Public Partnerships, LLC
PO Box 5157
Charleston, WV 25361
Phone (866) 429-3465
Fax (866) 388-1626

public partnerships PPL
Your #1 choice for self-directed care™

West Virginia Personal Options
Aged and Disabled Waiver Program
Employee Packet

Welcome! You have received this packet because a West Virginia Personal Options participant has chosen to hire you to provide personal attendant services. The West Virginia Bureau for Medical Services has contracted with Public Partnerships, LLC (PPL) to provide financial management services on behalf of participants eligible for Medicaid Aged and Disabled Waiver service. If you need assistance, your employer (the participant) and PPL staff will be able to help walk you through the forms and answer any questions. Once you have completed the paperwork and your Employer has notified you of your start date you will complete and submit time entries or timesheets and/or transportation invoices to your employer for approval in order to be processed by PPL for payment. PPL will make payments on behalf of your employer and will reflect required tax federal and state tax withholdings.

IMPORTANT: You must complete a separate employment packet for each participant/employer who chooses to hire you. **PPL cannot pay for any hours worked until a completed packet for each participant/employer has been received and all requirements have been completed.**

Forms to complete and submit to the PPL resource consultant:

*****Note the forms below in bold are required before you may begin to work.**

Employee Data Form – Please provide your personal information and emergency contact information.

USCIS Form I-9 - Department of Homeland Security - Employment Eligibility Verification: Your employer must verify your eligibility to work in the United States. *Please use the additional "Employee Form I-9 Instructions" provided to complete this form*.

IRS Form W-4 - Employee's Withholding Allowance Certificate: This form is used to calculate federal income tax withholding. If you do not submit this form, PPL will withhold taxes at the highest level.

WV Form IT-104 - West Virginia Employee's Withholding Exemption Certificate: This form is used to calculate state tax withholding. If you do not submit this form, PPL will withhold taxes at the highest level.

Medicaid Direct Service Worker Agreement: This is an agreement between the Department of Health and Human Resources - Bureau for Medical Services and you as a provider of Medicaid services. The agreement clarifies that you are an employee of the participant and not an employee of PPL or the state of West Virginia.

Employment Agreement: This is an agreement between you and the participant/employer.

Tax Exemption Form: The IRS exempts some employees from paying some federal and state taxes based on family relationship or age. This form must be completed and signed by you and the

employer.

Pre-Employment Training Verification Form: This form verifies that you have completed required pre-employment training. **This form must be submitted to PPL with a copy of current CPR and First Aid card prior to employment.**

Annual On-going Training Verification Form: This form is used annually to verify that you have completed the required on-going training requirements. If training is not kept current you will not be eligible for payment. Note: **PPL must be provided with a copy of current CPR and First Aid card for on-going employment.**

Confidentiality Agreement: This agreement acknowledges your responsibility to respect your participant/employer's privacy and confidentiality of protected health information as defined by the Health Insurance Portability and Accountability Act (HIPAA).

EFT Application: Use this form to have your payments direct deposited to your account or pay card. This payment option is recommended to avoid delays in your payment. If you do not want direct deposit do not submit this application.

Special Notice Regarding Earned Income Exclusions

You may qualify for the Federal Earned Income Tax Credit and/or the West Virginia Earned Income Exclusion. If you believe that you qualify, please contact a state or local tax organization to see how you may incorporate the exclusions on your year-end tax filings.

Forms to keep and use as needed

Employee Form I-9 Instructions: The U.S. Citizenship and Immigration Services (US-CIS) Form I-9 must be completed correctly and these additional instructions may help. PPL will not be able to issue payments to you until this form has been correctly filled out.

Criminal Background Check Instructions: All employees are required to submit and pass a criminal background check for employment. The fingerprinting requirements for both state and federal checks are outlined in the instructions. You must provide PPL with proof of having submitted the required background check(s) before you will be eligible for employment.

Tim4Care User Guide: In order to create time entries your employees will create their logins and navigate the app using these instructions.

Payroll Schedule: This schedule identifies the pay periods and the due dates for timesheets.

PPL Timesheet and Timesheet Instructions: PPL timesheet and timesheet instructions are available upon request or at our website www.publicpartnerships.com.

Personal Attendant Log (PAL): Use this form to report the daily activities you provide during your shift. This form is back-up documentation for the timesheet. Your employer will sign-off on this document and maintain it for audit and verification purposes.

Transportation Invoice: Complete this invoice and submit to PPL if you have been approved to provide transportation services. Before you provide transportation, your employer should verify that you have a current driver's license and proof of insurance. The transportation invoice must be faxed to the number listed on invoice; not the fax number listed on the timesheet.

After you start working for a participant, you will:

- Receive a paycheck for hours worked and reimbursement for transportation services (if applicable);
- Receive a W-2 Wage Statement from PPL every year, on behalf of your employer.

Who is responsible for approving timesheets and invoices?
Your employer must approve invoices and time entries or time sheets according to the payroll schedule in order to be processed by PPL for payment.

What taxes will be withheld?
PPL will withhold Social Security, Medicare (FICA), and state and federal income taxes. A summary of all tax withholdings will appear on your paycheck stub. PPL will mail you a W-2 form each February. You will need this W-2 form to file your individual tax return by April of each year. Your employer will receive regular reports from PPL about your total hours worked.

What additional fees will be withheld?
If you work for an employer who lives in a city that requires a city service fee your employer is required to withhold that fee from your wages, unless you already have this fee withheld by another employer. Your PPL resource consultant will provide you with the required forms, and will answer any questions.

IMPORTANT: Mandatory Workplace Posters
It is your employer's responsibility to inform you of your rights. Mandatory workplace posters can be provided by your employer, found on the PPL website (below), or the PPL resource consultant can provide you with a copy.

For more information:
Visit the PPL website at www.publicpartnerships.com to get more information and paperwork.

Questions?
PPL encourages you to call us toll free at 866-429-3465 or by email pplwvadw@pcgus.com if you have any questions.

We look forward to serving you.

Sincerely,
Public Partnerships, LLC
Fiscal/Employer Agent and Resource Consultant

Public Partnerships LLC
PO Box 5157
Charleston, WV 25361
Phone (866) 429-3465
Fax (304) 988-4201

public partnerships PPL
Your #1 choice for self-directed care™

West Virginia Personal Options
Aged and Disabled Waiver Program
Employee Data Form

The Information you list on this form is confidential. This form will help ensure your application will be processed without any delays. The information requested on this form is voluntary and will not affect your employment status.

Personal Information

Name:_____ **Gender:**_____**Male**_____**Female**

Date of Birth:_____ **SSN:**_____

Mailing Address:_____

City:_____**State:**_____ **Zip:**_____

Physical Address (if different from Mailing Address):_____

City:_____**State:**_____ **Zip:**_____

County: _____

Phone:_____**Alternate Phone:** _____

Fax: _____

Country of Birth:_____**State of Birth:**_____

Emergency Contact Information

Contact:	**Relationship:**	**Phone:**
_____	_____	_____
_____	_____	_____

PPLProviderConnect.com
PPL Provider Connect directory is for those who choose to self-direct their home care and need to hire caregivers, and, for caregivers seeking jobs. Participants post information regarding the type of assistance they need, while caregivers post their work experience and search the job postings to find a match.

Participant/Employer Name:

_____
Please indicate the name of the participant/employer who you will be serving.

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 07/31/2026

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Additional Information

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS

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

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

Acceptable Receipts

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Supplement B,
Reverification and Rehire (formerly Section 3)

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

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

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

Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the Handbook for Employers: Guidance for Completing Form I-9 (M-274)

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

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

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

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

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

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

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2024

Step 1: Enter Personal Information

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

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

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

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

Step 3: Claim Dependent and Other Credits

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

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

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

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

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2024 if you meet both of the following conditions: you had no federal income tax liability in 2023 **and** you expect to have no federal income tax liability in 2024. You had no federal income tax liability in 2023 if (1) your total tax on line 24 on your 2023 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2024 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2025.

