PDS Employee Requirements:

Any employee wishing to seek employment under the Participant Directed Service Option (PDS) of the Michelle P. Waiver (MPW), Acquired Brain Injury – Acute Waiver (ABI-A), or the Acquired Brain Injury – Long Term Care Waiver (ABI-LTC) after 5/1/2024 must complete the following:

- Submit a completed Employee Packet
    - With submission of an employee packet, employee and employer acknowledge background checks will be run on the prospective employee including a criminal record check, nurse aide abuse registry check (NAAR), central registry check (CAN), caregiver misconduct registry check and sex offender registry check
- Complete all necessary trainings
    - Abuse, Neglect, and Exploitation Training (with post test); this is on online training and the link for the training and the post test will be emailed to you by your Support Broker/Case Manager
    - Electronic Visit Verification (EVV) Training; this is an online training and the link for the training will be emailed to you by your Support Broker/Case Manager or can be found on the EVV PDS Employee Training Verification Form found in the employee packet. The EVV training consists of the following two training videos:
        - Mobile Caregiver+ Mobile Application
        - Kentucky CHFS Participant Directed Services (PDS) Providers.
    - Once the employee completes watching the EVV training videos, they, along with the PDS Representative (Rep), sign the EVV training verification form found in the employee packet.
    - Any additional trainings designated by Medicaid or New Vista
- If the participant's plan includes transportation, and new employee will be providing transportation to the participant as part of their care in working with them, a copy of **employee's valid drivers license** and **current proof of insurance** must be maintained and on file for the duration of their employment

<u>Prior to starting employment, employee must provide verification of the following</u>:

- A Full Panel Drug Screening
- A TB Skin Test or TB Risk Assessment completed by a licensed healthcare professional

*Note – your Support Broker/Case Manager can provide you with a list of resources where you can seek out these requirements, but the cost of these are the responsibility of the employee/employer and will not be paid for by New Vista

<u>Requirements that need to be resubmitted as it expires:</u>

- Driver's license (if transporting participant)
- Proof of current car insurance (if transporting participant)

*NOTE – If there is a gap in time between renewal requirements, any visits completed during that gap will not be approved for payment through waiver funds and the employee will not receive back pay from the PDS Budget for work completed during the gap in service.

Updated 5.1.2024

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

2026

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.)

Caution: To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(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):

(a) Multiply the number of qualifying children under age 17 by $2,200 . . . . . **3(a)** $

(b) Multiply the number of other dependents by $500 . . . **3(b)** $

Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here . . . . . **3** $

Step 4: 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. Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) Enter the result here . . **4(b)** $

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

Exempt from withholding

I claim exemption from withholding for 2026, and I certify that I meet **both** of the conditions for exemption for 2026. See *Exemption from withholding* on page 2. I understand I will need to submit a new Form W-4 for 2027 . ☐

Step 5: Sign Here

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

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

Employers Only

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

General Instructions

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

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2026 if you meet both of the following conditions: you had no federal income tax liability in 2025 **and** you expect to have no federal income tax liability in 2026. You had no federal income tax liability in 2025 if (1) your total tax on line 24 on your 2025 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2026 tax return. To claim exemption from withholding, certify that you meet both of the conditions by checking the box in the *Exempt from withholding* section. 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 16, 2027.

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

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

1. Are submitting this form after the beginning of the year;

2. Expect to work only part of the year;

3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;

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

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

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

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

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

Specific Instructions

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

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work. Submit a separate Form W-4 for each job.

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

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

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 15, if you expect to claim deductions other than the basic standard deduction on your 2026 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for qualified tips, overtime compensation, and passenger vehicle loan interest; student loan interest; IRAs; and seniors. You (and/or your spouse if married filing jointly) must have the required social security number to claim certain deductions. For additional eligibility requirements, see Pub. 501.

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 when you file your tax return.

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 5. 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 5 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 5 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 (plus any other additional amount you want withheld) . . . . . **4** $ _____

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

See the Instructions for Schedule 1-A (Form 1040) for more information about whether you qualify for the deductions on lines 1a, 1b, 1c, 3a, and 3b.

1 Deductions for qualified tips, overtime compensation, and passenger vehicle loan interest.

- **a** **Qualified tips.** If your total income is less than $150,000 ($300,000 if married filing jointly), enter an estimate of your qualified tips up to $25,000 . . . . . **1a** $
- **b** **Qualified overtime compensation.** If your total income is less than $150,000 ($300,000 if married filing jointly), enter an estimate of your qualified overtime compensation up to $12,500 ($25,000 if married filing jointly) of the "and-a-half" portion of time-and-a-half compensation . . . . . **1b** $
- **c** **Qualified passenger vehicle loan interest.** If your total income is less than $100,000 ($200,000 if married filing jointly), enter an estimate of your qualified passenger vehicle loan interest up to $10,000 **1c** $

2 Add lines 1a, 1b, and 1c. Enter the result here . . . . . **2** $

3 **Seniors age 65 or older.** If your total income is less than $75,000 ($150,000 if married filing jointly):

- **a** Enter $6,000 if you are age 65 or older before the end of the year . . . . . **3a** $
- **b** Enter $6,000 if your spouse is age 65 or older before the end of the year and has a social security number valid for employment . . . . . **3b** $

4 Add lines 3a and 3b. Enter the result here . . . . . **4** $

5 Enter an estimate of your student loan interest, deductible IRA contributions, educator expenses, alimony paid, and certain other adjustments from Schedule 1 (Form 1040), Part II. See Pub. 505 for more information . . . . . **5** $

6 **Itemized deductions.** Enter an estimate of your 2026 itemized deductions from Schedule A (Form 1040). Such deductions may include qualifying:

- **a** **Medical and dental expenses.** Enter expenses in excess of 7.5% (0.075) of your total income . **6a** $
- **b** **State and local taxes.** If your total income is less than $505,000 ($252,500 if married filing separately), enter state and local taxes paid up to $40,400 ($20,200 if married filing separately) . **6b** $
- **c** **Home mortgage interest.** If your home acquisition debt is less than $750,000 ($375,000 if married filing separately), enter your home mortgage interest expense (including mortgage insurance premiums) . . . . . **6c** $
- **d** **Gifts to charities.** Enter contributions in excess of 0.5% (0.005) of your total income . . . . **6d** $
- **e** **Other itemized deductions.** Enter the amount for other itemized deductions . . . . . **6e** $

7 Add lines 6a, 6b, 6c, 6d, and 6e. Enter the result here . . . . . **7** $

8 **Limitation on itemized deductions.**

- **a** Enter your total income . . . . . **8a** $
- **b** Subtract line 4 from line 8a. If line 4 is greater than line 8a, enter -0- here and on line 10. Skip line 9 **8b** $

9 Enter:
- $768,700 if you're married filing jointly or a qualifying surviving spouse
- $640,600 if you're single or head of household
- $384,350 if you're married filing separately

. . . . . **9** $

10 If line 9 is greater than line 8b, enter the amount from line 7. Otherwise, multiply line 7 by 94% (0.94) and enter the result here . . . . . **10** $

11 **Standard deduction.**

Enter:
- $32,200 if you're married filing jointly or a qualifying surviving spouse
- $24,150 if you're head of household
- $16,100 if you're single or married filing separately

. . . . . **11** $

12 **Cash gifts to charities.** If you take the standard deduction, enter cash contributions up to $1,000 ($2,000 if married filing jointly) . . . . . **12** $

13 Add lines 11 and 12. Enter the result here . . . . . **13** $

14 If line 10 is greater than line 13, subtract line 11 from line 10 and enter the result here. If line 13 is greater than line 10, enter the amount from line 12 . . . . . **14** $

15 Add lines 2, 4, 5, and 14. Enter the result here and in Step 4(b) of Form W-4 . . . . . **15** $

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	$480	$850	$850	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020
$10,000 - 19,999	0	480	1,480	1,850	2,050	2,220	2,220	2,220	2,220	2,220	2,220	2,620
$20,000 - 29,999	480	1,480	2,480	3,050	3,250	3,420	3,420	3,420	3,420	3,420	3,820	4,820
$30,000 - 39,999	850	1,850	3,050	3,620	3,820	3,990	3,990	3,990	3,990	4,390	5,390	6,390
$40,000 - 49,999	850	2,050	3,250	3,820	4,020	4,190	4,190	4,190	4,590	5,590	6,590	7,590
$50,000 - 59,999	1,020	2,220	3,420	3,990	4,190	4,360	4,360	4,760	5,760	6,760	7,760	8,760
$60,000 - 69,999	1,020	2,220	3,420	3,990	4,190	4,360	4,760	5,760	6,760	7,760	8,760	9,760
$70,000 - 79,999	1,020	2,220	3,420	3,990	4,190	4,760	5,760	6,760	7,760	8,760	9,760	10,760
$80,000 - 99,999	1,020	2,220	3,420	4,240	5,440	6,610	7,610	8,610	9,610	10,610	11,610	12,610
$100,000 - 149,999	1,870	4,070	6,270	7,840	9,040	10,210	11,210	12,210	13,210	14,210	15,360	16,560
$150,000 - 239,999	1,870	4,100	6,500	8,270	9,670	11,040	12,240	13,440	14,640	15,840	17,040	18,240
$240,000 - 319,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,780	14,980	16,180	17,380	18,580
$320,000 - 364,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,860	15,860	17,860	19,860	21,860
$365,000 - 524,999	2,720	5,920	9,390	12,260	14,760	17,230	19,530	21,830	24,130	26,430	28,730	31,030
$525,000 and over	3,140	6,840	10,540	13,610	16,310	18,980	21,480	23,980	26,480	28,980	31,480	33,990

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	$90	$850	$1,020	$1,020	$1,020	$1,070	$1,870	$1,870	$1,870	$1,870	$1,870	$1,970
$10,000 - 19,999	850	1,780	1,980	1,980	2,030	3,030	3,830	3,830	3,830	3,830	3,930	4,130
$20,000 - 29,999	1,020	1,980	2,180	2,230	3,230	4,230	5,030	5,030	5,030	5,130	5,330	5,530
$30,000 - 39,999	1,020	1,980	2,230	3,230	4,230	5,230	6,030	6,030	6,130	6,330	6,530	6,730
$40,000 - 59,999	1,020	2,880	4,080	5,080	6,080	7,080	7,950	8,150	8,350	8,550	8,750	8,950
$60,000 - 79,999	1,870	3,830	5,030	6,030	7,100	8,300	9,300	9,500	9,700	9,900	10,100	10,300
$80,000 - 99,999	1,870	3,830	5,100	6,300	7,500	8,700	9,700	9,900	10,100	10,300	10,500	10,700
$100,000 - 124,999	2,030	4,190	5,590	6,790	7,990	9,190	10,190	10,390	10,590	10,940	11,940	12,940
$125,000 - 149,999	2,040	4,200	5,600	6,800	8,000	9,200	10,200	10,950	11,950	12,950	13,950	14,950
$150,000 - 174,999	2,040	4,200	5,600	6,800	8,150	10,150	11,950	12,950	13,950	14,950	16,170	17,470
$175,000 - 199,999	2,040	4,200	6,150	8,150	10,150	12,150	13,950	15,020	16,320	17,620	18,920	20,220
$200,000 - 249,999	2,720	5,680	7,880	10,140	12,440	14,740	16,840	18,140	19,440	20,740	22,040	23,340
$250,000 - 449,999	2,970	6,230	8,730	11,030	13,330	15,630	17,730	19,030	20,330	21,630	22,930	24,240
$450,000 and over	3,140	6,600	9,300	11,800	14,300	16,800	19,100	20,600	22,100	23,600	25,100	26,610

