or other entity shall willfully or knowingly disclose, permit, or encourage disclosure of the contents of records or reports in violation of the confidentiality requirements of K.S.A. 38-2209. Violation of this statute is a class A nonperson misdemeanor and the court may impose a civil penalty of up to \$1,000.*

Contact Person: Patti May Agency/Org.: Southeast Kansas Independent Living
 Phone #: (620) 421-5502 Address: P.O. Box 957
 Email: pattim@skilonline.com City/State/Zip: Parsons, Kansas 67357

Return Results by: Encrypted email (list if different than above): _____ Postal Mail

Payment/Account Information (check box which applies)

<input type="checkbox"/> <i>Fee included</i>	\$10 per request. Check, Money Order (payable to DCF) or cash. Postal mail only.
<input type="checkbox"/> <i>Online Payment*</i>	www.dcf.ks.gov – ‘Online DCF Payments’ icon at bottom of page. Submit receipt with ROI form(s).
<input checked="" type="checkbox"/> <i>Pre-Pay Account*</i>	Agency/Org. has Pre-Pay Account. FEIN: 48-1117893
<input type="checkbox"/> <i>Mentoring Account*</i>	As listed in the Kansas Mentors' Partner Directory. http://mentorkansas.org/Find-a-Program
<input type="checkbox"/> <i>Exempt*</i>	No fee for State government agencies (Sub-contracting agencies not included).

*Release of Information forms may be submitted via email to DCF.CentralRegistry@ks.gov

APPLICANT: *Instructions: PRINT CLEARLY. All requested information is required for processing. Incomplete or illegible information will result in processing delays for the Release of Information. Use 'N/A' rather than leaving a space blank.*

FIRST, MIDDLE, LAST NAME: _____

I give permission for the release of any of my information in the Child Abuse/Neglect Central Registry to the contact listed above. I understand the information released is for their exclusive and confidential use: Yes No
This organization/person/agency may check my information each year I am employed or associated with them: Yes No

OTHER NAMES USED: (Any/all aliases, married, maiden, nicknames, etc. 'N/A' if none used.): _____

DATE OF BIRTH: _____ **RACE:** _____

SOCIAL SECURITY #: _____ **GENDER:** Male Female

CURRENT ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE: _____ **EMAIL:** _____

SIGNATURE: _____ **DATE:** _____

DCF ONLY:	MATCH	CLEARED
	<p><i>This applicant is listed in the Child Abuse/Neglect Central Registry.</i></p> <p><i>Per KSA 65-504 and 65-516 this person prohibited from working, residing, or volunteering in a licensed child care home or facility.</i></p> <p>(see attached document for more info.)</p>	

I, _____, give permission for the release of information concerning
(PRINT Full Name)

myself in the Adult Abuse, Neglect, Exploitation Central Registry to:

Contact Person(s)* Patti May **Phone** (620) 421-5502
Agency name Southeast Kansas Independent Living
Agency mailing address P.O. Box 957, Parsons, Kansas 67357
Email address: Will return via Encrypted email unless marked otherwise pattim@skilonline.com

Maiden Name and/or Other Names Known By: _____
(PRINT ONLY)

Address: _____
Street **City** **State** **Zip Code**

DOB: _____ **SS#:** _____ Male Female
(mm/dd/yyyy) **(mark one)**

I understand that all information released will be for the exclusive and confidential use of the above named organization/person. I have read and understand this form and information provided is true and correct to the best of my knowledge.

I give permission for the release of any information concerning myself in the Adult Abuse, Neglect, Exploitation Central Registry each year while I am employed or associated with the above agency. Yes No

Signature: _____ **Date:** _____
(An Ink Signature or a Verified E-Signature is Required for Processing) **(mm/dd/yyyy)**

RETURN TO:

Email: DCF.APSRegistry@ks.gov

Mail: Office of Background Investigations

Adult Abuse Registry

P.O. Box 751043

Topeka, Kansas 66675

(Please allow 3-5 days for processing email requests and an additional 5-7 days if returning by US Postal Service)

For Official Use Only: Mark in this area if PROHIBITED	For Official Use Only: Mark in this area if CLEARED
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SOUTHEAST KANSAS INDEPENDENT LIVING
P.O. BOX 957, PARSONS, KS 67357
(620) 421-5502

Kansas Department of Aging and Disability Services
Health Occupations Credentialing
503 South Kansas
Topeka, KS 66603

Request for Criminal History Records

To Whom It May Concern:

I authorize the Kansas Department for Aging and Disability Services – Health Occupations Credentialing Department to provide Southeast Kansas Independent Living (SKIL) with access to the criminal history records on my behalf. My personal information is as follows:

Full Legal Name: _____
Last First Middle

Current Address: _____
Street Address City State Zip

Maiden Name or Other Names Known By: _____

Birthdate: _____ Race: _____ Sex: _____ SSN: _____

I understand that all information retrieved will be for the confidential use of Southeast Kansas Independent Living (SKIL).

