Reset

NEW HIRE PACKET

PCA/HMK/DSP

Dear Applicant:

Thank you for taking the time to apply for our position. We appreciate your interest in Metropolitan Community Services.

To process your application / background studies we need to have the following:

- Copy of Driver's License or State ID
- Copy of Social Security Card
- If Applicable, copy of a Green Card
- If Applicable, copy of an Employment Authorization
- Copy of the voided check or Bank Letter

For PCA/HMK position:

- PCA/CFSS Certificate:
  - ✓ *Review the Individual PCA training course as often as needed*

    https://registrationcourses.dhs.state.mn.us/PCACourse/cfss/training-languages.html
  - ✓ *Register through the online training registration page to take the online test*

    https://registrationtraining.dhs.state.mn.us/?BusinessUnitID=16
  - ✓ *You may take the test as often as needed, or until successfully completed).*
  - ✓ ***To register:***
    - ➢ Check the following option: PCA/CFSS support workers: Individuals who help people with daily tasks in either PCA or CFSS
    - ➢ Click on the PCA/CFSS support workers option
    - ➢ Click the Next – Register button to open and complete the registration page and submit your registration
    - ➢ Check your email for the next steps
  - ✓ After passing the test, you will be able to print a certificate of successful completion. DHS will also send a copy of the certificate to the email address used to register for the test. Please forward a copy of the completion certificate to FrontDesk@mcsmn.com and keep a copy for your own records. If you lose your certificate, you can attempt to retrieve your certificate using the Certificate Lookup feature on the registration page. If you are unable to find your certificate, you can request a copy using the PCA certificate request form.

For DSP position:

You will be contacted by our 245D Department to complete the required training.

METROPOLITAN COMMUNITY SERVICES

7900 Excelsior Blvd. Suite 200 • Hopkins MN 55343
Phone: 952-658-8995 • Fax 952-777-2263
www.mcsmn.com

APPLICATION FOR EMPLOYMENT

PERSONAL INFORMATION

Last Name	First Name	Middle Name
Address		
City	State	Zip Code
Phone Number	E-Mail	
Are you at least 16 years of age? ◯ Yes ◯ No	Are you legally authorized to work in the US? ◯ Yes ◯ No	

EMPLOYMENT DESIRED

Position You Are Applying For:

☐ PCA/CFSS ☐ DSP ☐ Administrative
☐ HMK ☐ QP ☐ Driver

Position Desired:

☐ Full-Time (=40 hrs/week)
☐ Part-Time (< 40 hrs/wk)

Days and Hours you are available to work:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

How did you hear about this job?_____

EMPLOYMENT HISTORY

1	Employer			Phone
	Address			May we contact this employer? ◯ Yes ◯ No
	City	State	Zip Code	Dates Employed (mm/yyyy) From To
	Supervisor's Name and Title			Position Title

2	Employer			Phone
	Address			May we contact this employer? ◯ Yes ◯ No
	City	State	Zip Code	Dates Employed (mm/yyyy) From To
	Supervisor's Name and Title			Position Title

3	Employer			Phone
	Address			May we contact this employer? ◯ Yes ◯ No
	City	State	Zip Code	Dates Employed (mm/yyyy) From To
	Supervisor's Name and Title			Position Title

EDUCATION

Print the Name and Address of Each School	No. Years Attended	Did you Graduate?	Course of Study	Degree Earned
High School		◯ Yes ◯ No		◯ HS Diploma ◯ GED
		◯ Yes ◯ No		
		◯ Yes ◯ No		
		◯ Yes ◯ No		

PROFESSIONAL REFERENCES

Please list below three people not related to you who have knowledge of your work performance and/or personal qualifications.

	Name / Title	Company Name	Phone #	Years acquainted
1				
2				
3				

It is the policy of Metropolitan Community Services (hereinafter "MCS") to provide equal employment opportunity (EEO) to all persons regardless of age, color, national origin, citizenship status, physical or mental disability, race, religion, creed, gender, sex, sexual orientation, gender identity and/or expression, genetic information, marital status, status with regard to public assistance, veteran status, or any other characteristic protected by federal, state or local law.

