IMAGINE ENTERPRISES

2025 New Hire Packet

All documents are required unless stated otherwise. The new hire cannot be processed and eligible to start working until all documents are received.

____ Current and valid Driver's License (**REQUIRED FOR BACKGROUND CHECK**)

____ Social Security Card (**REQUIRED FOR BACKGROUND CHECK**)

____ Auto Liability Card (if providing transportation)

____ either a VOIDED check or bank document that verifies the account and routing number if they want direct deposit

ALL signatures must be real signatures. A typed signature cannot be accepted

HHSC/Imagine Enterprises Documents

**** PLEASE FILL OUT ALL SECTIONS OF THE DOCUMENTS.**
Failure to do so will delay the process and require the documents to be sent back for corrections. The form title will be in the upper right-hand corner**

___Form 1725 & DPS Form

___Form 1727 (2 pages total)

___ Form 1728

___ Form 1729

___ Form 1730

___ Form 1731

___ Form 1732

___ Form 1732-EMR

___ Form 1733 (2 pages total)

___ Form 1734 (3 pages total)

___ Form 1737 (2 pages total)

___ Form 1739

___ I-9

___ W-4

___ Relationship Disclosure Form

___ Employee Certification Form

___Direct Deposit Form

___Electronic W-2 Form

Please scan in Black and White to reduce size before emailing

- * Use an Employee Application if your family is unfamiliar*
- Please ask your Employer Services Manager for this document

THIS FORM IS NOT TO BE USED AS A CONSENT/AUTHORIZATION FORM.
Agency to retain this CCH Verification Form for DPS auditing purposes.

DPS Computerized Criminal History (CCH) Verification Form

Section 1: Applicant must acknowledge the information in Section 1. Signature & date required.

Applicant Name (Print):

I acknowledge that a Computerized Criminal History (CCH) check may be performed by accessing the Texas Department of Public Safety Secure Website and may be based on name and DOB identifiers. Authority for this agency to access an individual's criminal history data may be found in Texas Government Code 411, Subchapter F https://statutes.capitol.texas.gov/.

Name-based information is not an exact search and only fingerprint record searches represent true identification to criminal history record information (CHRI), therefore the organization conducting the criminal history check is **not** allowed to discuss with me any CHRI obtained using the name and DOB method.

Optional Only: If the agency directly requests that I also have a fingerprint search performed to clear any misidentification based on the result of the name and DOB search, I can make an appointment with the Fingerprint Applicant Services of Texas (FAST) by visiting the Crime Records General Information | DPS (texas.gov) *Review of Personal Criminal History* or call the DPS Program Vendor at 1-888-467-2080, submit a full and complete set of fingerprints, request a copy be sent to the agency listed below, and pay a fee of $25.00 to the fingerprinting services company. Once this process is completed the information on my fingerprint criminal history record may be discussed with me.

Applicant Signature:	Date:

Sign and date to acknowledge the statement above.

Section 2: Agency use only. Must be completed by authorized personnel conducting search.

Agency Name:	**Imagine Enterprises**
Authorized Searcher:	
Signature of Authorized Searcher:	
Date of Search:	

Section 3: Agency use only. Name Based CHRI /CCH Tracking information. Check all that apply.

Purpose for CHRI Search.	■ Applicant ☐ Volunteer ☐ Contractor ☐ Other:
Is any part of CHRI stored by agency?	**Reminder: DPS does not recommend storing any part of CHRI.** ■ NO, CHRI is not stored by agency. ☐ YES, CHRI is stored by agency.
CHRI Retention Period	☐ Temporarily Only ☐ Annual ■ None Stored/Saved ☐ Other:
CHRI Storage Method	■ Physical/Printed (paper copy) ☐ Digital/Electronic (on device/computer)
CHRI Retention Purpose	Explain: **FMSA provide results to employer verbally, then destroyed**
Date CHRI Destroyed	**Reminder: CHRI must be destroyed after authorized purpose has ended.**
Destruction Method	Explain: **Shred**

CHRI + Audit Resources (CJIS Launch Pad) link

TEXAS Health and Human Services

Form 1725
March 2023

Consumer Directed Services

Criminal Conviction History and Registry Checks

The applicant is a person under consideration for hire as a service provider in the CDS option (employee or independent contractor [when required]). This form covers only criminal history conviction history and registry checks.

Note: An applicant may not be hired by the CDS employer, and must not start providing services for payment, until and unless the required criminal history and registry checks are conducted, in addition to other employee qualification checks. The CDS employer and Financial Management Services Agency (FMSA) review the results of all required qualification checks to determine that an applicant can be hired. This form is signed by the FMSA.

Section I - Applicant Authorization and Acknowledgment (Applicant must complete this section.)

I, (applicant's printed name) _____, give my permission to check for a criminal conviction history, to check the required registries annually, and to check the state and federal lists of people and entities excluded from participation in Medicaid (LEIE) monthly as part of my application as a service provider through the Consumer Directed Services (CDS) option. I also understand that a criminal conviction or a registry listing that prohibits a person from employment in a health care setting in the state of Texas may prohibit my employment.

I understand I may not begin delivering services until the FMSA and Employer confirm that I meet all qualifications to be hired.

Applicant Information Required by the Texas Department of Public Safety (DPS) (Applicant must complete this section.)

Individual's Name (Last, First, Middle)	Alias	Maiden Name

Date of Birth (mm/dd/yyyy)	Social Security No.

_____ _____

Signature - Applicant | Date

Section II - Criminal Conviction History Check and Registry Verification Process (Employer must complete this section.)

Individual's Name	Employer Name

Criminal Conviction History Check (Check each box to certify agreement):

☒ I request that my FMSA obtain a **current** Criminal Conviction History Check of the applicant from DPS. I authorize the FMSA to be reimbursed for the cost of obtaining the DPS Criminal Conviction History Check and if I request the report, the cost of sending the report from my budgeted funds.