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	$280	$850	$950	$1,020	$1,020	$1,020	$1,020	$1,560	$1,870	$1,870	$1,870
$10,000 - 19,999	280	1,280	1,950	2,150	2,220	2,220	2,220	2,760	3,760	4,070	4,070	4,210
$20,000 - 29,999	850	1,950	2,720	2,920	2,980	2,980	3,520	4,520	5,520	5,830	5,980	6,180
$30,000 - 39,999	950	2,150	2,920	3,120	3,180	3,720	4,720	5,720	6,720	7,180	7,380	7,580
$40,000 - 59,999	1,020	2,220	2,980	3,570	4,640	5,640	6,640	7,750	8,950	9,460	9,660	9,860
$60,000 - 79,999	1,020	2,610	4,370	5,570	6,640	7,750	8,950	10,150	11,350	11,860	12,060	12,260
$80,000 - 99,999	1,870	4,070	5,830	7,150	8,410	9,610	10,810	12,010	13,210	13,720	13,920	14,120
$100,000 - 124,999	1,870	4,270	6,230	7,630	8,900	10,100	11,300	12,500	13,700	14,210	14,720	15,720
$125,000 - 149,999	2,040	4,440	6,400	7,800	9,070	10,270	11,470	12,670	14,580	15,890	16,890	17,890
$150,000 - 174,999	2,040	4,440	6,400	7,800	9,070	10,580	12,580	14,580	16,580	17,890	18,890	20,170
$175,000 - 199,999	2,040	4,440	6,400	8,510	10,580	12,580	14,580	16,580	18,710	20,320	21,620	22,920
$200,000 - 249,999	2,720	5,920	8,680	10,900	13,270	15,570	17,870	20,170	22,470	24,080	25,380	26,680
$250,000 - 449,999	2,970	6,470	9,540	12,040	14,410	16,710	19,010	21,310	23,610	25,220	26,520	27,820
$450,000 and over	3,140	6,840	10,110	12,810	15,380	17,880	20,380	22,880	25,380	27,190	28,690	30,190

FORM **K-4**

Commonwealth of Kentucky
Department of Revenue

KENTUCKY'S WITHHOLDING CERTIFICATE

2026

Social Security Number

Name—Last, First, Middle Initial

Mailing Address (Number and Street including Apartment Number or P.O. Box)

City, Town or Post Office | State | ZIP Code

All Kentucky wage earners are taxed at a flat 3.5% rate with a standard deduction allowance of $3,360. The Department of Revenue annually adjust the standard deduction in accordance with KRS 141.081(2)(a).

Check if exempt:

☐ 1. Kentucky income tax liability is not expected this year (see instructions)

☐ 2. You qualify for the Fort Campbell Exemption Certificate. I am a resident of _____
State

☐ 3. You qualify for the nonresident military spouse exemption

☐ 4. You work in Kentucky and reside in a reciprocal state

Additional withholding per pay period under agreement with employer $_____

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

_____ Signature

_____ Date

Instructions to Employees

All Kentucky wage earners are taxed at a flat 3.5% tax rate with an allowance for the standard deduction.

You may be exempt from withholding if any of the four conditions below are met:

1. You may be exempt from withholding for 2026 if both the following apply:
   - For 2025, you had a right to a refund of all Kentucky income tax withheld because you had no Kentucky income tax liability, and
   - For 2026, you expect a refund of all your Kentucky income tax withheld.

Income Tax Liability Thresholds—The 2025 filing threshold amount based upon federal poverty level is expected to be $15,650 for a family size of one (single, or married living apart from your spouse for the entire year), $21,150 for a family of two (single with one dependent child or a married couple), $26,650 for a family of three (single with two dependent children or a married couple with one dependent child) and $32,150 for a family of four or more (single with three dependent children or a married couple with two or more dependent children). Modified gross income is equal to your federal adjusted gross income plus any interest income from other states municipal bonds and pension income from a qualifying lump-sum distribution. If your combined modified gross income is expected to be less than the threshold amount for your family size, then you (and your spouse, if applicable) may not have an income tax liability.

If both the above statements apply, you are exempt and may check box 1. Your exemption for 2026 expires February 15, 2027.

2. Under the provisions of Public Law 105–261, pay and compensation earned at the Fort Campbell, Kentucky, military base is exempt from Kentucky income tax if you are not a resident of Kentucky. KRS 141.010(32) defines "resident" as an individual domiciled within this state or an individual who is not domiciled in this state, but maintains a place of abode in this state and spends in the aggregate more than one hundred eighty-three (183) days of the taxable year in this state.

Check box 2 if you certify that you are not a resident of Kentucky and only earn wages as an employee at Fort Campbell, Kentucky. This exemption must be revoked within 10 days of a move or change of address to Kentucky.

3. You may be exempt from withholding, if you meet the conditions set for under the Servicemember Civil Relief Act as amended by the Military Spouses Residence Relief Act. You must complete the worksheet below to determine if you are eligible.

In order to qualify you must complete this form in full, certify that the you are not subject to Kentucky withholding tax because you met the conditions set forth below, and provide a copy of your spouse's military picture ID issued to the employee by the U.S. Department of Defense.

---

1. My spouse is a military servicemember.....(check one) ☐ YES ☐ NO
2. I am NOT a military servicemember.....(check one) ☐ YES ☐ NO
3. My military servicemember spouse has a current military order assigning him or her to a military location in Kentucky.....(check one) ☐ YES ☐ NO
4. I and my military servicemember spouse live at the same address.....(check one) ☐ YES ☐ NO
5. My military servicemember's state of domicile is a state other than Kentucky and I am electing to use that state of domicile.....(check one) ☐ YES ☐ NO
   If yes, enter the 2-letter state code of the servicemember's state of domicile _____
6. I am present in Kentucky solely to be with my military servicemember spouse.....(check one) ☐ YES ☐ NO

If you checked "YES" to all the statements above, your earned income is exempt from Kentucky withholding tax.