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

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

1. Expect to work only part of the year;

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

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

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

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

Specific Instructions

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

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

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

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

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

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

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2024 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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

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

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

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

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

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

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

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

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

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

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

1 Enter an estimate of your 2024 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $

2 Enter:
- $29,200 if you're married filing jointly or a qualifying surviving spouse
- $21,900 if you're head of household
- $14,600 if you're single or married filing separately

. . . . . **2** $

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

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

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

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$780	$850	$940	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,370
$10,000 - 19,999	0	780	1,780	1,940	2,140	2,220	2,220	2,220	2,220	2,220	2,570	3,570
$20,000 - 29,999	780	1,780	2,870	3,140	3,340	3,420	3,420	3,420	3,420	3,770	4,770	5,770
$30,000 - 39,999	850	1,940	3,140	3,410	3,610	3,690	3,690	3,690	4,040	5,040	6,040	7,040
$40,000 - 49,999	940	2,140	3,340	3,610	3,810	3,890	3,890	4,240	5,240	6,240	7,240	8,240
$50,000 - 59,999	1,020	2,220	3,420	3,690	3,890	3,970	4,320	5,320	6,320	7,320	8,320	9,320
$60,000 - 69,999	1,020	2,220	3,420	3,690	3,890	4,320	5,320	6,320	7,320	8,320	9,320	10,320
$70,000 - 79,999	1,020	2,220	3,420	3,690	4,240	5,320	6,320	7,320	8,320	9,320	10,320	11,320
$80,000 - 99,999	1,020	2,220	3,620	4,890	6,090	7,170	8,170	9,170	10,170	11,170	12,170	13,170
$100,000 - 149,999	1,870	4,070	6,270	7,540	8,740	9,820	10,820	11,820	12,830	14,030	15,230	16,430
$150,000 - 239,999	1,960	4,360	6,760	8,230	9,630	10,910	12,110	13,310	14,510	15,710	16,910	18,110
$240,000 - 259,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$260,000 - 279,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$280,000 - 299,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,380
$300,000 - 319,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,980	17,980	19,980
$320,000 - 364,999	2,040	4,440	6,840	8,310	9,710	11,280	13,280	15,280	17,280	19,280	21,280	23,280
$365,000 - 524,999	2,720	6,010	9,510	12,080	14,580	16,950	19,250	21,550	23,850	26,150	28,450	30,750
$525,000 and over	3,140	6,840	10,540	13,310	16,010	18,590	21,090	23,590	26,090	28,590	31,090	33,590

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$240	$870	$1,020	$1,020	$1,020	$1,540	$1,870	$1,870	$1,870	$1,870	$1,910	$2,040
$10,000 - 19,999	870	1,680	1,830	1,830	2,350	3,350	3,680	3,680	3,680	3,720	3,920	4,050
$20,000 - 29,999	1,020	1,830	1,980	2,510	3,510	4,510	4,830	4,830	4,870	5,070	5,270	5,400
$30,000 - 39,999	1,020	1,830	2,510	3,510	4,510	5,510	5,830	5,870	6,070	6,270	6,470	6,600
$40,000 - 59,999	1,390	3,200	4,360	5,360	6,360	7,370	7,890	8,090	8,290	8,490	8,690	8,820
$60,000 - 79,999	1,870	3,680	4,830	5,840	7,040	8,240	8,770	8,970	9,170	9,370	9,570	9,700
$80,000 - 99,999	1,870	3,690	5,040	6,240	7,440	8,640	9,170	9,370	9,570	9,770	9,970	10,810
$100,000 - 124,999	2,040	4,050	5,400	6,600	7,800	9,000	9,530	9,730	10,180	11,180	12,180	13,120
$125,000 - 149,999	2,040	4,050	5,400	6,600	7,800	9,000	10,180	11,180	12,180	13,180	14,180	15,310
$150,000 - 174,999	2,040	4,050	5,400	6,860	8,860	10,860	12,180	13,180	14,230	15,530	16,830	18,060
$175,000 - 199,999	2,040	4,710	6,860	8,860	10,860	12,860	14,380	15,680	16,980	18,280	19,580	20,810
$200,000 - 249,999	2,720	5,610	8,060	10,360	12,660	14,960	16,590	17,890	19,190	20,490	21,790	23,020
$250,000 - 399,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$400,000 - 449,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$450,000 and over	3,140	6,450	9,110	11,610	14,110	16,610	18,430	19,930	21,430	22,930	24,430	25,870

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$510	$850	$1,020	$1,020	$1,020	$1,020	$1,220	$1,870	$1,870	$1,870	$1,960
$10,000 - 19,999	510	1,510	2,020	2,220	2,220	2,220	2,420	3,420	4,070	4,070	4,160	4,360
$20,000 - 29,999	850	2,020	2,560	2,760	2,760	2,960	3,960	4,960	5,610	5,700	5,900	6,100
$30,000 - 39,999	1,020	2,220	2,760	2,960	3,160	4,160	5,160	6,160	6,900	7,100	7,300	7,500
$40,000 - 59,999	1,020	2,220	2,810	4,010	5,010	6,010	7,070	8,270	9,120	9,320	9,520	9,720
$60,000 - 79,999	1,070	3,270	4,810	6,010	7,070	8,270	9,470	10,670	11,520	11,720	11,920	12,120
$80,000 - 99,999	1,870	4,070	5,670	7,070	8,270	9,470	10,670	11,870	12,720	12,920	13,120	13,450
$100,000 - 124,999	2,020	4,420	6,160	7,560	8,760	9,960	11,160	12,360	13,210	13,880	14,880	15,880
$125,000 - 149,999	2,040	4,440	6,180	7,580	8,780	9,980	11,250	13,250	14,900	15,900	16,900	17,900
$150,000 - 174,999	2,040	4,440	6,180	7,580	9,250	11,250	13,250	15,250	16,900	18,030	19,330	20,630
$175,000 - 199,999	2,040	4,510	7,050	9,250	11,250	13,250	15,250	17,530	19,480	20,780	22,080	23,380
$200,000 - 249,999	2,720	5,920	8,620	11,120	13,420	15,720	18,020	20,320	22,270	23,570	24,870	26,170
$250,000 - 449,999	2,970	6,470	9,310	11,810	14,110	16,410	18,710	21,010	22,960	24,260	25,560	26,860
$450,000 and over	3,140	6,840	9,880	12,580	15,080	17,580	20,080	22,580	24,730	26,230	27,730	29,230

FORM WV IT-104
WEST VIRGINIA EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE

Complete this form and present it to your employer to avoid any delay in adjusting the amount of state income tax to be withheld from your wages.

If you do not complete this form, the amount of tax that is now being withheld from your pay may not be sufficient to cover the total amount of tax due the state when filing your personal income tax return after the close of the year. You may be subject to a penalty on tax owed the state.

Individuals are permitted a maximum of one exemption for themselves, plus an additional exemption for their spouse and any dependent other than their spouse that they expect to claim on their tax return.

If you are married and both you and your spouse work and you file a joint income tax return, or if you are working two or more jobs, the revised withholding tables should result in a more accurate amount of tax being withheld.

If you are Single, Head of Household, or Married and your spouse does not work, and you are receiving wages from only one job, and you wish to have your tax withheld at a lower rate, you must check the box on line 5.

When requesting withholding from pension and annuity payments you must present this completed form to the payor. Enter the amount you want withheld on line 6.

If you determine the amount of tax being withheld is insufficient, you may reduce the number of exemptions you are claiming or request additional taxes be withheld from each payroll period. Enter the additional amount you want to have withheld on line 6.

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WV/IT-104
Rev. 12/20

WEST VIRGINIA EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE

Name _____ Social Security Number _____

Address _____

City _____ State _____ Zip Code _____

1. If SINGLE, and you claim an exemption, enter "1", if you do not, enter "0 ..... _____
2. If MARRIED, one exemption each for husband and wife if not claimed on another certificate.
   (a) If you claim both of these exemptions, enter "2"
   (b) If you claim one of these exemptions, enter "1" ☐ ..... _____
   (c) If you claim neither of these exemptions, enter "0" ☐
3. If you claim exemptions for one or more dependents, enter the number of such exemptions. ..... _____
4. Add the number of exemptions which you have claimed above and enter the total ..... ☐
5. If you are Single, Head of Household, or Married and your spouse does not work, and you are receiving wages from only one job, and you wish to have your tax withheld at a lower rate, check here ☐
6. Additional withholding per pay period under agreement with employer, enter amount here ..... $ _____

I certify, under penalties provided by law, that the number of exemptions claimed in this certificate is not in excess of those to which I am entitled.

Date _____ Signature _____

FORM WV IT-104NR
WEST VIRGINIA CERTIFICATE OF NONRESIDENCE

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WV/IT-104NR
Rev. 12/20

WEST VIRGINIA CERTIFICATE OF NONRESIDENCE

This form is to be completed by employees who reside in Kentucky, Maryland, Ohio, Pennsylvania, Virginia or by an employee who is a Military Spouse exempt from income tax on wages.