☒ I understand that if I request the report, the FMSA must send it to me through a secure method, DPS approved encrypted software or certified mail.

☒ I understand that all criminal records and reports obtained by my FMSA, and the information they contain, are confidential information.

☒ I understand all DPS criminal history information reports must be destroyed five days after I make the hiring decision. Paper records need to be shredded, pulped or burned. For electronic records, destroying the media or using specialized software to copy over the data are acceptable methods.

☒ I understand that sharing of criminal history information with any person or agency may be prosecuted as a Class A Misdemeanor.

☒ I understand I may not allow the applicant to begin delivering services until the FMSA and I confirm the applicant meets all qualifications to be hired.

_____ _____

Signature - Employer | Date

Registry Check

☒ I request that my FMSA obtain the applicant's status with the Employee Misconduct Registry and the Nurse Aide Registry initially and annually.

☒ I understand that the FMSA will screen the applicant initially and monthly using both the state and federal lists of excluded individuals and entities (LEIE).

☒ I also understand that the applicant cannot provide services and cannot be paid with program funds until the criminal history and registry checks are completed and my FMSA has notified me that the applicant meets the qualifications.

_____ _____

Signature - Employer | Date

Consumer Directed Services

Occupational Exposure to Bloodborne Pathogens

Universal Precautions

Blood has long been recognized as a potential source of pathogenic microorganisms that may present a risk to individuals who are exposed during the performance of their duties. Universal precautions is the method of control required by the Occupational Safety and Health Administration (OSHA) to protect employees from exposure to all human blood and body fluids. **Universal precautions** refers to a concept of bloodborne disease control, which requires that all human blood and certain human body fluids be treated as if known to be infectious for HIV (the virus that causes AIDS), the Hepatitis B virus and other bloodborne pathogens.

Protective barriers reduce the risk of exposure to blood, body fluids containing visible blood and other fluids to which universal precautions apply. Examples of protective barriers include gloves, gowns, masks and protective eyewear. Universal precautions are intended to supplement rather than replace recommendations for routine infection control, such as hand-washing and using gloves to prevent gross microbial contamination of hands. Universal precautions will be used during the provision of services as applicable and appropriate.

Employee Initials: _____ Date: _____

Hepatitis B

Hepatitis B is a serious infection involving the liver. Hepatitis B virus (HBV) can cause lifelong infection, cirrhosis (scarring) of the liver, liver cancer, liver failure and death. Hepatitis B is spread when blood or body fluids from an infected person enters the body of a person who is not infected. HBV is a major infectious occupational hazard for health care. Any health-care worker may be at risk for HBV exposure depending on the tasks that he or she performs. Workers should be vaccinated if their tasks involve contact with blood or blood-contaminated body fluids.

Employee Initials: _____ Date: _____

Hepatitis B Vaccination

OSHA standards effective June 4, 1992, require that employers make available the Hepatitis B vaccine and vaccination series to all employees who have occupational exposure. The Hepatitis B vaccine is available at no cost to the employee. The cost to provide vaccinations is an administrative expense to the employer and is reimbursable through the individuals's program budget.

The vaccine is administered in a prescribed series of three injections over a six-month period:

Dose 2 is administered 30 days after Dose 1.

Dose 3 is administered five months following Dose 2.

The employee is responsible for requesting from the healthcare provider administering the vaccination additional information specific to the efficiency, safety, benefits, method of administration and potential side effects of the Hepatitis B vaccination.

The employee may elect to **receive** or **decline** the Hepatitis B vaccination.

Employee Initials: _____ Date: _____

Informed Choice Related to Hepatitis B

Vaccination Employee Statement – Check ONLY one statement below.

☐ I **agree** to receive the Hepatitis B vaccination and will be reimbursed by my employer within 30 days of presenting a paid receipt for each dose. I understand that I will only be reimbursed for doses received while employed by the employer.

☐ I **agree** to receive the Hepatitis B vaccination and the employer and I have agreed to the following arrangement(s) related to covering the cost of the vaccination:

Choose 1 option

Employers: if you do not have reimbursement for the Hep B vaccine in your budget, please have the employee's select one of the declining options

☐ I **decline** the Hepatitis B vaccination at this time because I have previously received the Hepatitis B vaccination.

☐ I **decline** the Hepatitis B vaccination.

*** I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine at this time. However, I decline the Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.**

Federal Register: 61 FR 5507, February 13, 1996
*OSHA 1910.1030 App A - *Mandatory Declination Statement*

Certification by Employee

I, , the **employee**, acknowledge and certify that I have received information on occupational exposure to bloodborne pathogens, universal precautions, Hepatitis B and Hepatitis B vaccination. I have been provided the opportunity to ask questions and to seek additional information. I have made my choice (as documented above) related to the Hepatitis B vaccination based on informed choice.

* I may decide in the future to request and accept the vaccination at no charge to me.

Employee:	**Employer:**
X _____	X _____
Printed Name	Printed Name
X _____	X _____
Signature	Signature
_____	_____
Date	Date

Consumer Directed Services

Liability Acknowledgement

Liability Acknowledgement Between the Employer and the Applicant for Employment

The person who receives services or the person's legally authorized representative (LAR) is the employer in the Consumer Directed Services (CDS) option.

The employer hires, manages and terminates service providers employed as employees. The employer is solely responsible and liable for any negligent acts or omissions by the employer, the employee, other service provider(s) or contractors, the person who receives services, and if applicable, the employer's designated representative.

Employees or service providers are **not** employed or retained by the Texas Health and Human Services Commission (HHSC), any other state or federal governmental agency or by the Financial Management Services Agency (FMSA).

As an applicant for employment through the CDS option, I acknowledge I have read and understand the above information about the employer and employee liability.