Check box 3 if you checked "YES" to all the statements listed in the worksheet. You are exempt from Kentucky income tax withholding. This exemption will terminate if any of the answers to the questions changes to "NO". In general, the exemption termination date will be the earlier of:

- The day the military servicemember is no longer in the military;
- The day the employee enlists in the military;
- The day the employee and the military servicemember no longer live at the same address; or
- The day the military servicemember's permanent duty station changes to a location outside of Kentucky.

4. You may be exempt from withholding if you work in Kentucky but reside in one of the following reciprocal states: Illinois, Indiana, Michigan, West Virginia, Wisconsin, Virginia and you commute daily or Ohio and you are not a shareholder–employee who is a "twenty (20) percent or greater" direct or indirect equity investor in a S corporation.

   In order to qualify you must complete the worksheet below:

I have not been a resident of Kentucky during the year. (Check block in front of applicable statement.) I work in Kentucky and reside in:

☐ Illinois, ☐ Indiana, ☐ Michigan, ☐ West Virginia, ☐ Wisconsin
☐ Virginia and commute daily to my place of employment in Kentucky. *(Must commute daily to apply.)*
☐ Ohio and I am not a shareholder-employee who is a "twenty (20) percent or greater" direct or indirect equity investor in an S corporation.

Check box 4 if you certify you work in Kentucky and reside in a reciprocal state.

If you meet any of the four exemptions you are exempted from Kentucky withholding. However, you must complete this form and file it with your employer before withholding can be stopped. You will need to maintain a copy of the K-4 for your permanent records.

Instructions to Employers

Form K-4 is only required to document that an employee has requested an exemption from withholding OR to document that an employee has requested additional withholding in excess of the amounts calculated using the formula or tables. If neither situation applies, then an employer is not required to maintain Form K-4.

Upon receipt of this form, properly completed, you are authorized to discontinue withholding for an employee who qualifies for one of the four exemptions. Retain a copy of all K-4's received from employees.

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Aging and Independent Living &

PARTICIPANT DIRECTED SERVICES
EMPLOYMENT APPLICATION

Participant/Employer Name: _____

Applicant Instructions

1. *Please print answers to all questions;*
2. *A resume will not be accepted in lieu of this application;*
3. *Proof of eligibility to work in the United States must be submitted prior to employment;*
4. *Registry and/or background checks must be completed prior to employment; and*
5. *Any false statements and/or omissions may result in a rejection of this application and/or removal from employment after hire.*

Personal Information

_____
Last Name First Name Middle Name

_____
Date of Birth SSN # Telephone #

_____
Street Address (Including Apt. # or P.O. Box #) City State Zip Code

If you have not lived in Kentucky within the past year, please provide a previous address:

_____
Street Address (Including Apt. # or P.O. Box #) City State Zip Code

_____
Street Address (Including Apt. # or P.O. Box #) City State Zip Code

If required to transport, can you provide proof of valid Liability Vehicle insurance? ☐Yes ☐No
Can you lift more than 50lbs while standing? ☐Yes ☐No
Are you legally eligible for employment in the United States? ☐Yes ☐No
Have you ever been arrested or convicted of a criminal offense? ☐Yes ☐No

_____
If yes, please describe. *Please note that an affirmative answer will not automatically disqualify you from being considered as a candidate for employment.*

What is your relationship to the participant/employer? _____

Certification/Education

Are you currently certified in CPR/ First Aid? ☐Yes ☐No
If yes, please provide case management agency with documentation.

Please list any other certifications relevant to the position: _____
_____

Please list highest level of education completed: _____

Work Experience

Do you have experience as a caregiver? ☐Yes ☐No

_____

If yes, please describe.

Are you currently employed? ☐Yes ☐No

_____

Company Name Supervisor Name Telephone #

_____

Street Address (Including Apt. # or P.O. Box #) City State Zip Code

_____

Start Date Schedule (Days & Hours Working)

Please list any job history relative to the position, beginning with the most recent.

1) _____

Company Name Supervisor Name Telephone #

_____

Street Address (Including Apt. # or P.O. Box #) City State Zip Code

_____

Start Date (Month/Year) End Date (Month/Year) Reason(s) for Leaving

2) _____

Company Name Supervisor Name Telephone #

_____

Street Address (Including Apt. # or P.O. Box #) City State Zip Code

_____

Start Date (Month/Year) End Date (Month/Year) Reason(s) for Leaving

3) _____

Company Name Supervisor Name Telephone #

_____

Street Address (Including Apt. # or P.O. Box #) City State Zip Code

_____

Start Date (Month/Year) End Date (Month/Year) Reason(s) for Leaving

References

1) _____

Full Name | Occupation | Telephone #

_____

Street Address (Including Apt. # or P.O. Box #) | City | State | Zip Code

2) _____

Full Name | Occupation | Telephone #

_____

Street Address (Including Apt. # or P.O. Box #) | City | State | Zip Code

3) _____

Full Name | Occupation | Telephone #

_____

Street Address (Including Apt. # or P.O. Box #) | City | State | Zip Code

Emergency Contacts

1) _____

Full Name | Relationship | Telephone #

_____

Street Address (Including Apt. # or P.O. Box #) | City | State | Zip Code

2) _____

Full Name | Relationship | Telephone #

_____

Street Address (Including Apt. # or P.O. Box #) | City | State | Zip Code

I certify that the information provided within this employment application is true and correct to the best of my knowledge.

_____ _____

Signature **Date**

Kentucky Participant Directed Services (PDS)
Employee/Provider Contract

I (*employee name)* _____, last four of Social Security Number_____
have agreed to work under the employment of *(employer name/waiver participant name)*
_____ Medicaid ID_____.

I understand that, as a waiver participant, I can choose a PDS representative to help me with my responsibilities as an employer.

Participant Directed Services Representative Name (if applicable) _____.

Financial Management Agency Name _____.

Case Manager Agency Name _____.