If you are a resident of Kentucky, Maryland, Ohio, Pennsylvania or Virginia and your only source of income from West Virginia is wages or salaries, you are exempt from West Virginia Personal Income Tax Withholding. Upon receipt of this form, properly completed, your employer is authorized to discontinue the withholding of West Virginia Income Tax from your wages or salaries earned in West Virginia.

If you are a military spouse and (a) your spouse is a member of the armed forces present in West Virginia in compliance with military orders; (b) you are present in West Virginia solely to be with your spouse; and (c) you maintain your domicile in another State and you are claiming exemption under the Servicemember Civil Relief Act, enter your state of domicile (legal residence) on the following statement and attach a copy of your spousal military identification card.

I certify that I am a legal resident of the state of_____and am not subject to West Virginia withholding because I meet the requirements set forth under the Servicemembers Civil Relief Act, as amended by the Military Spouses Residency Relief Act.

Social Security Number _____

Name_____

Address_____

City_____State_____ Zip Code _____

I hereby certify, under penalties provided by law, that I am not a resident of West Virginia, that I reside in the State of_____and live at the address shown on this certificate, and request is hereby made to my employer to NOT withhold West Virginia income tax from wages paid to me. If at any time hereafter I become a resident of West Virginia, or otherwise lose my status of being exempt from West Virginia withholding taxes, I will properly notify my employer of such fact within ten (10) days from the date of change so that my employer may then withhold West Virginia income tax from my wages.

I certify that the above statements are true, correct, and complete.

Date_____Signature_____

Public Partnerships LLC
PO Box 5157
Charleston, WV 25361
Phone (866) 429-3465
Fax (866) 388-1626

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Your #1 choice for self-directed care™

West Virginia Personal Options
Aged and Disabled Waiver Program
Medicaid Direct Service Worker Agreement

This agreement outlines the terms and conditions of providing services for a Personal Options participant(s). The parties to this agreement are: The West Virginia Department of Health and Human Resources – Bureau for Medical Services (WVDHHR-BMS); Public Partnerships LLC (PPL); and the Direct Service Worker (Employee)

_____.

Direct Service Worker Responsibilities

The Direct Service Worker agrees to:

1. Adhere to policies and procedures of the West Virginia Aged and Disabled Waiver and Personal Options, including meeting the minimum requirements for employment.
2. Provide services for payment only after approved by PPL, provide only services authorized in the participant's approved spending plan, and maintain and submit accurate and timely time entries or timesheets, invoices, and documentation to PPL for services and activities performed.
3. Report changes in participant conditions (including hospitalizations and reasons for discontinuation of services such as placement in a rehabilitation facility or nursing home), and report allegations or suspicion of abuse, neglect, and exploitation as required by applicable laws and regulations.
4. Authorize PPL to withhold Federal and State taxes and legal obligations, accept payment from PPL as payment in full for services rendered and not request or require additional payment from the participant, and refund PPL in full in the event of overpayment for services rendered.

Acknowledgements

Direct Service Worker understands and acknowledges that employment is with the participant, and not the WVDHHR – BMS or PPL. No principal-agent or employer-employee relationship is contemplated or created with the State of West Virginia or PPL by this agreement or by provision of services. The direct service worker shall not be eligible to participate in any benefit program provided by WVDHHR or PPL. To the extent allowed by law the provider agrees to hold harmless, release, and forever discharge the State of West Virginia and PPL from any claims and/or damages that might arise out of any actions or omissions by the direct service worker.

Signatures

_____ _____
Direct Service Worker Date

_____ _____
Public Partnerships LLC Date

Note: PPL is signing this agreement as the sub-agent to the WV DHHR – BMS, which serves as the government fiscal/employer agent.

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Charleston, WV 25361
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West Virginia Personal Options
Aged and Disabled Waiver Program
Employment Agreement

Purpose and Parties to Agreement

This agreement confirms the conditions of employment between the following:

_____ _____
Participant (Employer) Employee

Starting Hourly Wage: $ _____ (to be determined by the Employer)

Starting Mileage Reimbursement Rate: $ _____ (to be determined by the Employer, if applicable)

Mutual Responsibilities

Both parties agree to adhere to all policies and procedures of the Aged and Disabled Waiver program and Personal Options.

Employer Responsibilities

The employer must:

- Verify employee qualifications, including criminal background check, required training, current certification in Cardio-Pulmonary Resuscitation (CPR), and First Aid. CPR and First Aid must be a BMS approved vendor. See BMS website for full list.
- Schedule employee to provide services for payment only after being authorized by Public Partnerships LLC (PPL)
- Orient, train, schedule, and supervise employee
- Provide a safe workplace free from excess hazards, employment discrimination, and harassment
- Request employee to perform permitted and planned duties, as determined in the Participant Directed Service Plan. The employee should not perform prohibited services such as administering medication, dressing wounds, and tube feeding
- Notify employee in advance if services are not required or if participant is no longer eligible for services
- Verify services provided by employee by reviewing and approving time entries or timesheets, invoices, and documentation of services rendered, and ensuring submission to PPL. Non-live-in employees must use our Time4Care App or Telephony to clock in and clock out for each shift in order to comply with Federal Regulations for Electronic Visit Verification (EVV).
- Accept responsibility for payment of services not authorized in approved spending plan

Employee Responsibilities

The employee must:

- Upon employment, pass a criminal background check and every five years thereafter
- Complete mandatory pre-employment training and on-going annual training, which includes 4 hours of on-the-job or training focused on enhancing your direct service delivery knowledge
- Non-live-in employees must use our Time4Care App or Telephony to clock in and clock out for each shift in order to comply with Federal Regulations for Electronic Visit Verification (EVV).
- Be punctual, neatly dressed, and respectful of employer's person, belongings, family members, and acquaintances
- Use employer's personal property only if agreed upon by both parties
- If providing transportation services, furnish employer with proof of valid driver's license and minimum automobile liability insurance
- Report allegations or suspicion of abuse, neglect, and exploitation as required by applicable laws and regulations
- Maintain confidentiality of all participant information as defined by the Health Insurance Portability and Accountability Act (HIPAA) and only release information with the written consent of the participant
- Notify the employer in advance if not able to provide services as scheduled or if quitting employment
- Complete accurate time entries or timesheets, invoices, and documentation to employer for review and signature

Consent to Obtain National Provider Identifier Number

Employee gives consent for PPL to obtain a National Provider Identifier (NPI) number on their behalf as a provider in the West Virginia Personal Options Program. This is a requirement from the Centers for Medicare and Medicaid (CMS) for the provider to have in order to bill for services to a participant on the Personal Options Program.

Privacy Act Statement

Section 1173 of the Social Security Act authorizes the adoption of a standard unique health identifier for all health care providers who conduct electronically any standard transaction adopted under 45 CFR 162. The purpose of collecting this information is to assign a standard unique health identifier, the NPI, to each health care provider for use on standard transactions. The NPI will simplify the administrative processing of certain health information. Further, it will improve the efficiency and effectiveness of standard transactions in the Medicare and Medicaid programs and other Federal health programs and private health programs. The information collected is entered into a system of records called the National Plan and Provider Enumeration System (NPPES), HHS/CMS/OIS No. 09-70-0008. In accordance with the NPPES Data Dissemination Notice (CMS-6060), published May 30, 2007, certain information that you furnish will be publicly disclosed.

The NPPES Data Dissemination Notice can be found at https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/Downloads/DataDisseminationNPI.pdf

Acknowledgements

Employee understands and acknowledges the following:

- Employee is employed by the participant. Employee is not employed by the State of West Virginia or PPL
- Employment is “at-will”. No guarantee or promise of continued employment is intended or implied by this agreement
- In accordance with the Fair Labor Standards Act, employee is considered a domestic employee providing homecare companionship services to a household employer and is therefore not entitled to overtime pay for hours worked in excess of 40 hours per week for a single employer
- In West Virginia household employers are not required to obtain worker’s compensation insurance coverage. Employers may not use funds from the approved budget for worker’s compensation coverage
- Employee is responsible for informing the employer of any non-workplace injury that would interfere with the performance of their duties. The employee is responsible for reporting workplace injuries to the employer within 24 hours
- **IMPORTANT:** Any false claims, statements, documents or concealment of material facts by employer or employee may be considered **Medicaid fraud** and will be reported for review and potential prosecution under applicable Federal and State laws

Payment for Services and Work Performed

PPL shall pay the employee for services provided by the employee and verified by the employer in accordance with the rate specified in the approved spending plan in effect at the time of service provision.