APPLICANT'S STATEMENT IMPORTANT – READ BEFORE SIGNING

By my signature below, I promise that the information provided in this employment application (and accompanying resume or documentation, if any) and during the hiring process is true and complete, and I understand that any false or misleading information or relevant omissions may disqualify me from further consideration for employment and may lead to my immediate dismissal from employment, if I have been hired.

I agree to immediately notify the Metropolitan Community Services if I am convicted of, or plead guilty or no contest to a felony, or any crime involving dishonesty, breach of trust, controlled substances, sexual misconduct, abuse, or violence, while my job application is pending or during my period of employment, if hired.

I understand that employment with the Metropolitan Community Services is contingent upon investigation of my previous employment record, references, and other matters without any further notification to me. I authorize any person, school, current employer, past employer(s), and organizations named in this application (and accompanying resume, if any) to provide the Metropolitan Community Services with any information and opinion requested by the Metropolitan Community Services in connection with my application, and I release the Metropolitan Community Services (and its employees and agents) from any and all liability for seeking information and opinions on me and all such persons and organizations from any legal liability in providing information.

I understand that nothing in this application and Metropolitan Community Services policies, procedures, or handbooks that I may receive create a contract of employment.

I understand that if hired, I am obliged to comply with any and all current and subsequently adopted policies and procedures.

I understand that, if hired, my employment is at-will. This means that I do not have a contract of employment for any duration or limiting the grounds for my termination in any way. I understand that my employment can be terminated, with or without prior notice, and with or without cause, at any time, at the option of either Metropolitan Community Services or myself.

I have read, understand, and agree to the above statements.

Applicant's Signature: _____ Date: _____

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EQUAL EMPLOYMENT OPPORTUNITY (EEO)

SELF-IDENTIFICATION FORM

Metropolitan Community Services ("MCS") is committed to equal employment opportunity and affirmative action. MCS is required by the Minnesota Department of Human Rights to request and maintain the following data on all applicants for employment. This information will be used for statistical summaries of employment practices, and to monitor the agency's compliance with equal employment opportunity and affirmative action. Your voluntary completion and return of this form is encouraged.

Qualified applicants are considered for employment without regard to race, religion, sex, national origin, age, marital status, sexual orientation, veteran status, disability, or other protected characteristic. In the event that you do provide the information requested, the information and this form will be processed and maintained separately from your employment application forms and, if you are hired by the Company, your personnel file.

Employee Name:_____ **Phone #:**_____

Position applied for:_____ **Date Applied:**_____

GENDER IDENTIFICATION:_____

RACE/ETHNIC IDENTIFICATION (CHECK ONE):

☐ **Hispanic or Latino -** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa

If you did not check "Hispanic or Latino" above, please select one of the following race/ethnic identifications:

☐ **White (Not Hispanic or Latino) -** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa

☐ **Black or African American (Not Hispanic or Latino) -** A person having origins in any of the black racial groups of Africa

☐ **Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino) -** A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands

☐ **Asian (Not Hispanic or Latino) -** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippines, Thailand, and Vietnam

☐ **American Indian or Alaska Native (Not Hispanic or Latino) -** A person having origins in any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment

☐ **Two or More Races (Not Hispanic or Latino) -** All persons who identify with more than one of the above five races

DISABILITY IDENTIFICATION (CHECK ONE):

☐ Yes, I have a disability, or have a history/record of having a disability

☐ No, I don't have a disability, or have a history/record of having a disability

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition. Disabilities include, but are not limited to:

- Autism
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, or HIV/AIDS
- Blind or low vision
- Cancer
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or hard of hearing
- Depression or anxiety
- Diabetes
- Epilepsy
- Gastrointestinal disorders, for example, Crohn's Disease, or irritable bowel syndrome
- Intellectual disability
- Missing limbs or partially missing limbs
- Nervous system condition for example, migraine headaches, Parkinson's disease, or Multiple sclerosis (MS)
- Psychiatric condition, for example, bipolar disorder, schizophrenia, PTSD, or major depression

Please tell us if you require reasonable accommodation to apply for a job or to perform your job. Examples of reasonable accommodation include making a change to the application process or work procedures, providing documents in an alternate format, using a sign language interpreter, or using specialized equipment.