Services delivered under this contract will consist of the following:

Service Provided	Service Code	Rate Per Hour	Hours Per Week	Anticipated Start Date*	End Date**

**Anticipated start date should reflect the date services are anticipated to begin.*
*** Only complete end date if the employee stops providing the service.*

***not to exceed more than
40 hours weekly for all services combined

Please see the attached list for a list of services available via PDS. For a full waiver service listing and max rates, please see the Home and Community Based Services Waiver Rates document on https://www.chfs.ky.gov/agencies/dms/Pages/feesrates.aspx.

For official use only:

Employee Expiration Dates:

TB Test:

Car Insurance:

Driver's License:

CPR/First Aid (or Acknowledgement Form):

Kentucky Participant Directed Services (PDS)
Employee/Provider Contract

As the employee:

- ☐ I agree to provide the services as specified by my employer (the waiver participant) as defined in the table above.
- ☐ I understand civil or criminal penalties can be pursued and termination from employment can occur if allegations of fraud against the Department for Medicaid Services are substantiated.
- ☐ I understand that I shall not be allowed to provide services based on the results of my background check, all applicable screenings and/or failing to complete trainings/certifications required by my employer (the waiver participant).
- ☐ I understand that under KRS 205.5607 (Kentucky Independence Plus Through Consumer Directed Services Program) Workers Compensation (KRS Chapter 342) shall not apply to my employment as a PDS employee. This means that neither the state, nor any state agency, nor political subdivision, nor any fiscal intermediary, nor representative, nor case manager can be held liable for any injuries or losses I may incur while providing services.
- ☐ I understand that I must maintain employee/employer confidentiality.
- ☐ I understand this is an at-will contract and either party may terminate this agreement at any time.
- ☐ I understand that I must notify my employer (the waiver participant) of the contraction of any infectious disease(s) and I shall abstain from work until the infectious disease can no longer be transmitted as documented by a medical professional.
- ☐ I agree to follow all relevant state and federal statutes and regulations, including the use of Electronic Visit Verification.
- ☐ I have received and fully understand the list of employment guidelines and will follow them to the best of my ability. I further understand that any or all items of this contract may be subject to renewal or change upon agreement by my employer (the waiver participant) and myself.

Kentucky Participant Directed Services (PDS)
Employee/Provider Contract

As the employer (waiver participant):

- ☐ I understand that I may be responsible for wages for my employee should my employee or I not provide employee qualifications by the respective deadlines.
- ☐ I understand that I can only require my employee to assist with duties that are relevant to my needs and outcomes that are specified on the Person-Centered Service Plan for Medicaid payment.
- ☐ I understand that I may be responsible for payment for any hours I may require my employee to work beyond any prior authorization limits or waiver regulation guidelines.

Employee Signature Date

Employer/Participant Date

PDS Representative (if applicable) Date

Kentucky Participant Directed Services (PDS)
Employee/Provider Contract

Waiver Services Available via PDS		
Waiver Program	**Service**	**Code**
ABI Acute	Companion	S5135 HI
ABI Acute	Personal Care	97535 HI
ABI Acute	Respite	T1005 HI
ABI Acute	Supported Employment	H0039 HI
ABI LTC	Community Living Supports	97535 HI
ABI LTC	Respite	T1005 HI
ABI LTC	Supported Employment	H0039 HI
HCB	Attendant Care	S5108 HI
HCB	Non-specialized Respite	T1005 HI
MP	Attendant Care	S5125 HI
MP	Community Living Supports	97535 HI
MP	Homemaker	S5130 HI
MP	Personal Care	T1019 HI
MP	Respite	T1005 HI
MP	Supported Employment	H0039
SCL	Community Access	97535 HI
SCL	Community Access Group	97537 HI
SCL	Community Guide	H2015 HI
SCL	Personal Assistance	T1019 HI
SCL	Respite	T1005 HI
SCL	Supported Employment	T2019 HI

New Vista of the Bluegrass, Inc.
Participant Directed Services Program
Employee – Employer Acknowledgment Form

I (employee name) _____, have agreed to work under the employment of (employer name) _____.

By reading and signing this form, both employee and employer expressly acknowledge their respective understanding of the following:

1) Upon the approval of the Kentucky Cabinet for Health and Family Services, New Vista of the Bluegrass, Inc. will provide services to employer under the Participant Directed Services (PDS) as a fiscal intermediary as defined in K.R.S §205.5606.

2) New Vista of the Bluegrass, Inc. is not an employer under PDS.

3) New Vista of the Bluegrass, Inc. is under no legal duty to provide worker's compensation coverage under PDS.

4) New Vista of the Bluegrass, Inc. is under no legal duty to provide any benefits and/or insurance coverage, including, but not limited to retirement benefits, health, life, disability, home, auto, and liability under PDS.

5) New Vista of the Bluegrass, Inc. will not be liable for any injuries or losses incurred by employee or employer under PDS.

6) I (employee) authorize New Vista of the Bluegrass, Inc. to complete the following required criminal record checks: Central Registry Check, Caregiver Misconduct Registry, Administrative Office of the Courts, Kentucky Nurse Abuse Registry, the Cabinet for Families and Children and Adult Protective Services.

7) I (employee) authorize that a copy of any of the record checks may be forwarded to the employer for their review. This review may be a determining factor regarding my employment.

8) I (employee) and (employer) understand that the employee cannot begin work until the employer receives notification that results of the all required background checks have been received by New Vista of the Bluegrass, Inc. and meet the requirements established in state regulations. Completed background checks for the first four employees hired each plan of care year shall be paid for by the Financial Management Agency. Subsequent background checks shall be paid for by the employee/er.

9) I (employee) and (employer) understand that I may be responsible for payment for any hours worked beyond prior authorization limits or waiver regulation guidelines. I understand New Vista of the Bluegrass, Inc. may recoup future hours/wages from (employee) or (employer) up to the number of hours billed beyond prior authorization limits or waiver regulation guidelines.