Termination of Agreement

Either party may terminate this agreement by notifying the other party and the PPL resource consultant in writing.

Signatures

By signing below, the Employer and Employee agree to the above terms and conditions.

_____	_____
Participant (Employer)	Date
_____	_____
Employee	Date

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TAX EXEMPTIONS

Provider Name					
First:		**Last:**		**PPL ID:**	
Participant Name					
First:		**Last:**		**PPL ID:**	

The statements below are used to determine the tax exemptions that may apply to you and the Employer, based on IRS regulations and applicable Federal/State tax laws. As a reminder, Public Partnerships LLC is not your employer.

Please complete Part 1 and Part 2.

Part 1 (you must select one of the following statements)

- ☐ I am the spouse of the Employer.
- ☐ I am the parent of the Employer (including legally adopted children).

  Select all that apply:

  - ☐ I also provide care for my grandchild or step-grandchild in my child's home.
  - ☐ My grandchild or step-grandchild is under 18 or has a physical or mental condition that requires personal care of an adult for at least four weeks in a row during the calendar quarter in which services are performed.
  - ☐ My child (son or daughter) is widowed, divorced, not remarried or living with a spouse who has a mental or physical condition so the spouse cannot care for my grandchild for at least four weeks in a row during the calendar quarter in which services are performed.
- ☐ I am the child of the Employer (including legally adopted children).
- ☐ I am not the spouse, parent, or child of the Employer.

Part 2 (select all that apply)

- ☐ I am a full-time student.
- ☐ This job of performing household services (respite) is my primary job.
- ☐ I am a non-resident alien temporarily in the United States on an F-1, J-1, M-1 or Q-1 visa admitted to the US for providing domestic services.

! IMPORTANT: If your information changes you must report it.

Agree and Sign

I confirm:

- I read all of this form.
- The details provided are accurate and complete.
- Any false statement on this form may result in my dismissal.
- This document is not a contract between the signing parties, PPL, or the State.
- Employment depends upon verifying my right to work in the US.

Provider Signature: **Date:**

Public Partnerships LLC
PO Box 5157
Charleston, WV 25361
Phone (866) 429-3465
Fax (866) 388-1626

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West Virginia Personal Options
Aged and Disabled Waiver Program

Confidentiality Agreement

I,_____(Employee), understand that in the performance of my duties for_____(Participant/Employer), I will have access to privileged information about the participant I am serving, and that such information may include medical, insurance, and other confidential/personal information.

I agree to restrict my use of such information to the performance of my duties.

I will not discuss the participant's name, or otherwise reveal or disclose information pertaining to the participant, except when in direct contact with representatives of:

- West Virginia Bureau for Medical Services
- West Virginia Bureau of Senior Services
- Kepro
- Public Partnerships LLC
- or_____

and then only for the purpose of assisting the participant.

I hereby acknowledge my obligation to respect the participant's privacy and confidentiality of the information pertaining to the participant, and to exercise good faith and integrity in all dealings with the participant and their personal information in performance of my duties.

I also understand that any authorized use or disclosure of information pertaining to the participant may result in my immediate suspension or dismissal and may subject me to civil liability for breaching the participant's right to privacy.

_____ _____
Employee Signature Date

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DIFFICULTY OF CARE FEDERAL INCOME EXCLUSION

Provider Name					
First:		**Last:**		**PPL ID:**	
Participant Name					
First:		**Last:**		**PPL ID:**	

Some employees may not owe taxes on their Self-Directed Services earnings. This is because they qualify for the Difficulty of Care Federal Income Exclusion (DOC). In that case, Public Partnerships LLC (PPL) will not report the payments as income and will not withhold applicable taxes. As a reminder, PPL is not your Employer.

To determine if you qualify, read the items below.

Part 1: Applying for Difficulty of Care Federal Income Exclusion

Select all that apply:

☐ I provide services to the Participant in my home.

☐ I do not have a separate home where I live.

☐ This is the home where I live and perform the routines of private life, including shared meals and holidays.

! IMPORTANT:

- If all the above apply, you qualify for the DOC.
- If both the state taxing authority and program rules follow federal guidelines for DOC, the exclusion would also apply at the state level.
- You understand that if you no longer live with the Participant, you will no longer qualify. You must cancel the DOC by completing Part 2 below.

If none of the above apply, select the option below.

☐ None of the above.

Part 2: Cancelling Difficulty of Care Federal Income Exclusion

Select if applies:

☐ I no longer live with the Participant that I provide services to.

Agree and Sign

I confirm:

- I have read all of this form.
- I am providing services to the Participant receiving payments under a state Medicaid, Home and Community-Based Services program.
- The details provided are accurate and complete.

Provider Signature: **Date:**

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FAIR LABOR STANDARDS ACT LIVE-IN EXEMPTION

Provider Name					
First:		**Last:**		**PPL ID:**	
Participant Name					
First:		**Last:**		**PPL ID:**	

The United States Department of Labor (US DOL) and Fair Labor Standards Act (FLSA) requires that providers are paid overtime for hours worked unless the provider is eligible for a "live-in exemption". Employers use this form to determine if their provider is eligible.

This form needs to be filled out for every provider you have in Self-Directed Services.

Part 1: Applying for Live-In Exemption

Select which Residency Test option applies:

☐ Provider lives with the Participant seven days a week. This means they do not have another home.

☐ Provider lives with the Participant for an extended period of time.
This means they work and sleep five days a week.
- Any five days in a week (120 hours or more)
- Five days in a row

! IMPORTANT: Provider is eligible if either of the above choices are selected.

☐ Provider does not live with the Participant.

Part 2: Cancelling Live-In Exemption

Select if applies:

☐ Provider no longer lives with the Participant they provide services to.

Agree and Sign

The Provider, Participant, and/or Employer confirm:
- I have read all of this form.
- The details provided are accurate and complete.
- I must inform Public Partnerships when the Provider no longer lives with the Participant.
- I agree to accept the risks if I fail to inform Public Partnerships.
- I know that all hours including overtime (over 40 hours per workweek) will be paid at regular hourly rates.

Provider Signature: **Date:**

Participant or Employer or Representative Signature: **Date:**

WV MEDICAID DIRECT CARE PROVIDER ENROLLMENT AGREEMENT and SIGNATURE www.wvmmis.com

Name of Agency_____ **Agency NPI #**_____

A SEPARATE PROVIDER AGREEMENT MUST BE COMPLETED BY EACH DIRECT CARE PROVIDER AND A REPRESENTATIVE OR AUTHORIZED DELEGATE FOR THE GROUP/FACILITY.

1. The Provider hereby agrees to comply with all applicable laws, rules and written policies pertaining to the West Virginia Medicaid Program (Medicaid), including, but not limited to, Title XIX and Title XXI of the Social Security Act, the Code of Federal Regulations, West Virginia State Laws the West Virginia State Medicaid Plan, the Department of Health and Human Resources, Bureau for Medical Services' (Medicaid or Department/Bureau), written manuals, program instructions, policies and this document.
2. The Provider is not an employee of the Department/Bureau under this enrollment form and any subsequent amendments.
3. The Provider may not, on the grounds of race, color, national origin, creed, sex, religion, political ideas, marital status, age or disability subject persons to discrimination under the Medicaid program or any activity connected with the provision of Medicaid services.
4. The Provider agrees to protect the confidentiality of the member.
5. The Provider acknowledges that this enrollment is effective for the category of services that will be provided by the above agency. A separate provider enrollment form and/or a separate provider agreement may be necessary if you work for other agencies. The Provider further certifies that all information listed on this and any application is true, accurate and complete.
6. Within fifteen (15) business days, the Provider agrees to notify Medicaid, in writing, of any changes in the provider information.

I UNDERSTAND THAT PAYMENT OF CLAIMS WILL BE FROM FEDERAL AND STATE FUNDS AND THAT ANY FALSIFICATION OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER FEDERAL AND STATE LAW.

Direct Care Provider Name (Please Print)_____ Direct Care Provider NPI #_____

Direct Care Provider Signature_____ Date of Signature_____

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DIRECT DEPOSIT UPDATE

Employee Name

First: _____ **Last:** _____ **PPL ID:** _____

Participant Name

First: _____ **Last:** _____ **PPL ID:** _____

Please select how you want to be paid: Direct Deposit to your Bank Account or by Debit Card. You will be paid by paper check until direct deposit is set up. This is because it takes one to two pay periods for direct deposit to become active. If you need to update your bank account details, you must submit a new form.