X _____ _____ X _____ _____

Signature – Employer
The employer must sign

Date

Signature – Applicant for Employment

Date

Liability Notice to Applicants for Employment

Section I

EMPLOYER'S MUST SELECT 1 OPTION FROM BELOW

The employer:

☐ **is** a subscriber of Texas Workers' Compensation through the Texas Department of Insurance, Division of Workers' Compensation.

☐ **is not** a subscriber of Texas Workers' Compensation through the Texas Department of Insurance, Division of Workers' Compensation. Employer completes Section II if this option applies.

Section II

Employer checks the correct option if the employer is not a subscriber to Texas Workers' Compensation.

☐ I have made the following arrangement(s) for employee work-related injuries or illnesses:

- ☐ self-insurance,
- ☐ homeowner's personal liability insurance,
- ☐ renter's personal liability insurance,
- ☐ medical coverage insurance,
- ☐ risk pool insurance,
- ☐ other: _____

☑ I have **no** insurance or other protection against employee work-related injuries or illnesses for my employee(s).

Acknowledgement by Employer and Applicant for Employment

I acknowledge I have read and understand the information in Section I and in Section II.

X _____ _____ X _____ _____

Signature – Employer
The employer must sign

Date

Signature – Applicant for Employment

Date

TEXAS Health and Human Services

Form 1729
July 2024

Consumer Directed Services

Applicant Verification for Employees

Person's Name	Employer Name
X	X
Applicant's Name	**Applicant Social Security No.**
X	X

The employer must verify the applicant meets each criterion. The employer must ensure the following forms or copies of documentation used to verify the criteria are valid and kept in the employee's personnel file. This form and supporting documentation **must** be sent to the Financial Management Services Agency (FMSA) for verification before the employer can hire the applicant.

Employment Qualifications

- ☐ The applicant is at least 18.
- ☐ The applicant is not disqualified based on a Yes response on Form 1734, Service Provider and Employer Certification of Relationship Status for CDS.
- ☐ The applicant is not barred from employment based on the results of the Texas Department of Public Safety (DPS) criminal conviction history check, the Texas Health and Safety Code Chapter 250 registry checks, or the Medicaid exclusion list (Form 1725, Criminal Conviction History and Registry Checks).
- ☐ The applicant has completed Form 1728, Liability Acknowledgement.
- ☐ The applicant has read Notice Concerning Workers' Compensation in Texas (TWC Notice 5).
- ☐ The applicant has current cardiopulmonary resuscitation (CPR) and first aid certification for Medically Dependent Children Program (MDCP) flexible family support and respite services.
- ☐ The applicant has current hands-on CPR, first aid and choking prevention certification, if providing services in the Deaf Blind with Multiple Disabilities (DBMD) Program.
- ☐ The applicant has the following educational qualifications if providing services for DBMD, Home and Community-based Services (HCS), MDCP, Texas Home Living (TxHmL) or Community First Choice (CFC):
  - a high school diploma or a certificate recognized by a state as the equivalent of a high school diploma; or
    - documentation of a proficiency evaluation of the employee's experience and competence to perform job tasks, including an ability to provide the services needed by the individual, as demonstrated through a written competency-based assessment; and
    - at least three personal references from people not related by blood who evidence the person's ability to provide a safe and healthy environment for the person.
- ☐ The applicant has the following qualifications if providing services for DBMD:
  - is fluent in the communication methods used by the person, such as American Sign Language, tactile symbols, communication boards, pictures and gestures or has the ability to become fluent in the communication methods used by the person within three months after working with the person.

FMSA Certification

The applicant ◯ **does** ◯ **does not** meet qualifications for employment. Only applicants who meet all qualifications may be employed.

Acknowledgement

Employer signs only

The applicant and employer acknowledge the applicant meets the qualifications for employment and that a copy of this form must be submitted to the FMSA. The FMSA must verify the applicant's qualifications before the employer offers employment to the applicant.

X

Signature — Employer	Date	Signature — FMSA	Date

TEXAS Health and Human Services

Consumer Directed Services

Wage and Benefits Plan Employee Compensation

Form 1730
October 2013-E

Employee Name *(Last, First, Middle Initial)*		Social Security No.
Date of Hire **FMSA WILL COMPLETE**	First Date of Work **FMSA TO COMPLETE**	☐ Initial Wage and Benefit Plan ☐ Plan Change – Effective Date: _____
Name of Program Service Being Provided **HCS OR TXHML**		

Compensation

Regular Hourly Wage		**Calculation of Overtime Hourly Wage**				
☐ Employee =	_____	Hourly _____	+	_____	(50%) =	_____
☐ Respite =	_____	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.)*

None

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)*: _____

Acknowledgment or 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: see current pay rate chart

Paychecks are distributed by *(method)*: paper check or ACH at least twice a month on see current pay rate chart

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.

X _____ **Signature — Employer or Designated Representative** _____ **Date**

X _____ **Signature — Employee** _____ **Date**

TEXAS Health and Human Services

Form 1731
January 2007-E

Consumer Directed Services

Employee Work Schedule and Assigned Tasks

Employee Name: _____

Purpose of Form:
- ☑ Initial
- ☐ Change

Activity Involved:
- ☑ Tasks
- ☑ Schedule

Effective Date FMSA ONLY: _____

Schedule I **WRITE SCHEDULE BELOW**

Day	Time In	Time Out	Time In	Time Out	Time In	Time Out	Total Hours
Sunday							
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							
						Weekly Total Hours	

Schedule I - Tasks the employee will provide. MUST BE WRITTEN

Schedule II

Day	Time In	Time Out	Time In	Time Out	Time In	Time Out	Total Hours
Sunday							
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							
						Weekly Total Hours	

Schedule II - Tasks

Acknowledgment of Work Schedule and Assigned Tasks - Sign and Date:

X _____ _____

Signature — Employer Date

X _____ _____

Signature — Employee Date

TEXAS Health and Human Services

Form 1732
October 2024

Consumer Directed Services

Management and Training of Service Provider

FMSA will complete due date

Service Provider, Employee Name X	First Day of Work	Annual Evaluation Due Date
Client Name	Program **HCS OR TxHmL**	Services Delivered
Consumer Directed Services Employer Name		

I. Purpose

☒ Initial Orientation ☐ Ongoing Training

☐ Evaluation

☐ 30-Day ☐ Three-Month ☐ Six-Month ☐ Annual ☐ Other _____

☐ Supervision

☐ Verbal Warning: ☐ First ☐ Second ☐ Third ☐ Other _____

☐ Written Warning: ☐ First ☐ Second ☐ Third ☐ Other _____

☐ Conflict Resolution ☐ Other _____

II. Documentation of Topics Covered at Initial Orientation or Ongoing Training

Initial orientation must include training related to the person's condition, the tasks the service provider will perform and any required training described in an applicable addendum to Form 1735, Employer and Financial Management Services Agency Service Agreement.

EVV DATE:_____ LIST ALL TASKS EMPLOYEE HAS BEEN TRAINED ON/WILL PROVIDE TO CLIENT BELOW:

X

III. Documentation of Abuse, Neglect and Exploitation Training

Initial orientation must include training on acts that constitute abuse, neglect or exploitation of a person.

Employer and Employee reviewed ANE handout:_____ (Employee Initials)

IV. Evaluation or Performance Review

V. Corrective Action Plan if applicable

Date for follow-up on corrective action plan: _____

VI. Service Provider Comments

X _____ Service Provider Signature _____ Date

This document has been reviewed with the service provider listed above.

X _____ Employer Signature _____ Date _____ Witness Signature _____ Date

Date sent to FMSA _____ **Date received by FMSA** _____

Consumer Directed Services (CDS)

Management and Training of Service Provider Addendum

Employee Misconduct Registry Notification

Employee Name: _____ Date of Hire: **To be completed by FMSA**

Position: _____ Employer Name: _____

Long-term care employers in Texas, including Consumer Directed Service (CDS) employers, are required under 26 Texas Administrative Code (TAC), Part 1, Chapter 711 and Texas Health and Safety Code Chapter 253 to inform new unlicensed employees about the Employee Misconduct Registry (EMR).

The purpose of the EMR is to make sure an unlicensed person who commits an act of abuse, neglect or exploitation that meets the definition of reportable conduct against a consumer receiving services from a facility or against a person receiving services in the CDS option is not employed in the Texas Health and Human Services Commission (HHSC) regulated facilities and in certain programs including CDS. The EMR applies to employees who provide personal care services, treatment or any other personal services and are not licensed by the state to perform the services.

A person listed in the EMR is not employable by a facility, agency or individual employer. The EMR is governed by 26 TAC, Part 1, Chapter 711 and Texas Health and Safety Code Chapter 253. Regarding a CDS employee, the Department of Family and Protective Services (DFPS) conducts EMR investigations and makes findings per DFPS rules at 40 TAC, Part 19, Chapter 705, Subchapter O.

Rules about the EMR are on the Secretary of State's website at:
https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=40&pt=19&ch=705&sch=O&rl=Y
.

Questions may be directed to HHSC Professional Credentialing Enforcement Unit at 409-667-3081.

The employer must provide the employee with a copy of this notice.

I, _____, have read and understand the above notification.
Printed Employee Name

_____ _____
Employee Signature Date

TEXAS
Health and Human Services

Form 1733
January 2018-E

Employer and Employee Acknowledgement of Exemption from Nursing Licensure for Certain Services Delivered through Consumer Directed Services

The employer in the Consumer Directed Services (CDS) option is the individual receiving services or the individual's legally authorized representative (LAR). The employer may choose to have certain nursing services provided by an unlicensed person employed in the CDS option. The individual or the LAR must be capable of training the unlicensed employee in the performance of the task(s) and train and supervise the employee performing the task(s). The employee who delivers the service must not have been denied a license under Chapter 301, Occupations Code or have a license under Chapter 301, Occupations Code that is revoked or suspended.

When the employee is trained and supervised by the LAR, the employee delivers the service when the LAR is present or is immediately accessible to the employee. If the employee will perform the service when the LAR is not present, the LAR must observe the person performing the service at least once to assure the LAR that the employee performs the service correctly.

Government Code, Title 4, Subtitle I, Chapter 531, Subchapter B, Section 531.051, Consumer Direction for certain services for persons with disabilities, states the employee must not perform those service that are expressly prohibited from delegation by the **Texas Board of Nursing (*Texas Administrative Code, Section 225.13,Tasks Prohibited From Delegation),*** including***:***

1. physical, psychological, and social assessment, which requires professional nursing judgment, intervention, referral, or follow-up;
2. formulation of the nursing care plan and evaluation of the client's response to the care rendered;
3. specific tasks involved in the implementation of the care plan that require professional nursing judgment or intervention;
4. the responsibility and accountability for client or client's responsible adult health teaching and health counseling which promotes client or client's responsible adult education and involves the client's responsible adult in accomplishing health goals; and
5. the following tasks related to medication administration:
    A. calculation of any medication doses except for measuring a prescribed amount of liquid medication and breaking a tablet for administration, provided the RN has calculated the dose;
    B. administration of medications by an injectable route except for subcutaneous injectable insulin as permitted by Section 225.11(b) of this title (relating to Delegation of Administration of Medications From Pill Reminder Container and Administration of Insulin);
    C. administration of medications by way of a tube inserted in a cavity of the body except as permitted by Section 225.10(10) of this title (relating to Task That May Be Delegated);
    D. responsibility for receiving or requesting verbal or telephone orders from a physician, dentist, or podiatrist; and
    E. administration of the initial dose of a medication that has not been previously administered to the client.