Signature: _____ Date: _____

FOR OFFICE USE:

NO RECORD: ()

YES (Details Provided Below Or Attached):

Signature Of Staff: _____ Date: _____

SOUTHEAST KANSAS INDEPENDENT LIVING
P.O. BOX 957, PARSONS, KS 67357
(620) 421-5502

U.S. Department of Justice
950 Pennsylvania Avenue, NW
Washington, DC 20530

Request for National Sex Offender Records

To Whom It May Concern:

I authorize the USDOJ Dru Sjodin National Sex Offender Public Website (NSOPW) to provide Southeast Kansas Independent Living (SKIL) with access to the NSOPW on my behalf. My personal information is as follows:

Full Legal Name: _____
Last First Middle

Current Address: _____
Street Address City State Zip

Maiden Name or Other Names Known By: _____

Birthdate: _____ Race: _____ Sex: _____ SSN: _____

I understand that all information retrieved will be for the confidential use of Southeast Kansas Independent Living (SKIL).

Signature: _____ Date: _____

FOR OFFICE USE:

NO RECORD: ()

YES (Details Provided Below Or Attached):

Signature Of Staff: _____ Date: _____

INDIVIDUAL RIGHTS AND RESPONSIBILITIES

1. A provider shall at all times encourage and assist each person served to understand and exercise the person's individual rights and to assume the responsibilities that accompany these rights.
2. Each person served shall be guaranteed the same rights afforded to individuals without disabilities. These rights may be limited only by provisions of law or court order, including guardianship, conservatorship, power of attorney or other judicial determination. These rights shall include the following:
 - a. Being free from physical or psychological abuse or neglect and from financial exploitation;
 - b. Having control over the person's own financial resources;
 - c. Being able to receive, purchase, have and use the person's personal property;
 - d. Actively and meaningfully making decisions affecting the person's life;
 - e. Having privacy;
 - f. Being able to associate and communicate publicly or privately with any person or group of people of the person's choice;
 - g. Being able to practice the religion or faith of the person's choice;
 - h. Being free from the inappropriate use of a physical or chemical restraint, medication or isolation as punishment for the convenience of a provider or agent, in conflict with a physician's orders or as a substitute for treatment, except when physical restraint is in furtherance of the health and safety of the person;
 - i. Not being required to work without compensation, except when the person is living and being provided services outside of the home of a member of the person's family, and then only for the purposes of the upkeep of the person's own living space and of common living areas and grounds that the person shares with others;
 - j. Being treated with dignity and respect;
 - k. Receiving due process; and
 - l. Having access to the person's own records, including information about how the person's funding is accessed and utilized and what services were billed for on the person's behalf.
3. A provider shall train each agent regarding these rights. In addition, a provider shall offer training at least quarterly regarding these rights and effective ways to exercise them to each person served, to the guardian if one has been appointed and to the person's parent and other individuals from each person's support network.
4. This regulation shall take effect on and after October 1, 1998.

I have read and understand my employer's rights and responsibilities. I will respect their rights at all times and assist them, when needed, in exercising their rights.

Direct Support Worker Signature

Date

Customer / Guardian Signature

Date

EMERGENCY PREPAREDNESS WORKSHEET

Customer / Employer Name _____

Direct Support Worker Name _____

IN THE EVENT OF A FIRE

How will the customer leave the house if there is a fire in their home?

- Door
- Window
- Other (explain)

Where will you meet if there is a fire in your home?

- Parking lot
- Sidewalk
- Across the street
- Other (explain)

Who will call 911 once the customer is safely away from the fire?

- Staff
- Customer
- Other (explain)

If alone, who will you contact in case of a fire emergency?

- Will not be left alone
- Staff
- Guardian or parent
- Other (explain)

How will the customer be assisted during the fire emergency?

- Keep them calm
- Carry them out of home
- Anything they need
- Other (explain)

IN THE EVENT OF A TORNADO

How will the customer leave their home in case of a tornado?

- Door
- Window
- Other (explain)

Where will you go if there is a tornado in your area?

- Shelter at apartment
- Local shelter
- Shelter with staff
- Other (explain)

Who will call 911 once the tornado has passed if needed?

- Staff
- Customer
- Other (explain)

If alone, who will you contact in case of a tornado emergency?

- Will not be left alone
- Staff
- Guardian or parent
- Other (explain)

How will the customer be assisted during the tornado emergency?

- Keep them calm
- Carry them out of home
- Anything they need
- Other (explain)

Customer / Employer Name

Direct Support Worker Name

IN THE EVENT OF A POWER OUTAGE

Where will the customer go if there is a power outage lasting more than a few hours?