If you work for more than one Participant, you will need to submit a new direct deposit update form for each one.

Payment Details

☐ **Direct Deposit to Bank Account**

Account Type (select one): ☐ Checking Account ☐ Savings Account

Bank Name: _____

Routing Number: | | | | | | | | | |

Account Number: | | | | | | | | | | | | | | | | |

☐ **Deposit to Debit Card**

If you select Debit Card as your payment method, you must provide PPL with an address where you live. If you work for more than one Participant, all payments will be on one pay card.

Pay Stub

Your pay stub is available through the web portal or the mobile app. If you do not have access to the internet through a computer, tablet, or smart phone, then select the checkbox. ☐ Please send my pay stub in the mail.

Agree and Sign

The Employee confirms:

- I have read all of this form.
- The details I have provided are accurate and complete.
- PPL can deposit my payment directly into my bank account based on my choice above.
- If I fail to give complete and accurate details on this form, processing may be delayed, or my electronic payments may be erroneously made.
- PPL can withdraw from the designated account all amounts deposited electronically in error.
- If my account is closed or does not have enough money to allow withdrawal, then PPL can withhold any payment owed to me until the incorrect deposited amounts are repaid.
- If I want to cancel direct deposit, I will contact PPL customer service and provide both the account and routing number.

Employee Signature: _____ **Date:** _____

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VERIFICATION OF CITY SERVICE WITHHOLDING AUTHORIZATION

Check Program:___IDD _X_ADW ___TBI

Instructions: Check the box next to the statement that best describes where you will work, and your status regarding weekly city service fees for Charleston, Fairmont, Huntington, Madison, Morgantown, Parkersburg, Romney, or Weirton. Please submit to Public Partnerships LLC (PPL).

This form must be complete for each participant you work for within each of the cities listed below. Employees that select Prior Payment must complete and submit this form annually (by December 31). If this form is not submitted, PPL will withhold the required weekly withholding.

Employee Name:	**Employee ID:**
Participant Name:	**Participant ID:**

My place of employment under the Personal Options Program is in (select one):

☐ **Charleston** ☐ **Fairmont** ☐ **Huntington** ☐ **Madison**

☐ **Morgantown** ☐ **Parkersburg** ☐ **Romney** ☐ **Weirton**

☐ **I do not work in the city limits of any of the above listed Cities**

I understand that I am required to have a City Service Fee withheld from my paycheck for working for the participant listed above. I authorize PPL to withhold the weekly City Service Fee from my paycheck and to send the amount withheld to the city selected above.

Based upon your city service fee selection above, select one of the following (if applicable):

☐ **Prior Payment (a copy of a current pay stub with proof of withholding must be submitted)**
I already have the weekly City Service Fee deducted from my pay from another employer in the same city in which I work. If you have the fee withheld from another employer, please submit paystub and provide your employer's name/place of employment: _____

NOTE: This must be completed and submitted annually (by December 31). If this form is not submitted, PPL will withhold the required weekly withholding.

☐ **Fairmont or Romney**
I live in and work in city of Fairmont or Romney. Please provide your physical address and a copy of proof of residency (e.g., Water bill showing fee withheld):

_____
Physical Address **City** **State** **Zip Code**

☐ **I no longer work in the city limits of Charleston, Fairmont, Huntington, Madison, Morgantown, Parkersburg, Romney, or Weirton**

IMPORTANT: As an employee, it is your responsibility to notify PPL if your City Service Fee status changes. Changes to withholdings will NOT be done automatically.

SIGNATURES

Employee Signature **Date** **Participant/Representative Signature** **Date**

Public Partnerships LLC
PO Box 5157 Charleston, WV 25361

West Virginia Personal Options Criminal Background Check Instructions

---------- December 2022 ----------

You must submit and pass a State and Federal Criminal Background Check (CBC) through WV Cares before being able to bill for services. You are also required to repeat this CBC every five years while you are billing for services. You must pay for the CBCs. It is very important that you keep your CBC appointment because you will **not** be able to provide services for payment until we receive a letter stating you can begin providing services from WV Cares.

Your results will be kept by the State Police and FBI so updates of any criminal history or changes can be submitted to us. Public Partnerships, LLC (PPL) will receive monthly updates regarding your CBC. If the result of the initial or ongoing CBC reveals negative findings, WV CARES will put you on a list of providers who can no longer provide services.

PPL will schedule your appointment through WV CARES. Please fill out the Scheduling Form included in your CBC packet. This will allow us to contact you about your CBC appointment. Be sure to include a working phone number and email address and print information clearly.

You will not be able to bill for services if you have been convicted of the following crimes:

- State or Federal health and social services program-related crimes
- Patient abuse or neglect
- Health care fraud
- Felony drug crimes
- Crimes against care-dependent or vulnerable individuals
- Felony crimes against the person
- Felony crimes against property
- Sexual offenses
- Crimes against chastity, morality and decency
- Crimes against justice

IMPORTANT: PPL is not the employer and has no role in making employment decisions. If you can't provide services because of the results of the CBC; the participant/employer will not be able to hire you for the Waiver Program.

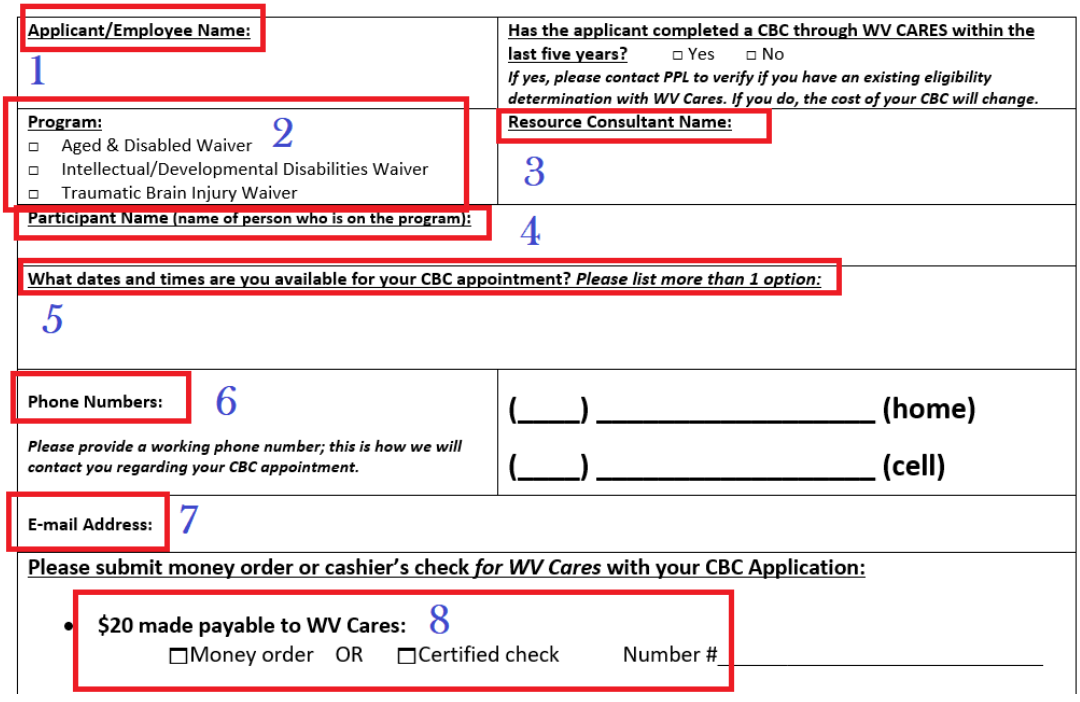
INSTRUCTIONS BELOW
DO NOT FILL OUT THIS PAGE

A complete CBC application must be submitted to PPL prior to employment. This includes the **Criminal Background Check Scheduling Form**, the two-page **Self-Disclosure Application and Consent Form (Parts I, II, and III), a copy of your Driver's License or ID card, and a Money Order or Certified Check for $20 made out to WV Cares** all mailed to:

Public Partnerships, LLC
ATTN: CBC Processing
PO Box 5157
Charleston, WV 25361

Review the guides below before moving forward. **If your application is not completed correctly, or payments are not received, your fingerprint appointment cannot be scheduled, and services cannot be billed.**

CBC Scheduling Form Guide



Applicant/Employee Name: 1

Has the applicant completed a CBC through WV CARES within the last five years? ☐ Yes ☐ No
If yes, please contact PPL to verify if you have an existing eligibility determination with WV Cares. If you do, the cost of your CBC will change.