Examples of services that may be exempt from nursing licensure and can be included in the Individual Service Plan for the CDS option if all the qualifying conditions are met include:

1. bathing, including feminine hygiene;
2. grooming, including nail care, except for individuals with medical conditions like diabetes;
3. feeding, including feeding through a permanently placed feeding tube;
4. routine skin care, including decubitus Stage 1;
5. transferring, ambulation or positioning;
6. exercising and range of motion; and digital stimulation;
7. the administering of a bowel and bladder program, including suppositories, catheterization, enemas, manual evacuation and digital stimulation;
8. administering oral medications that are normally self-administered, including administration through a gastrostomy tube; and
9. non-invasive and non-sterile treatments with low risk of infection.

Employee:	Employer:
X Printed Name Date X Signature	X Printed Name Date X Signature

Certification – We, the employee and the employer, certify that the employer has trained and supervised the employee in the delivery of the services listed below. We understand that those services that cannot be provided by anybody except a licensed nurse, according to Texas Administrative Code, Section 225.13, **Tasks Prohibited From Delegation**, must not be provided by the employee. Checked tasks indicate the employee may perform those tasks when the LAR is not present to supervise.

- ☐ WRITE TASKS IN FROM FORMS 1731 and 1732.
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐

TEXAS Health and Human Services

Form 1734
February 2025

Consumer Directed Services (CDS)

Service Provider and Employer Certification of Relationship Status

Section 1 – Service Provider Applicant's Information

Service Provider Applicant Name		Maiden Name, if applicable	
Applicant Street Address	City	State	ZIP Code
Person Receiving Services	CDS Employer Name, if different than person receiving services		
Person Receiving Services Street Address	City	State	ZIP Code
Applicant's Relationship to Person Receiving Services	Designated Representative (DR), if applicable		
Applicant's Relationship to CDS Employer	Applicant's Relationship to DR		

Section 2 – Service Provider Applicant's Status and Relationship

The Service Provider Applicant must answer the following questions.

1. Are you younger than 18?	◯ Yes ◯ No
2. Are you the person's legally authorized representative (LAR)? That is, the person's natural parent, legal or adopted parent, stepparent or managing conservator if the person is a minor younger than 18 or the court-appointed guardian of a person of any age.	◯ Yes ◯ No
3. Are you the spouse* of the person's LAR? That is, the spouse of the person's natural parent, legal or adopted parent, stepparent or managing conservator if the person is a minor younger than 18 or the spouse of the court-appointed guardian of a person of any age.	◯ Yes ◯ No
4. Are you the spouse* of the person? Consumer Managed Personal Attendant Services (CMPAS) service providers mark not applicable.**	◯ Yes ◯ No ● Not applicable
5. Are you the spouse* of the employer? CMPAS service providers mark not applicable.**	◯ Yes ◯ No ● Not applicable
6. If the person is a Texas Department of Family and Protective Services (DFPS) foster child or adult, are you their foster parent? If the person is not a DFPS foster child or adult, mark not applicable.	◯ Yes ◯ No ● Not applicable
7. If the person is a DFPS foster child or adult, are you the spouse* of the foster parent? If the person is not a DFPS foster child or adult, mark this item not applicable.	◯ Yes ◯ No ● Not applicable
8. Are you the power of attorney, attorney in fact or agent for financial responsibilities on behalf of the person?	◯ Yes ◯ No
9. Are you the DR or the CDS employer for the person?	◯ Yes ◯ No
10. Are you the spouse* of the employer's DR?	◯ Yes ◯ No

* **Spouse** is defined as either a legal marriage or a marriage without formalities, a common law marriage, per the Texas Family Code.

** The spousal relationship is not applicable in CMPAS for questions 4 and 5. The spouse may be employed.

Section 3 – MDCP Applicant's Status and Relationship

If providing services in the Medically Dependent Children Program (MDCP) program, answer the following questions. Mark **not applicable**, if the person is not enrolled in MDCP.

1. Are you the parent or primary caregiver of the person?	◯ Yes ◯ No ◯ Not applicable
2. Are you the spouse* of the parent or primary caregiver?	◯ Yes ◯ No ◯ Not applicable

Section 4 – HCS and TxHmL Applicant's Status and Relationship

If providing Community First Choice Personal Assistance Services or Habilitation (CFC PAS/HAB), respite, adaptive aids or behavioral support services in the Home and Community-based Services (HCS) and Texas Home Living (TxHmL) program, answer the following questions, as applicable. Mark **not applicable**, if the person is not receiving an applicable HCS or TxHmL service.

1. Do you live in the same household as the person receiving services? Applies to CFC PAS/HAB and respite services.	◯ Yes ◯ No ◯ Not applicable
2. Are you related to the person within the fourth degree of consanguinity or within the second degree of affinity? Applies to adaptive aids and behavioral support services.	◯ Yes ◯ No ◯ Not applicable

Section 5 – CLASS Respite Applicant's Status and Relationship Service Providers Only

If providing respite services in the Community Living Assistance and Support Services (CLASS) program **and the primary caregiver is the CFC PAS/HAB applicant**, answer the following additional question. Mark this item **not applicable** if the person is not receiving CLASS respite services. Also mark this item **not applicable** if the person is receiving CLASS respite services, but the primary caregiver is not the CFC PAS/HAB service provider.

1. Do you live in the same household as the person?	◯ Yes ◯ No ◯ Not applicable

Section 6 – PHC, CAS and FC Applicant's Status and Relationship

If providing Primary Home Care (PHC), Community Attendant Services (CAS) and Family Care (FC), answer the following questions. Mark **not applicable**, if the person is not enrolled in PHC, CAS or FC.