10) I (employee) and (employer) understand that all PDS employees must keep current TB Risk Assessment/TB Skin Test, as well as updated driver's license, and car insurance (if transporting the client is part of the service provided). Copies of documentation shall be submitted to the Case Manager/Support Broker prior to the due date. I understand that if documentation is not provided timely, the employee is ineligible to work and will not be paid for services provided until the documentation is provided to the Case Manager/Support Broker. Cost of the TBST shall be the responsibility of the employee/er.

11) I (employee) **have/have not** lived out of state in the past year. I understand that if I have had residency out of state within the past year I am required to have New Vista of the Bluegrass, Inc. complete the Nationwide Criminal Search. ***(Please circle which is accurate)***

_____ _____

Employee Date Employer Date

Support Broker: _____

Client: _____

Waiver:_____

Intellicorp: _____ Yes _____ No Out of State Residency: _____ Yes _____ No

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.

ADMINISTRATIVE OFFICE OF THE COURTS
RECORDS UNIT
1001 VANDALAY DRIVE
FRANKFORT, KENTUCKY 40601
502-573-1682 or 800-928-6381
records@kycourts.net

The process to obtain the information contained in CourtNet is as follows:

Individuals

Requesting a record on yourself requires a $25.00 fee **(check or money order)**. If you do not receive a response in 30 days contact us at the number listed above.

Nonprofit/Commercial/Others

Requesting a record on individuals requires a $25.00 fee **(check or money order)**.

Fees are paid to the order of the KENTUCKY STATE TREASURER by check or money order ONLY. FAILURE TO COMPLY WITH THESE PROCEDURES WILL RESULT IN THE REQUEST BEING RETURNED UNPROCESSED. If you suspect information contained on the record is incorrect, or have any questions, please contact the Records Unit at (502) 573-1682 or (800) 928-6381.

PLEASE **PRINT OR TYPE** THE INDIVIDUAL'S INFORMATION **CLEARLY**.

SOCIAL SECURITY NUMBER: _____ DLN: _____

NAME: _____ _____ _____
FIRST MIDDLE LAST

MAIDEN NAME(S) AND/OR ALIAS: _____

DATE OF BIRTH: _____

STREET ADDRESS/P.O. BOX: _____

CITY, STATE, ZIP CODE: _____

I understand the information supplied by me must be truthful and falsification with an intent to mislead may result in my prosecution under KRS 523.100. I have provided the basic information necessary to qualify for record processing and exemption of fees - if applicable.

*** ALL INFORMATION BELOW IS REQUIRED.**

_____
Date

_____
Company (*If applicable*)

_____
Requestor/Contact Person

_____
Address

_____
City, State, Zip

_____
Telephone Number

_____
E-mail Address

Please denote which purpose applies to this request:

- ◯ Employment
- ◯ Criminal Investigation
- ◯ Screening Housing Applicants
- ◯ Volunteer/Care over Juvenile
- ◯ Licensing
- ◯ Other (please explain)

DPP-156
(R. 12/2021)
922 KAR 1:470

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
Department for Community Based Services

CENTRAL REGISTRY CHECK

FOR THE FOLLOWING TYPES OF EMPLOYMENT OR VOLUNTEERISM, STATE LAW OR KENTUCKY ADMINISTRATIVE REGULATION AUTHORIZES A CHILD ABUSE/NEGLECT (CA/N) CHECK AS A CONDITION OF EMPLOYMENT OR VOLUNTEERISM. PLEASE CHECK THE CATEGORY LISTED BELOW THAT APPLIES TO YOU FOR WHICH THE CHILD ABUSE OR NEGLECT CHECK IS BEING REQUESTED:

- ☐ Child-Placing Agency (Foster/Adoption/Independent Living) Employee or Volunteer (Required by 922 KAR 1:310)
- ☐ Residential Child-Caring Facility Employee or Volunteer (Required by 922 KAR 1:300)
  (Institution/Group Home/Emergency)
- ☐ Public School Employee, Student Teacher, Contractor, or School-Based Decision-Making Council Member (Required by KRS 160.380)
- ☐ Private, Parochial, or Church School Employee or Student Teacher (Permitted by KRS 160.151)
- ☐ Youth Camp Employee, Contractor, or Volunteer (Required by KRS 194A.380-194A.383)
- ☐ Power of Attorney Regarding the Care and Custody of a Child (Required by KRS 403.352)
- ☐ Supports for Community Living (SCL) Employee [(Required by 907 KAR 12:010)
- ☐ Michelle P. Waiver (Required by 907 KAR 1:835)
- ☐ Home and Community Based (HCB) Waiver (Required by 907 KAR 1:160 and 7:010)
- ☐ Acquired Brain Injury Waiver Services (Required by 907 KAR 3:090)
- ☐ Children's Advocacy Center (Required by 922 KAR 1:580)
- ☐ Court Appointed Special Advocate (CASA) (Required by KRS 620.515)
- ☐ Personal Care Attendant (Required by 910 KAR 1:090)

Other

If you are requesting this check due to it being required for an out of state employer, please include the statutory or regulatory authority for that state that requires the check be completed.
If none of the above categories are applicable, please explain the reason for requesting a child abuse or neglect check, including the statutory or regulatory authority for the request.
If a regulation or statute is not listed, your request will be cancelled and no refund will be issued.

PERSONAL INFORMATION REGARDING THE INDIVIDUAL SUBMITTING TO A CHILD ABUSE OR NEGLECT CHECK (Please print and submit identifying information such as a copy of your driver's license, social security card/individual taxpayer ID, passport, work ID, or birth certificate):
If you are under the age of 18, you MUST upload a parental consent form.