Program: 2
- ☐ Aged & Disabled Waiver
- ☐ Intellectual/Developmental Disabilities Waiver
- ☐ Traumatic Brain Injury Waiver

Resource Consultant Name: 3

Participant Name (name of person who is on the program): 4

What dates and times are you available for your CBC appointment? *Please list more than 1 option:* 5

Phone Numbers: 6
Please provide a working phone number; this is how we will contact you regarding your CBC appointment.

(____) _____ (home)
(____) _____ (cell)

E-mail Address: 7

Please submit money order or cashier's check *for WV Cares* with your CBC Application:

- **$20 made payable to WV Cares:** 8
  ☐Money order OR ☐Certified check Number #_____

1- name of person getting the CBC completed
2 - program you will be working for (if you are unsure contact your Resource Consultant (RC)
3 - RC name (person who works at PPL)
4 - name of person you will be working with
5 - dates you are available to complete CBC; please enter at least 5 dates and times
6 - current, working phone number; so PPL can call you to schedule your appointment
7 - email address; so IdentGo can email you your appointment information
8 - number of the cashier's check or money order

Revised 12-08-2022

Part III Self-Disclosure Application and Consent Form Guide

Answer the questions on Part I and sign your name on Part II.
Attach a copy of your License or ID and proceed to Part III.

PART III

Applicant Last Name: _____ First Name: _____ MI: ____ Generation (ex. Jr., II): ____

Gov't Issued ID Number: _____ (Driver's License # / State ID # / Military ID # / Passport #) Expiration: _____ State of Issue: _____ Type of ID: _____ (Driver's License / State ID / Military ID / Passport)

Gender: Male___ Female___ Race: _____ Height: _____ft. _____in. Weight: ____lbs.

Hair Color: ☐ Brown ☐ Blonde ☐ Bald ☐ Black ☐ Gray ☐ Other ☐ Red ☐ White

Eye Color: ☐ Blue ☐ Hazel ☐ Brown ☐ Red ☐ Black ☐ Other ☐ Green ☐ Gray

only have to choose one.

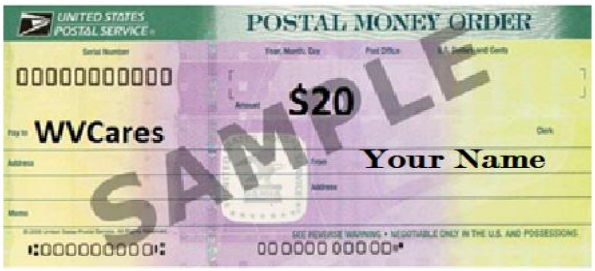
Social Security Number: __ __ __-__ __ - __ __ __ __ Date of Birth: ____/____/_____

Place of Birth (City & State): _____ Citizenship: _____ (Citizen of the US: Yes or No)

Current Mailing Address: _____ (address, city, state and zip (where you get your mail)) County: _____

Current Physical Address: _____ (address, city, state and zip (where your house is). You can also write SAME if it is the same as your mailing address.) County: _____

Money Order Sample and Instructions



- Must be a Money Order or Certified Check. Personal Checks are NOT accepted.
- Must be made out to WV Cares (a blank payment can be cashed by anyone).
- Must print your name so we can match your payment to the correct application.

❖ *Payment of **$37.25** is required at the **IdentoGo** fingerprinting location. Employees with existing active results in WV Cares are not required to re-print. The application and $20 fee are still required to access your results.*

After submitting a completed application

- PPL will schedule your fingerprinting appointment at the **IdentoGo** location near you.
- PPL will contact you at the number or email listed on the scheduling form with your appointment details.
- You may reschedule your appointment by calling **IdentoGo** directly at **855-766-7746** and providing them with the UE code listed in your appointment details.
- DON'T FORGET to take your payment for **IdentoGo** with you to your fingerprinting appointment (**$37.25**).
  - Cashier's Checks, Money Orders, Debit, and Credit Cards are all accepted for payment.
  - Payment should be made out to **IdentoGo.**
  - Current photo ID is required.

❖ PPL checks the WV Cares system regularly for results. PPL will contact you when services can start.

Revised 12-08-2022

Public Partnerships LLC
PO Box 5157
Charleston, WV 25361
Fax: (304) 988-4201

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West Virginia Personal Options
Criminal Background Check (CBC) Scheduling Form

Public Partnerships LLC (PPL) will schedule the initial appointment on your behalf through WV CARES. Please fill out the form below.

You will not be able to provide services for payment until PPL receives your eligibility determination.

Applicant/Employee Name:	**Has the applicant completed a CBC through WV CARES within the last five years?** ☐ Yes ☐ No If yes, please contact PPL to verify if you have an existing eligibility determination with WV Cares. If you do, the cost of your CBC will change.
Program: ☐ Aged & Disabled Waiver ☐ Intellectual/Developmental Disabilities Waiver ☐ Traumatic Brain Injury Waiver	**Resource Consultant Name:**
Participant Name (name of person who is on the program):	
What dates and times are you available for your CBC appointment? Please list more than one option:	
Please provide a working phone number; this is how we will contact you regarding your CBC appointment. **Home:** _____ **Cell:** _____	
Email Address:	

Please submit money order or cashier's check for WV Cares with your CBC Application:

- **$20 made payable to WV Cares:**
  - ☐ Money order OR ☐ Certified check Number #_____
- **Please take the IdentoGo Payment of $37.25 with you to your CBC Appointment.**
  - Cashier's Check, Money Order, and Credit Cards are accepted.

- Changes to your CBC appointment can be made by calling IdentoGo at (855) 766-7746.

Public Partnerships Use ONLY		
Appointment Date:	Appointment Time:	Date of Notification of Appointment:
IdentoGo Location:		
Notes:		

Revised
12-08-2022

WV CARES

West Virginia Clearance for Access: Registry and Employment Screening

SELF-DISCLOSURE APPLICATION AND CONSENT FORM

PART I

I, the below-named applicant, understand that this form cannot be completed until an offer of employment is made. The offer of employment is made pending the results of the investigation of registries and a fingerprint-based background check. I understand that refusal to complete Parts I, II, and III of this form constitutes my rejection of the employment offer.

I, the below-named applicant, swear/affirm, that the information contained within this application is true and correct to the best of my knowledge.

Applicant Last Name: _____ First Name:_____ MI:_____ Generation (ex. Jr., II):_____

Clearly answer truthfully YES or NO to the following questions:

	Yes	No
1. Are you addicted to alcohol, a controlled substance or a drug or are you an unlawful user thereof?		
2. Have you **ever** been convicted of, pled guilty or nolo contendere (no contest) to a **misdemeanor** or **felony in any state or federal court**?		
3. Have you ever been convicted of an act of violence involving a deadly weapon or an act of domestic violence?		
4. Are you under indictment or do you have any criminal charges pending against you?		
5. Are you currently serving a sentence of confinement, parole, probation or other court ordered supervision?		
6. Are you the subject of a restraining order as a result of a domestic violence act or subject to a verified petition of domestic violence or subject to a protective order?		

NOTE: **If any questions 1-6 listed above are answered YES, a brief letter of explanation by the applicant must accompany this form.** Failure to provide explanations could result in disqualification.

PART II

Consent for Investigation for Employment Purposes and Acknowledgement of Receipt of Notice

I hereby authorize the Department of Health and Human Resources (DHHR) to conduct an investigation including, but not limited to, registry and state and federal fingerprint-based background checks, into information contained in this application. I understand that my fingerprints will be retained by the West Virginia State Police for the purpose of RapBack services during my employment in a WVCARES covered provider. **Furthermore, I understand that the falsification of any information contained within this application constitutes false swearing and is an excluding act under the fitness determination process being conducted by DHHR.**

I, _____, acknowledge receipt of the information contained in the Notice to All Applicants.

(Applicant's printed name)

Signature of Applicant: _____ Date: _____

WV CARES

West Virginia Clearance for Access: Registry and Employment Screening

SELF DISCLOSURE APPLICATION AND CONSENT FORM

PART III

Applicant Last Name: _____ First Name:_____ MI:____ Generation (ex. Jr., II):____

Gov't Issued ID Number/Expiration: _____ State of Issue: _____Type of ID: _____

Gender: Male___ Female___ Race: _____ Height: _____ft. _____in. Weight:____lbs.