1. Are you the primary caregiver for the person?	◯ Yes ◯ No ◯ Not applicable
2. Are you the spouse* of the primary caregiver for the person?	◯ Yes ◯ No ◯ Not applicable

Section 7 – Employer and Service Provider Applicant Verification

If any item above is marked **Yes**, the applicant is **not eligible** to be a paid employee, contractor or vendor, in the CDS option for this person.

If every item above is marked **No** or **Not applicable**, the applicant meets relationship eligibility for employment in the CDS option for this person, unless contraindicated by requirements of the person's program. **Not applicable** only applies where indicated. The employer and the applicant certify that the responses are accurate.

Employer confirmation and acknowledgement: As the CDS employer, I confirm that the information provided on this form is true and correct to the best of my knowledge. I understand that an applicant cannot be paid to provide services if they are not eligible for employment.

X _____ X _____ _____

Printed Employer Name **Signature – Employer** **Date**

Applicant confirmation and acknowledgement: As the applicant, I confirm that the information provided on this form is true and correct to the best of my knowledge. I understand that I cannot be paid for providing services if I am not eligible for employment.

X _____ X _____ _____

Printed Service Provider Applicant Name **Signature – Service Provider Applicant** **Date**

TEXAS Health and Human Services

Form 1737
September 2013-E

Consumer Directed Services

Employer and Employee Service Agreement

The name of individual receiving services, hereafter referred to as the "**Individual**," is:

Client Name: _____ .

The Individual's program, **Client's Program (circle one): HCS TxHmL** , hereafter referred to as the "**program**," is funded and administered by the Texas Health and Human Services Commission (HHSC).

The name of the employer, hereafter referred to as "**Employer**" is: _____ .

The Employer is the ☐ Individual, ☐ parent of a minor or ☐ court-appointed guardian of the Individual.

This agreement is between the Employer and **Employee Name:** _____

hereafter referred to as "**Employee**."

The Employer Agrees:

1. **To give notice to the Employee as soon as possible of any change(s) in the work schedule, the tasks to be performed or the number of hours the Employee will work.**
2. To adhere to all federal, state, and local employment-related laws and regulations.
3. To assume responsibility for:
   a. liability for any negligent acts or omissions by the Employer, his/her Employee(s) and service provider(s), the Designated Representative (if applicable), the Individual or others in the work place; and
   b. managing the risk and liability of any incidence(s) of Employee work-related injury/injuries or illnesses.
4. To provide orientation and training to the Employee of tasks and activities to be performed.
5. To provide the Employee with written notice of compensation for services delivered.

The Employee Agrees: Employee Name

1. I, _____ the Employee, am willing and able to perform the tasks as outlined by, and at the direction of, the Employer, the Individual or the Designated Representative, if applicable.
2. To provide information and documents to the Employer, as required, to maintain current, up-to-date personnel records. The information and documents include at least changes in address and/or telephone numbers, criminal convictions and evidence of employment status and qualifications.
3. To not use the personal property of the Employer or the Individual without prior approval. The Employee will reimburse the Employer for any expense incurred related to his/her personal use of the personal property.
4. To respect the rights and dignity of the Individual and to follow safety procedures for the benefit of the Individual and the Employee.
5. To notify the Employer as soon as possible when the Employee will be late for work or is not able to work, as well as not report to work when illness or another condition may jeopardize the health and safety of the Individual.

Both the Employer and the Employee Agree:

1. That this document serves as an agreement, not an employment contract.
2. That the Employer employs the Employee. The Employee is not an independent contractor. The Employer controls the training and management, evaluation and firing/termination of the Employee.
3. That the Employee is not barred by relationship to the Individual, Employer or Designated Representative, if applicable, from being an Employee.
4. That a Financial Management Services Agency (FMSA) is responsible for the administration of program funds on behalf of the Employer, including payroll functions.
5. That funds for services to pay the Employee is from public sources, and financial accountability and liability applies to the use of the funds. Both the Employer and the Employee have an individual and joint responsibility to be accountable for the public funds spent through the Consumer Directed Services (CDS) option and understand that submitting false or fraudulent time sheets, submitting a time sheet of an unqualified service provider, submitting a time sheet for tasks other than those approved on the service plan or implementation plan will be reported to the appropriate authorities for investigation and possible prosecution as Medicaid fraud.

6. To provide an accurate accounting of services delivered by the Employee, and to submit accurate time sheets and documentation for reimbursement to the FMSA.
7. To bill only for actual time worked, allowable benefits and CDS-related expenses (billing for services and items not allowed or budgeted results in non-payment by the FMSA).
8. The Employer must not charge any fee to the Employee. The Employee must not make any payment to the Employer related to the Employee's employment. Any corrections to payroll are made by the FMSA.
9. That neither the FMSA or HHSC is responsible or liable for any negligent acts, work-related injuries or omissions by the Employer, Individual, Employee, other Employees and service providers and/or the Designated Representative, if applicable.
10. That personal medical and personal information and data about the Individual and the Employee is confidential. This information is not to be discussed, directly or indirectly, with others outside of the work environment at any time, currently or in the future.

Duration and Modification of Service Agreement

1. This service agreement will be in effect as of the date this agreement is signed by the Employer and Employee. This service agreement must not precede the date the Individual is eligible to participate in the program or in CDS
2. This service agreement can be modified by agreement of both parties, unless prohibited by HHSC rules or policy, or by applicable state, federal and/or local regulations.
3. This service agreement will terminate when:
   a. the Individual's participation in CDS ends voluntarily or involuntarily;
   b. the individual is no longer eligible for the HHSC program or for CDS participation;
   c. the Employee is convicted of a crime or listed on a registry that forbids employment by law;
   d. a relationship change occurs and continued employment is prohibited; or
   e. the Employee fails to maintain and provide documentation of eligibility or qualifications for continued employment.
4. This service agreement may be terminated, without cause, by either party with 14-calendar days written notice. A different time frame may be used if both parties agree in writing.