- Shelter in place
- Shelter with staff
- Shelter with guardian or family
- Other (explain)

Who will call the power company to inform them of the power outage?

- Staff
- Customer
- Other (explain)

If alone during a power outage, who will you contact?

- Will not be left alone
- Staff
- Guardian or family
- Other (explain)

How will the customer be assisted during the power outage emergency?

- Keep them calm
- Anything they need
- Other (explain)

IN THE EVENT OF A FLOOD

Where will the customer go if there is a flood that is threatening their home or the area that they live?

- Shelter in place (if possible)
- Shelter with staff
- Shelter with guardian or family
- Other (explain)

If alone during a flood, who will you contact?

- Will not be left alone
- Staff
- Guardian or family
- Other (explain)

How will the customer be assisted during the flood emergency?

- Keep them calm
- Carry them out of home
- Anything they need
- Other (explain)

When leaving the home with the customer, please make sure that you take any of the following items that you may need while you are out of the home.

(Please mark and add all items that apply to the customer)

- Medication
- Oxygen
- Assistive Devices
- Any other needed items: _____
- Blankets
- Flashlight

By signing this worksheet, I am certifying that I have been trained on my customer's needs in case of an emergency and I fully understand my role and responsibilities in the emergencies listed above.

Employee Signature

Date

Customer / Employer Signature

Date

I/DD SELF-DIRECTED TRAINING CERTIFICATE

This is to certify that

Print Direct Support Worker Name

Has received sufficient training relative to my needs
under my control and direction in the areas of:

- *Abuse, Neglect and Exploitation***
- *Rights and Responsibilities**
- * Emergency Preparedness**

Customer / Guardian

Date

SOUTHEAST KANSAS INDEPENDENT LIVING

1801 Main, P.O. Box 957, Parsons, KS 67357

Phone: (620) 421-5502 Fax: (620) 421-2096

BACKGROUND CHECK REQUIRED DOCUMENT

The total amount required for **ALL** background checks is **\$45.00**.
This amount already includes the \$10.00 fee mentioned on the
Child Abuse and Neglect Central Registry form.

I, _____, hereby authorize
Southeast Kansas Independent Living (SKIL) to complete all the needed background checks
required to work for the Self-Directed Employer listed below.

Employer Name: _____

This authorization includes deducting the amount of \$45.00 from the first payroll and will appear
as a garnishment.

DSW – Print Name: _____

DSW – Signature: _____

Date: _____

Note:

If as an individual, you have copies of current background checks that fall within the guidelines of
the Southeast Kansas Independent Living (SKIL) requirements, contact:

Southeast Kansas Independent Living
1801 Main
P.O. Box 957
Parsons, KS 67357
(800) 688-5616

Your documents will be reviewed, and if approved, will qualify for the needed required
background checks.

CONSUMER ACKNOWLEDGEMENT

By signing below I, _____, (Consumer) fully
Consumer Printed Name

understand that I cannot allow my new hire, _____,
DSW Printed Name

(Direct Support Worker) to begin working for me until I am notified by Southeast Kansas Independent Living (SKIL) that my new hire's required background checks have been completed and approved by the State of Kansas.

I also understand that Southeast Kansas Independent Living (SKIL) **will not** pay any hours to my Direct Support Worker (DSW) that were worked prior to receiving the notification from Southeast Kansas Independent Living (SKIL).

Consumer – Print Name: _____

Consumer – Signature: _____

Date: _____

SAVE ALL DOCUMENTS BEYOND THIS POINT FOR FUTURE REFERENCE

- Sleep Cycle Requirement
- Authenticare Instructions To Check-In Using IVR
- Authenticare Instructions To Check-Out Using IVR
- Authenticare Call In & Out Exception Form
- Authenticare Call In & Out Requirement

DO NOT

**return any documents beyond this
point with your New Hire packet.**

(documents are listed above)

Thank you!



~ REMINDER ~

SLEEP CYCLE REQUIREMENT

**All Sleep Cycle Support
workers must work a
minimum of
8 hours per shift.**

**Failure to comply will
result in not being paid for
the time worked while on
that shift.**

**Working 7 hours and 59 minutes will not be paid out.
(ie: To guarantee pay, work 8 hours and 1 minute).**

AUTHENTICARE

INSTRUCTIONS TO CHECK-IN USING THE IVR

1. Dial **(800) 903-4676** using a verified client phone number.
"Welcome to Kansas AuthentiCare."
2. *"Enter your Worker ID followed by the pound (#) sign."*
Enter your Worker ID and press pound (#).
3. *"To check-in, press 1. To check-out, press 2. For hours worked this week, press 3. For hours worked today, press 4."*
Press 1 to check-in.
4. *"If the client is <Client Name>, press 1. To enter the Client ID, press 8."*
If the client is correct, press 1. If using an unverified phone number, you will hear, "Please enter your client ID followed by the pound (#) sign". Reach out to your provider administrator with questions.
5. *"If you know your service number, enter 1, otherwise press pound (#)."*
Press 1 if you know the static service number. Press pound (#) if you do not know the static service number.
6. If you pressed 1 in step 5, you will hear the following prompt: *"Please enter the service number."* Enter the static number for the service.