Hair Color: ☐Brown ☐Blonde ☐Bald ☐Black ☐Gray ☐Other ☐Red ☐White

Eye Color: ☐Blue ☐Hazel ☐Brown ☐Red ☐Black ☐Other ☐Green ☐Gray

Social Security Number: __ __ __-__ __ - __ __ __ __ Date of Birth: ____/____/_____

Place of Birth (City & State):_____ Citizenship:_____

Current Mailing Address: _____ County: _____

Current Physical Address: _____ County: _____

List all cities and states (outside of WV) where you have <u>lived</u> within the past 5 years and provide approximate dates:

_____

_____

List all cities and states (outside of WV) where you have <u>worked</u> within the past 5 years and provide approximate dates:

_____

_____

List all names and aliases you have used formally and informally (Include maiden names, married names, nicknames, and any other name used or known as)**:**

_____

_____

For Office Use Only (This form expires 60 days after the date of the signature in Part II):

I affirm that I have compared the government issued identification presented by the applicant.

Signature: _____ Date: _____

Printed Name: _____ Position: _____

WV CARES

West Virginia Clearance for Access: Registry and Employment Screening

NOTICE TO ALL APPLICANTS

Obtaining Criminal History Report: An individual may request of copy of his or her own criminal history report (or proof that one does not exist) for a personal review by visiting MorphoTrust at www.identogo.com or calling 1-855-766-7746.

Appeals: If the applicant wishes to challenge the information contained in the identity history summary, a challenge of record may be filed pursuant to W.Va. St. R. §69-10-8 with the WV State Police at http://www.wvsp.gov/Criminal%20Records/Pages/default.aspx and/or the FBI at https://www.fbi.gov/services/cjis/identity-history-summary-checks.

PRIVACY ACT STATEMENT:

Authority: The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

Social Security Account Number (SSAN). Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal agencies to use this number to help identify individuals in agency records.

Principal Purpose: Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

Routine Uses: During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including the Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine uses include, but are not limited to, disclosures to: employing, governmental or authorized non-governmental agencies responsible for employment, contracting licensing, security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.

Additional Information: The requesting agency and/or the agency conducting the application-investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice in the Federal Register describing any system(s) of records in which that agency may also maintain your records, including the authorities, purposes, and routine uses for the system(s).

West Virginia Personal Options
Aged and Disabled Waiver Program

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INITIAL TRAINING VERIFICATION

All Personal Options employees must complete all of the following areas before providing services for payment.

- Cardiopulmonary Resuscitation (CPR) and First Aid – a copy of the CPR and First Aid cards must be submitted to PPL and must be maintained current (no gaps in between) as defined by the terms of the certifying agency.
  - CPR and First Aid: Must be provided by a certified trainer from the American Heart Association, American Red Cross, American Health and Safety Institute, American CPR, National Safety Council, Emergency Care and Safety Institute, EMS Safety Services, ProTrainings, and Know CPR. Skills must be demonstrated in person. Online (only) instruction may be permissible during an active Public Health Emergency. Contact your RC to confirm your options first. PPL cannot accept certifications from unapproved providers.
- Universal Precautions (OSHA): material is provided in PPL Initial Training packet.
- Personal Attendant Skills: training on assisting people with Activities of Daily Living (ADL's). Under Personal Options, your participant is your Employer. Your participant will be responsible for providing Personal Attendant Skills training specific to their needs addressed in their Service Plan.
- Abuse/Neglect/Exploitation Identification: material is provided in PPL Initial Training packet.
- HIPAA: material is provided in PPL Initial Training packet.
- Direct Care Ethics: training on ethics such as promoting physical and emotional well-being, respect, integrity and responsibility, justice, fairness, and equity. Material is provided in PPL Initial Training packet.
- Health and Welfare for Person Receiving Services: include emergency plan response, fall prevention, home safety and risk management. Material is provided in PPL Initial Training packet.
- Person-Centered Planning: material is provided in PPL Initial Training packet.

Training Topic	Start Time	Stop Time	Duration	Location of Training	Source
Universal Precautions (OSHA)					PPL Training Packet
Personal Attendant Skills					PPL Training Packet
Abuse/Neglect/Exploitation Identification					PPL Training Packet
HIPAA					PPL Training Packet
Direct Care Ethics					PPL Training Packet
Health and Welfare for Person Receiving Services					PPL Training Packet
Person-Centered Planning					PPL Training Packet

By signing below, the participant (or their representative) confirm that the training topics above were provided to the employee listed below, and that they have completed those training topics and entered them in each column above.

Participant Name	**Participant or Representative Signature**	**Date**
Employee Name	**Employee Signature**	**Date**

Resource Consultant Name _____

Please submit the completed test and verification form to your Resource Consultant or fax it to 304-988-4201

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Participant Name:_____ **Employee Name:** _____

Resource Consultant Name:_____ **Month:**_____ **Year:**_____

WEST VIRGINIA PERSONAL OPTIONS
AGED AND DISABLED WAIVER PROGRAM

INITIAL TRAINING TEST

Participant/Program Representative Signature: _____

☐ Passed *(at least 35 correct answers)* ☐ Failed

1. **True or False**: In the Personal Options program the participant is encouraged to be actively involved in their assessments, planning meetings and appropriate management of their federally and state provided budgets, their employees and program requirements.
2. **True or False**: You can bill for services provided before being approved as an employee of a participant in Personal Options.
3. **As an employee through Personal Options providing Personal Attendant services, you:**
   a. Are responsible for reporting to the Case Manager (if applicable) and Resource Consultant on the participant's health, safety, and welfare
   b. May not bill for services when the participant is in the hospital, nursing facility or rehab center
   c. Must report <u>any</u> incident or Abuse, Neglect and Exploitation regarding the participant to Adult Protection Services, the case manager (if applicable) and the Resource Consultant
   d. All of the above
4. **Blood borne pathogens that may cause infections can be transmitted through:**
   a. Accidental injury by a sharp object including broken glass, exposed dental wires, needles or any sharp object that can puncture or cut the skin
   b. Open cuts or skin abrasions
   c. Indirect contact from the contaminated item with the mucous membranes of the mouth, eyes, nose or open skin
   d. All of the above
5. **True or False:** You should treat blood and body fluids as if they are known to be infectious.
6. **When providing nail and foot care, you should:**
   a. Soak feet/hands in warm water prior to performing care
   b. Ensure areas between toes are dry
   c. Clean under nails with an orange stick
   d. All of the above
7. **True or False:** Personal Attendants are not permitted to cut nails or attempt to remove or treat corns or calluses of participants who have diabetes or impaired circulation.

8. **When providing skin care, you should:**
   a. Ensure skin is kept clean and dry
   b. Pay special attention to skin folds and creases where body fluids and moisture may be a problem
   c. Use skin care products according to the person's individualized needs or requests
   d. All of the above

9. **True or False:** In treating a choking victim, you should not intervene as long as they are coughing and may dislodge the obstruction.

10. **When assisting with eating, you should:**
   a. Keep the person's head up
   b. Feed small bites to prevent choking
   c. Inspect the person's mouth frequently for accumulated foods
   d. All of the above

11. **When assisting a burn victim, you should:**
   a. Remove jewelry or shoes from affected area before swelling makes them difficult to remove
   b. Remember that cold water lowers temperature of burned area and lessens severity of minor burns
   c. Make sure source of the burn is no longer a threat
   d. All of the above

12. **True or False:** Assistive devices are tools that help people function independently, despite physical limitations or disabilities. They help people preform daily activities, such as eating, dressing, talking, and walking.

13. **The Personal Attendant can impact how well their participant adapt to their assistive device by:**
   a. Encourage the participant to express their feelings about an assistive device.
   b. Remember that the participant may be grieving over the loss of their independence and may need some time to adjust to the device.
   c. Focusing on what the participant is still able to do, not on what they cannot do.
   d. Emphasize the positive aspects of assistive devices.
   e. All of the above

14. **Does your participant currently have any type of assistive devices in their home?**

   ☐ YES ☐ NO

   If yes, what are they? _____

   If no, what kind of assistive devices do you think your participant can benefit from?

   _____

15. **Ways to prevent falls:**
    a. Good lighting in the rooms and hallways
    b. No clutter or objects in floors and walkways
    c. Throw rugs should be avoided if possible
    d. All of the above

16. **True or False:** You are not required to sign a confidentiality form with your participant before providing services.