FMSA WILL COMPLETE DATE OF SIGNATURE

The following required documents are incorporated by reference:

Document	Date of Signature
HHSC Form 1725, Criminal Conviction History and Registry Checks	
HHSC Form 1729, Applicant Verification for Employees	
HHSC Form 1733, Employer and Employee Acknowledgement of Exemption from Nursing Licensure for Certain Services Delivered through Consumer Directed Services, if applicable	
HHSC Form 1734, Applicant and Employer Certification of Relationship for Employment	

Acknowledgement of service agreement, including documents incorporated by reference:

Employer:

X _____
Printed Name

X _____
Signature

_____
Date

Employee:

X _____
Printed Name

X _____
Signature

_____
Date

TEXAS Health and Human Services

Consumer Directed Services
Service Provider Agreement

Form 1739
October 2013-E

This agreement is between the **Texas Health and Human Services Commission** (HHSC), the state Medicaid agency; a **Financial Management Services Agency** (FMSA); and a **service provider** providing services to one or more individuals through the Consumer Directed Services (CDS) Option.

The **service provider,** Employee name: _____ ☒ an individual or

☐ an entity, located at (Address) Employee address _____,

_____; Telephone Employee's _____ Fax _____

The service provider agrees to:

- provide services, items or goods that are authorized prior to purchase to individuals in home and community support programs in accordance with program rules and policy;
- keep records of purchased services, items and goods in accordance with program rules and policy;
- accept checks from the FMSA as full and complete payment for authorized services, items or goods purchased for individuals served through home and community-based programs;
- neither impose on or accept from individuals any additional charges for the services, items or goods paid for by the check; and
- provide records and other information upon request to the individual, the FMSA, HHSC, or their representative.

The FMSA and HHSC agree:

- that the FMSA will pay the service provider for services, items or goods provided to the individual in accordance with this agreement and program rules and policy; and
- to allow the service provider to charge the individual for approved upgrades or purchases not authorized or paid for in accordance with this agreement, program rules and policy.

The service provider, FMSA and HHSC mutually agree that:

- the FMSA Imagine Enterprises, doing business in Seabrook, Texas, provides financial management services (FMS) to the individual receiving services for purchases from the service provider;
- the FMSA is responsible for acquiring the completed agreement and retaining the original on behalf of HHSC;
- payment from the FMSA will not be issued prior to the receipt of this agreement by the FMSA;
- payment from the FMSA is funded by HHSC with government funds; and
- the FMSA is not a Texas or federal government agency.

This agreement is effective _____, and terminates when the service provider is no longer providing services to individuals through the FMSA. FMSA WILL COMPLETE EFFECTIVE DATE

X _____	X _____	_____
Service Provider or Representative* (Print)	Service Provider or Representative* (Signature)	Date
_____	_____	_____
FMSA Representative* (Print)	FMSA Representative* (Signature)	Date

** If the service provider is an entity, a representative from the entity with authorization to negotiate this agreement on behalf of the entity must sign.*

EMPLOYER CERTIFICATION REGARDING HIGH SCHOOL DIPLOMA, GED, OR SUBSTITUTE DOCUMENTS

For HCS & TxHmL Consumer Directed Services

PARTICIPANT NAME (Client): _____

APPLICANT NAME (Employee): _____

I _____ certify that I am **Choose 1 option below**

- ❑ The participant
- ❑ The legally authorized representative ❑ The designated representative.

I certify that I have a copy of the applicant's (Employee)

- ❑ High school diploma
- ❑ GED
- ❑ The applicant did not have either of these documents.

If the above applicant **did not** have a copy of his/her high school diploma or GED, I have obtained the following:

- documentation of a proficiency evaluation of the employee's experience and competence to perform job tasks, including an ability to provide the services needed by the individual, as demonstrated through a written competency-based assessment; and
- at least three personal references from people not related by blood that evidence the person's ability to provide a safe and healthy environment for the individual.

3 Personal References:

_____	_____
Name/Relation	Phone
_____	_____
Name/Relation	Phone
_____	_____
Name/Relation	Phone

I understand that I must keep these documents in my employee's file and produce them at the request of my case manager/service coordinator, FMSA, and any DADS or HHSC employee, including a utilization review nurse.

Employer's Signature:

X _____ DATE: _____

Imagine Enterprises
1402 Spring Cress Lane
Seabrook, TX 77586

AUTHORIZATION FOR DIRECT DEPOSIT OF EMPLOYEE PAY AND REIMBURSEMENTS

(Please print or type all information)

Employee ID#:_____

EMPLOYEE INFORMATION

Employee Name	
Address	

SECTION A: ENROLLMENT OR CHANGE AUTHORIZATION

(Complete this section for new enrollments, financial institution or account changes.) An employee may select up to a maximum of nine accounts. The employee should complete additional pages of the authorization form as needed.

SELECT ONE: ☐ New Enrollment ☐ Account Change EFFECTIVE DATE

FINANCIAL INSTITUTION INFORMATION

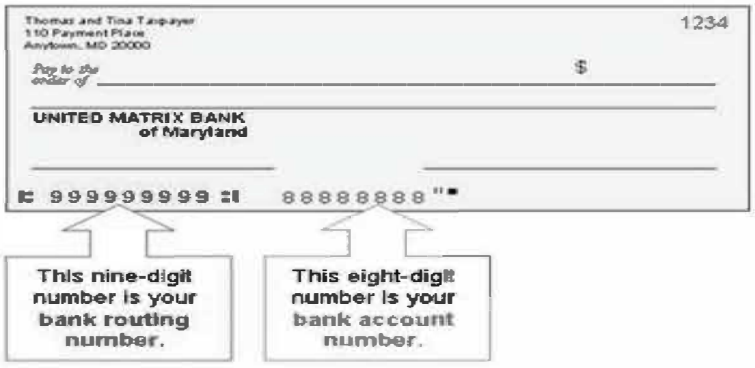
NAME		BRANCH			
CITY		STATE		ZIP	

BANK INFORMATION

See example below

ROUTING #	
ACCOUNT #	

- ◉ Checking
- ○ Savings
- ○ Issue Check



Need VOIDED check or document from bank verifying the routing & account numbers

I authorize the Imagine Enterprises to initiate accounting transactions to deposit my employee pay directly to the account(s) indicated above and to correct any errors which may occur from these transactions. I also authorize the Financial Institution to post these transactions to these accounts. This authorization is to remain in force until the Imagine Enterprises receives written notice from me to cancel or change this authorization.