NAME: _____
(first) (middle) (maiden/nickname/other) (last)

Sex: ___ Race: _____ Date of Birth: _____

Social Security/Individual Taxpayer Identification #:_____

Date of Initial Hire: _____

Current Address: _____
City State Zip Code

Living at the current address longer than 5 years? ☐ Yes (please list below) ☐ No

Previous Address: _____
City State Zip Code

Previous Address: _____
City State Zip Code

CENTRAL REGISTRY CHECK

Previous Address: _____
City State Zip Code

Previous Address: _____
City State Zip Code

Use another sheet of paper, if necessary.

A credit or debit card payment in the amount of ten dollars ($10.00) must accompany your request to process a Child Abuse or Neglect Check. The Child Abuse or Neglect Check will NOT be processed without payment.

I hereby authorize the Cabinet for Health and Family Services to complete a Child Abuse or Neglect check and to submit the results of the check to me and, on my behalf, to the employer or agency listed below. I also release the Cabinet for Health and Family Services, its officers, agents, and employees, from any liability or damages resulting from the release of this information.

All the information provided is complete and true to the best of my knowledge. I understand if I give false information or do not report all of the information needed, I may be subject to prosecution for fraud.

_____ _____
Signature of the Individual Submitting to the Child Abuse or Neglect Check Date

The individual authorizing a Child Abuse or Neglect check may submit a CHFS-305, Authorization for Disclosure of Protected Information, authorizing the Cabinet for Health and Family Services to disclose additional information regarding a finding to the employer or agency listed below should the employer or agency request additional information pursuant to 922 KAR 1:510, Authorization for disclosure of protection and permanency records.

In addition to receiving the results myself, I authorize the Cabinet for Health and Family Services to share the results with the following employer or agency:

NAME OF EMPLOYER/AGENCY: New Vista of the Bluegrass, Inc.

ADDRESS: 1351 Newtown Pike Bldg 5 **CITY**: Lexington

STATE: Kentucky **ZIP:** 40511 **PHONE:** 859-272-7483

E-MAIL ADDRESS: _____

RESULTS OF CHILD ABUSE OR NEGLECT CHECK [FOR OFFICIAL USE ONLY]

☐ No reportable incident found in accordance with 922 KAR 1:470
☐ Substantiated child abuse found on the registry Date of substantiated finding: _____
☐ Substantiated child neglect found on the registry Date of substantiated finding: _____
The substantiated abuse or neglect finding relates to sexual abuse, sexual exploitation, a child fatality, near fatality, or involuntary termination of parental rights ☐ Yes ☐ No
☐ A matter subject to administrative review found in accordance with 922 KAR 1:470

CHECK CONDUCTED ON _____ **BY** _____

Person Centered Planning

Supports for individuals with disabilities will:

- Ensure dignity and respect for each person as a valued individual.
- Be entitled to the rights, privileges, opportunities, and responsibilities of community membership.
- Be supported and encouraged to develop personal relationships, learning opportunities, work and income options, and worship opportunities as full participants in community life.
- Be based on individually determined goals, choices, and priorities.
- Be easily accessed and provided regardless of the intensity of the individual need.
- Be afforded the opportunity to direct the planning, selection, implementation and evaluation of their services.
- Require that funding be flexible and cost effective and make use of natural, generic and specialized resources.
- Be the primary decision makers in their own lives.
- Be evaluated based on outcomes for individuals.

The work we do and the way we work will:

- Ensure that all persons have dignity and value, and are worthy of respect.
- Provide safeguards to ensure personal security, safety, and protection of legal and human rights.
- Be coordinated on person-centered and family-centered principles, focusing on individual needs, strengths, and choices.
- Support that all people have strengths and abilities and are the primary decision-makers in their lives.
- Provide information and supports that promote informed decision-making.
- Be accessible and culturally responsible.
- Access informal and generic community resources whenever possible in the most integrated community setting appropriate to the person.
- Be based on best practice and utilize state-of-the-art skills and information.
- Be directed toward the achievement of interdependence, contribution, and meaningful participation in the community.
- Distribute resources in an equitable manner according to the individual need and comply with requirements governing public funds administered by the system.

_____ _____

Signature Date

_____

Print Name

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Aging and Independent Living & Department for Medicaid Services

PARTICIPANT DIRECTED SERVICES
EMPLOYEE TRAINING VERIFICATION

As a chosen employee, I certify that prior to direct services being initiated, I received training from my employer or in the presence of my employer on:

- Principles of Self-Determination;
- Employee Contracts;
- Employee Background Checks;
- Timesheets;
- Person-Centered Planning;
- Fraud, Abuse, Neglect, and Exploitation; and
- Any additional topics required by my support brokerage agency, DAIL, DMS or employer.

Employee Signature	**Date**
Participant/Representative/Employer Signature	**Date**
Support Broker Signature (if applicable)	**Date**

Direct Deposit Guidelines

- If you chose to participate in direct deposit, 100% of your net pay will be direct deposited into one valid checking or savings account. Paid amounts cannot be split between multiple accounts.

- To participate in direct deposit, please complete the Paycor Direct Deposit Worksheet.

- Leave the Employer Name field blank. Your Support Broker will add this information.

- Be sure to attach a voided check or written correspondence from your financial institution. If you supply written correspondence from your financial institution, it must be signed by an employee of the institution and contain the contact information for the employee that prepared the correspondence. Monthly statements will not be accepted.

- The voided check or correspondence from the financial institution must include, at a minimum, the employee name, routing number and account number.

- Be sure to sign and date at the bottom of the form.

- Only completed forms will be accepted.

- Direct Deposit Worksheets will only be accepted and processed during non-payroll weeks. They will not be accepted the week of payroll.

- Access to pay statements and W-2s are available on line. The employee should print their e-mail address on the space provided on the direct deposit form if they wish to gain on-line access.

- A link will be sent from Paycor once your email address is entered into the system. The email will contain the link needed to set up a username and password. It is the employee's responsibility to keep track of password information. Neither Paycor nor Bluegrass.org have access to the employee passwords.