17. **Which statement below is FALSE?**
    a. Personal Options participants should be able to make their own health care choices.
    b. When making ethical decision, if no one gets hurt, then it must be the right thing to do.
    c. Personal Options participants should expect quality support and care from their Personal Attendants.
    d. Making ethical decisions requires use of common sense, patience, compassion, and communication.

18. **True or False:** You are employed by Mr. Smith who has lung disease and must use oxygen at night. The doctor tells the family that if Mr. Smith doesn't stop smoking, he will soon have to use oxygen 24 hours a day. The family tells you to take away Mr. Smith's cigarettes and tell him he is no longer allowed to smoke. Since it's for Mr. Smith's own good, it's OK to ignore his right to smoke.

19. **Emergency procedures include:**
    a. Discussing participant specific emergency procedures, plans, and health needs that have already been established with/for the participant
    b. Developing any needed emergency procedures that have not been addressed with the person and his/her supports
    c. Notifying Case Manager (if applicable) and Resource Consultant with any needed changes
    d. All of the above

20. **True or False:** As a Personal Attendant, maintaining an environment that is safe and free of injury is a critical responsibility.

21. **True or False:** A crisis plan is a document prepared by the Resource Consultant or Case Manager (if applicable) and the participant. This plan is to be followed by Personal Attendants in the event of specific emergencies.

22. **True or False:** The Service Plan is completed by the Resource Consultant with the participant initially at the enrollment meeting, at 6-month visits, and if there is any change in need or service level.

23. **True or False:** Personal Attendants are required to complete the Wellness Scale section with the participant on each Personal Attendant Log (PAL) before submitting it to the Resource Consultant.

24. **True or False:** Every day you work with the person, you should closely monitor any changes in the person's needs, including physical and emotional health, and communicate these observations to the Resource Consultant to help create a plan written specifically for the individual.

25. **True or False:** Person-centered planning is NOT about making a plan to provide the person everything they may want.

26. **True or False:** The ADW participant must initial on the PAL each day that services were provided by the worker.

27. **True or False:** If the Personal Attendant bills for mileage or time transporting the participant, on the second page of the PAL, the Personal Attendant will document start and stop time for travel, total number of miles driven, and how much time was spent driving.

28. **True or False:** The Personal Attendant initials each box on the PAL for each activity that was performed on days worked.

29. **The PAL is used to:**
    a. Ensure the worker knows what to do, how to do it and when to do it.
    b. Ensures the participant knows what to expect.
    c. Reduces potential for misuse or abuse of service.
    d. All of the above

30. **True or False:** Penalties for committing fraud may include monetary fines and/or jail if convicted. Penalties may also include loss of the ability to obtain employment in numerous job settings, including health care, behavioral health, school systems, financial institutions, and many private businesses.

31. **Examples of fraudulent actions include:**
    a. Falsely signing/forging another person's signature on your timesheet
    b. Billing for services on one day that were provided on another day
    c. Billing for services when the participant is in nursing home or hospital
    d. All of the above

32. **True or False:** Caregiver abuse is acceptable.

33. **True or False:** Anyone has the potential to be an abuser.

34. **True or False:** Anyone has the potential to be a victim of abuse, neglect and/or exploitation.

35. **True or False:** The participant has the right to live any way he/she chooses.

36. **True or False:** Signs of self-neglect may include unkempt personal hygiene and rotten teeth.

37. **True or False:** Everyone taking this training is a mandated reporter.

38. **True or False:** Financial exploitation involves illegal, unethical and/or improper use of, or willful dissipation of an individual's funds, property, or other assets by a person, formal or informal caregiver, family member, or legal representative.

39. **True or False:** Sexual abuse only happens to young people.

40. **True or False:** There are more women than men as victims of abuse.

41. **True or False:** Adult abuse is a silent epidemic**.**

42. **True or False:** HIPAA means "Healthcare Insurance Portability and Accountability Act."

43. **True or False:** HIPAA has a privacy rule that was established by Congress.

44. **True or False:** Protected Health Information (PHI) includes Medicaid numbers and Social Security numbers.

45. **True or False:** The ADW person has a right to confidentiality of personally identifying and medical information.

46. **True or False:** As a Personal Attendant, although all participant documentations must remain in the participant's home, you must be organized and careful with your paperwork, report to your participant and Resource Consultant about any loss of information and learn from your mistakes.

47. **True or False:** If asked, you can provide the ADW person's Social Security number to the landlord.

48. **True or False:** It is acceptable to talk about your participant with other participants' workers.

49. **True or False:** As a Personal Attendant, you must not discuss information about an ADW person on social media.

50. **True or False:** It is not acceptable to disclose the ADW member's personal or medical information.

Please submit the completed test with the verification form to your Resource Consultant or fax to 304-988-4201

public partnerships PPL
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PAYMENT SCHEDULE

CALENDAR YEAR 2023

Please remember to submit and approve timesheets by the deadlines listed below. Public Partnerships cannot guarantee on-time payment for timesheets received after the deadline.

Pay Period		Timesheet Deadline	Posting Date
Start Date	**End Date**	**Timesheets must be Submitted and Approved by Midnight**	**Checks Mailed/Direct Deposit Issued**
Monday, December 19, 2022	Sunday, January 1, 2023	Tuesday, January 3, 2023	Friday, January 13, 2023
Monday, January 2, 2023	Sunday, January 15, 2023	Tuesday, January 17, 2023	Friday, January 27, 2023
Monday, January 16, 2023	Sunday, January 29, 2023	Tuesday, January 31, 2023	Friday, February 10, 2023
Monday, January 30, 2023	Sunday, February 12, 2023	Tuesday, February 14, 2023	Friday, February 24, 2023
Monday, February 13, 2023	Sunday, February 26, 2023	Tuesday, February 28, 2023	Friday, March 10, 2023
Monday, February 27, 2023	Sunday, March 12, 2023	Tuesday, March 14, 2023	Friday, March 24, 2023
Monday, March 13, 2023	Sunday, March 26, 2023	Tuesday, March 28, 2023	Friday, April 7, 2023
Monday, March 27, 2023	Sunday, April 9, 2023	Tuesday, April 11, 2023	Friday, April 21, 2023
Monday, April 10, 2023	Sunday, April 23, 2023	Tuesday, April 25, 2023	Friday, May 5, 2023
Monday, April 24, 2023	Sunday, May 7, 2023	Tuesday, May 9, 2023	Friday, May 19, 2023
Monday, May 8, 2023	Sunday, May 21, 2023	Tuesday, May 23, 2023	Friday, June 2, 2023
Monday, May 22, 2023	Sunday, June 4, 2023	Tuesday, June 6, 2023	Friday, June 16, 2023
Monday, June 5, 2023	Sunday, June 18, 2023	Tuesday, June 20, 2023	Friday, June 30, 2023
Monday, June 19, 2023	Sunday, July 2, 2023	Wednesday, July 5, 2023	Friday, July 14, 2023
Monday, July 3, 2023	Sunday, July 16, 2023	Tuesday, July 18, 2023	Friday, July 28, 2023
Monday, July 17, 2023	Sunday, July 30, 2023	Tuesday, August 1, 2023	Friday, August 11, 2023
Monday, July 31, 2023	Sunday, August 13, 2023	Tuesday, August 15, 2023	Friday, August 25, 2023
Monday, August 14, 2023	Sunday, August 27, 2023	Tuesday, August 29, 2023	Friday, September 8, 2023
Monday, August 28, 2023	Sunday, September 10, 2023	Tuesday, September 12, 2023	Friday, September 22, 2023
Monday, September 11, 2023	Sunday, September 24, 2023	Tuesday, September 26, 2023	Friday, October 6, 2023
Monday, September 25, 2023	Sunday, October 8, 2023	Tuesday, October 10, 2023	Friday, October 20, 2023
Monday, October 9, 2023	Sunday, October 22, 2023	Tuesday, October 24, 2023	Friday, November 3, 2023
Monday, October 23, 2023	Sunday, November 5, 2023	Tuesday, November 7, 2023	Friday, November 17, 2023
Monday, November 6, 2023	Sunday, November 19, 2023	Tuesday, November 21, 2023	Friday, December 1, 2023
Monday, November 20, 2023	Sunday, December 3, 2023	Tuesday, December 5, 2023	Friday, December 15, 2023
Monday, December 4, 2023	Sunday, December 17, 2023	Tuesday, December 19, 2023	Friday, December 29, 2023
Monday, December 18, 2023	Sunday, December 31, 2023	Tuesday, January 2, 2024	Friday, January 12, 2024