X _____ EMPLOYEE SIGNATURE _____ DATE

SECTION B: CANCELLATION

(Complete this section to cancel the Direct Deposit Authorization) EFFECTIVE DATE

I hereby cancel the authorization for the Imagine Enterprises to originate direct deposit entries to my checking/savings account(s).

_____ EMPLOYEE SIGNATURE _____ DATE

IMAGINE ENTERPRISES

Employment Relationship Disclosure

X _____ X _____

Employee FEIN Holder/Employer

INSTRUCTIONS: Each employee must provide the following information about his or her relationship with the FEIN Holder (EMPLOYER) before employment begins. Complete all sections below and sign/date at the bottom of the form. This information is required to begin employment.

1. Relationship Disclosure
   Before employment, my existing relationship with the above-name FEIN Holder (EMPLOYER) is (check one):
   - o Parent (Exempt)
   - o Step Parent (Exempt)
   - o Spouse (Exempt)
   - o Child under 21 (Exempt)
   - o Sibling
   - o No relationship
   - o Other: please describe: _____

2. Relationship and Employment Acknowledgements
   - **All employees are subject to Federal and State Tax Withholdings:** I understand that regardless of my relationship with the FEIN Holder (EMPLOYER), I am subject to all employment requirements including criminal background checks and Federal and State tax withholdings.
   - **Federal and state taxation rules change frequently:** Please consult with your tax advisor if you have any questions on completion of your W-4. If you discover that you tax situation has changed during the year, you may submit a revised W-4 for withholding adjustments on future pay.
   - **Exempt Employees:** If my relationship with the FEIN Holder (EMPLOYER) indicates Exempt above, I understand I am entering into an employment relationship that is exempt from FICA (social security), Medicare, FUTA (Federal Unemployment), and SUTA (State Unemployment) and those taxes will not be withheld or applied on my paycheck.
   - **By not paying into certain taxes it means I am not earning Social Security history work credits:** When you work and pay into FICA (Social Security), you earn work credits towards Social Security benefits. If my relationship with the FEIN Holder (EMPLOYER) indicates Exempt above, I understand I will not earn Social Security work Credits.

3. Amended Payroll Taxes
   Imagine Enterprises will file all required amended payroll tax returns in instances where there have been over collected Social Security and Medicare taxes from employees' compensation. The employee will receive funds of over collected social security and Medicare taxes directly from Imagine Enterprises. These refunds will be paid to the employee in January immediately following year-end. The employee agrees that they have not, or will not, file a claim for refund of over collected Medicare or Social Security with the IRS.

You are signing this document under penalties or perjury. Information provided must match that provided on the Service Provider and Employer Certification Relationship Status HHSC Form 1734.

X _____ _____

Employee Signature Date

X _____ _____

Employer Signature Date

For more information regarding the IRS employment taxes, see page 4 of: https://www.irs.gov/pub/irs-pdf/p926.pdf

NEW SERVICE!

Receive Your W-2 Electronically

IMAGINE ENTERPRISES

Many of you already use the Employee Self-Serve Payroll Portal (ESS Portal) for online access to your payroll information. This provides better, quicker access to paycheck statements without the wait of regular mail. Plus, the online statements can be retained and retrieved electronically for multiple years.

NOW – you can sign-up to receive your annual W-2 form through the Employee Self-Serve Payroll Portal. To receive this service, you must provide your written consent.

What is a W-2? Also known as the Wage and Tax Statement, Imagine is required to send you and the Internal Revenue Service (IRS) a report of your annual wages and the amount of taxes withheld from your paychecks.

What is the Benefit of obtaining a W-2 online?
You can access the document as soon as it is uploaded to the ESS Portal.

What happens if I don't sign up for the Employee Self-Serve Payroll Portal? You will receive your W-2 through the US Mail.

Do I sign-up every year, or just once? Just once. Your written consent lasts for the duration of your employment or until you decide to withdraw your consent.

If I sign-up, can I change my mind and withdraw consent? Absolutely! Provide written notification to withdraw your consent to Imagine's Payroll Department by DECEMBER 31 of the year prior the W-2 is issued.

Complete the information below and return it to Imagine Enterprises by mail or fax:

- Mail: PO Box 2056, Alvin, TX 77512
- Fax: 866-672-6062

Questions:

Taylor Morales
Central Texas and Gulf Coast employers
832-725-0461

Janice Norwood
North and West Texas employers
325-518-1950

__ I consent to receive my W-2 electronically for the duration of my employment or until this consent is withdrawn.

X __ I DO NOT want my W-2 electronically and want to receive a printed W-2 through the US Mail.

CDS Employee Signature: _____ Date: _____

Printed Name: _____

Employer(s) – Please list if more than one: _____

Your Email Address: _____

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No.1615-0047
Expires 05/31/2027

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

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

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

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

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

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

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. An alien 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)
X	

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.

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

City or town, state, and ZIP code

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

(c)
- ☐ **Single** or **Married filing separately**
- ☐ **Married filing jointly** or **Qualifying 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)

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 2025 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income	**1**	$
2	Enter: { • $30,000 if you're married filing jointly or a qualifying surviving spouse; • $22,500 if you're head of household; • $15,000 if you're single or married filing separately }	**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.