

Consumer Directed Services
Wage and Benefits Plan
Employee Compensation

Employee Name (Last, First, Middle Initial)		Social Security No.
Date of Hire	First Date of Work	<input type="checkbox"/> Initial Wage and Benefit Plan <input type="checkbox"/> Plan Change – Effective Date:

Name of Program Service Being Provided: _____

Compensation:

Regular Hourly Wage

Employee = \$ _____

Respite = \$ _____

Calculation of Overtime Hourly Wage

Hourly \$ _____ + \$ _____ (50%) = \$ _____

Hourly \$ _____ + \$ _____ (50%) = \$ _____

Benefits: *Optional*

Hepatitis B Vaccination (Attach completed Form 1727 if vaccination is requested by the employee.)

Employer: List other optional benefits here. (Attach additional sheet, if required.)

Withholdings:

W-4 Employee's Withholding Allowance Certificate (Attach completed Form W-4.)

Required Garnishments

Type:	Amount:
Frequency:	Payment To:

Voluntary Withholdings (not related to W-4)

Type:	Amount:
Frequency:	Payment To:

Other (specify): _____

Acknowledgement/Agreement:

Time Sheets/Service Delivery Logs must be completed accurately each work shift/day. Payment for services delivered is made from state and/or federal funds. Falsification of a time sheet is considered fraud and is punishable under the law.

Accurate, signed time sheets are due: _____

Paychecks are distributed by (method): _____ at least twice a month on _____
or every other week starting _____

Employee and employer mutually agree to the compensation, benefits, withholdings and all information above and agree that any changes or revisions must be documented and provided to the employee, the employer and the Financial Management Services Agency.

Signature - Employer or Designated Representative Date Signature - Employee Date