DIRECT DEPOSIT WORKSHEET

Employer Name: _____ **Paycor #:** _____

Employee Name: _____ **Employee #**_____

☐ New Employee ☐ Existing Employee ☐ Change to Existing Employee

ACCOUNT INFORMATION

☐ Savings ☐ Checking														
Bank Name														
Name on Account														
Routing & Transit Number (9 Digits)														
Account Number														

Attach Voided Check Here

- 100% of the employee's net pay can only be deposited into one checking or one savings account.
- The voided check must contain the employee's name, account # and routing # printed on the check.
- For savings accounts, please supply written correspondence from your financial institution. See the Direct Deposit Guidelines for requirements.
- If the financial institution returns funds due to inaccurate information provided by the employee, there will be a $15.00 fee charged to the employee and a paper check will be issued. A $30.00 fee will be assessed if an employee requests another direct deposit for the same pay period in lieu of a paper check.

To access check stubs and W-2's online; please enter e-mail address below:

_____

A link will be sent to the e-mail address above to set up user a user name and password. It is the employee's responsibility to maintain username and password information.

I authorize Paycor, Inc., acting on behalf of my employer, to initiate electronic credit entries and, if necessary, debit entries to reverse erroneous credit entries to my account(s). It is agreed that these deposits will be made in accordance with the rules of the National Automated Clearing House Association (NACHA). This authorization will remain in effect until Paycor, Inc., has received written notification from me of its termination in such time and in such a manner as to afford Paycor, Inc. and the bank a reasonable opportunity to act upon the termination request.

Employee Signature:	**Date:**

To be retained by Employer. Keep in your employee files. This form may be photocopied.

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PDS Employee Tellus/Mobile Caregiver+ EVV Training Verification

Participant Name: _____

PDS Employee Name: _____

Valid PDS Employee Email Address: _____

PDS Employee Mobile Phone Number: _____

PDS Employee Date of Birth: _____

- The State of Kentucky is implementing Electronic Visit Verification which is a requirement of the Federal 21st Century Cures Act.
- Kentucky Medicaid has mandated that effective January 1, 2021, no paper timesheets or service documentation will be accepted to process for payment for services.
- It is up to the employer/representative to make arrangements for the employee to have access to a compatible device to log their time in the Tellus system. New Vista will not be providing devices.
- The employer/representative is responsible for ensuring all employees complete training over the Tellus/Mobile Caregiver+ Mobile App that can be accessed at https://mobilecaregiverplus.com/training/
- Access to additional information on EVV including user guides, FAQ documents, and affected services can be found at http://chfs.ky.gov/agencies/dms/dca/Pages/evv.aspx
- Employees and Representatives may attend as many of the Tellus webinars and on demand video offerings as they would like. Due to the COVID 19 Pandemic, New Vista will not be offering any in person assistance to employees or representatives who have not attended at least 2 Tellus offerings, and attempted a Zoom meeting WITH video to troubleshoot app usage.
- PDS employees cannot begin providing services until EVV training has been complete and this form is signed and returned to your Support Broker. This will be stored in the participant's medical record.

Title of EVV Training	**Date of Training**
EVV Mobile Caregiver+ Mobile Application	

- Following the implementation of EVV, repeated issues with flagged/suspicious visits, missed punches, or activity that suggests fraud, will be referred by the support broker agency to the Office of the Inspector General for investigation.
- By signing my name and dating below, I acknowledge that I have read this document and provided accurate information to the support broker agency.

PDS Employee Signature: _____ Date: _____

PDS Representative Signature: _____ Date: _____

PDS Electronic Signature Utilization

☐ I am a PDS Employee wishing to use an electronic signature.

☐ I am a PDS Representative wishing to use an electronic signature.

1) I understand that New Vista of the Bluegrass will not provide me with software to configure an electronic signature.
2) I attest that I am the only person with access to the electronic signature of my choosing.
3) I attest that the electronic signature that I use will be (circle one):
    a. Digital Signature (cryptographic signature, digital key)
    b. Digitized image of a signature (actual signature converted to electronic image)
    c. Button, PIN, Biometric or Token

4) I acknowledge that if it is suspected that the electronic signature provided is not authentic, this could result in delays in payment or referrals being made to the Office of the Inspector General for an investigation into possible Medicaid fraud.

Printed Name: _____ Date: _____
Signature: _____ Date: _____

I (PDS Representative/Participant/Legal Guardian) _____ authorize this individual to utilize the electronic signature as stated above and release New Vista of the Bluegrass from any liability associated with misuse of the electronic signature.

Signature: _____ Date: _____

Participant Directed Services (PDS) Employment
CPR / First Aid Acknowledgement Form

I, _____ *(Participant, or Designated PDS Representative)*, am providing this acknowledgment as part of the employment documentation for _____ *(Prospective PDS Employee Name)* to be a PDS employee.

ACKNOWLEDGEMENT
I, as the PDS employer and/or my PDS representative, have the right to determine any training requirements my PDS employee must meet above and beyond what is required by the Department for Medicaid Services. I choose to waive the recommended CPR/First Aid certification for the prospective PDS employee named above. In doing so, I acknowledge that: ☑ The Department for Medicaid Services recommends CPR/First Aid certification as a component of PDS employee requirements within six (6) months of hire. ☐ There are potential health, safety, and welfare risks of employing a PDS employee without requiring the recommended CPR/First Aid certification. I am fully informed of my rights and responsibilities as a PDS employer and accept the risk and potential adverse outcomes associated with waiving the recommended CPR/First Aid certification for this prospective PDS employee.

Signature of Participant or PDS Representative	Date of Signature (month, day, year)
Printed or Typed Name of Participant or PDS Representative	
Participant Name	Medicaid ID Number

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Date

All parties agree that Michelle P waiver PDS employee _____ will not provide transportation for participant _____. If employee were to start providing transportation as a part of PDS services, a valid auto insurance card would need to be submitted to Support Broker/Case Manager in advance.

Participant/Guardian: _____ Date: _____

PDS Representative: _____ Date: _____

Support Broker/Case Manager: _____ Date: _____