If you pressed pound (#) in step 5, you will hear a list of services starting with authorized services. Use the phone keypad to select the service by pressing its corresponding number as provided by the IVR.

7. *"If you are <Worker Name> and you work for <Provider Name> and you are providing <Service Name> for <Client Name>, press 1. If this is not correct, press 2."*
AuthentiCare will repeat back your name, service and client's name for whom you are providing services. If this information is all correct, press 1. If the information is not correct, press 2 and you will be able to correct the information.

When you press 1 and the client's remaining authorized hours for the month are at 20% or less, you will hear: *"Prior to this visit, the remaining hours and minutes for all workers for this client are: <XX> hours and <XX>minutes. Press 1 to acknowledge. Press 2 to return to the main menu. Press 3 to end this call."* Press 1 to continue the check-in process.

When you press 1, if the remaining authorized hours for the month are at zero or at a negative balance, you will hear: *"Care plan exceeded. Remaining units are zero or a negative balance. Press 1 to acknowledge and provide unauthorized services. Press 2 to return to main menu. Press 3 to end this call."* Press 1 to continue the check-in process.

8. *"Your check in was successful at <Time>. To return to the main menu, press 1. To end this call, press 2. Thank you for calling Kansas AuthentiCare. Goodbye."*
Press 2 to end the call.

AUTHENTICARE

INSTRUCTIONS TO CHECK-OUT USING THE IVR

1. Dial **(800) 903-4676** using a verified client phone number.
"Welcome to Kansas AuthentiCare."
2. **"Enter your Worker ID followed by the pound (#) sign."**
Enter your Worker ID and press pound (#).
3. **"To check-in, press 1. To check-out, press 2. For hours worked this week, press 3. For hours worked today, press 4."**
Press 2 to check-out.
4. **"Please enter your Client ID followed by the pound (#) sign."**
If you call from a verified phone number, you will not hear this prompt. If you call from an unverified phone number, you must enter the Client ID and then press pound (#). Reach out to your provider agency administrator with any questions.
5. **"Please enter the place of service code, followed by the pound (#) sign."**
Enter the code that corresponds to the service delivery location and then press the pound (#) sign. Only one service location can be picked.
6. **"Please enter your activity codes followed by the pound (#) sign."** (With the exception of FE Waiver)
If the service performed allows for activity codes to be selected, you will hear this prompt. Choose activity code(s) that best fit the situation. After entering each code, press the pound (#) sign. Once all activity codes are entered, press 8 to move to the next step. You can find a list of activity codes in Part 3 of these instructions.
7. **"Please enter your observation codes followed by the pound (#) sign."** (Press 8 only)
If the service performed allows for observation codes selection, you will hear this prompt. Choose observation code(s) that best fit the situation. After entering each code, press the pound (#) sign. Once all observation codes are entered, press 8 to move to the next step. Press 8 if there are no observations to select. You can find a list of observation codes in Part 4 of these instructions.
8. **"If you are <Worker Name> and you work for <Provider Name> and you have provided providing <Service Name> for <Client's Name>, press 1. If this is not correct, press 2."**
Press 1 if the information is correct. Press 2 if the information is not correct.
9. **"Your check out was successful at <Time>. To return to the main menu, press 1. To end this call, press 2. For hours worked this week, press 4. Thank you for calling Kansas AuthentiCare. Goodbye."**
Press 2 to end the call.

**AUTHENTICARE CALL IN & OUT REQUIREMENT
(USE FOR CLOCKING IN & OUT)**

KANSAS AUTHENTICARE (800) 903-4676

This I/DD service is “IDD Enhanced Care Services”

You must choose this option when clocking in or out of Authenticare.

USE FOR SLEEP CYCLE SUPPORT

3 Minute Alert

The electronic call system requires you to call no more than 3 minutes before or after your shift start or stop times. Failing to call within the correct times could delay your paycheck.

CODE	SERVICE
115	IDD – Enhanced Care Services (ECS)

NO ACTIVITY CODES

CODE	PLACE OF SERVICE
03	School
12	Home
13	Assisted Living Facility
18	Place Of Employment - Worksite
99	Other Place Of Service

OBSERVATION

Press 8 To Bypass Observation