VETERAN'S PREFERENCE

General: To qualify for Veterans Preference, you must meet all of the following:

1. Have separated under honorable conditions from any branch of the armed forces of the United States.
2. Have served on active duty for 181 consecutive days or more OR for the full period ordered to active duty OR have separated by reason of disability incurred while serving on active duty.
3. Be a United States Citizen OR resident alien.

If you meet all of the above, check the appropriate box(es) below:

☐ I am a non-disabled veteran.

☐ I wish to claim credit for being a disabled veteran with a currently existing, compensable, service-connected disability as judged by the U.S. Veterans Administration or by the Retirement Board of the Branches of the Armed Forces.

☐ I am the widow/widower (not remarried of a deceased veteran).

☐ I am the spouse of a veteran wishing to claim credit for being disabled who is unable to qualify because of the disability.

_____ **Decline self-identification**

Applicant's Signature:_____ **Date:**_____

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BACKGROUND STUDY AUTHORIZATION

APPLICANT INFORMATION

Last Name	First Name	Middle Name

- If you don't have a middle name or middle initial, please write NONE in the middle name field.

DOB	SSN	Gender ◯ Male ◯ Female

Eye Color	Hair Color	Height	Weight	US Citizen ◯ Yes ◯ No	Place of Birth

Race

☐ Asian	☐ African American	☐ Hispanic / Latino	☐ White
☐ Pacific	☐ Native American	☐ Two or more races	☐ Unknown / Other

PERMANENT/PHYSICAL ADDRESS

Address	Apt. #	County
City	State	Zip Code
Phone #	E-Mail	

MAILING ADDRESS

Is mailing address the same as permanent/physical address: ☐ Yes ☐ No

Address	Apt. #	County
City	State	Zip Code

PIOR NAMES AND ALIASES

First Name	Middle Name	Last Name
First Name	Middle Name	Last Name

PRIOR ADDRESSES WITHIN THE U.S.

Please list all prior states within the U.S. other than Minnesota within the past 5 years

Years	City	State
From _____ To _____		
From _____ To _____		

By affirming my signature below, I certify the information provided on and in connection with this form is true, accurate, and complete. I further certify that I've been provided with copy of the privacy notice and that prior to signing this document I have had the opportunity to ask any questions. I sign this document voluntarily and with full understanding of its terms and legal significance.

Applicant's Signature: _____ **Date:** _____

DEPARTMENT OF HUMAN SERVICES

BACKGROUND STUDY NOTICE OF PRIVACY PRACTICES

Because the Department of Human Services (DHS) is asking you to provide private information, you have privacy rights under the Minnesota Government Data Practices Act. This law protects your privacy, but also allows DHS to give information about you to others when the law requires it. This notice describes how your private information may be used and disclosed, and how you may access your information.

Why is DHS asking me for my private information?

A background study from the Department of Human Services (DHS) is required for your job or position. The private information is needed to conduct the background study.

How will I be notified that a background study was submitted on me?

DHS will mail you a notice within three working days after a request for a background study is submitted on you. The notice will contain the background study result or let you know that more time is needed to complete the background study. The notice will also identify the entity that submitted the background study request.

What information must I provide to complete the background study?

You are required to provide enough information to ensure an accurate and complete background study. This includes your:

- first, middle, and last name and all names you have ever been known by or used;
- current home address, city, zip code, and state of residence;
- sex and date of birth;
- driver's license or other identification number; and,
- fingerprints and a photograph, as required by law.

How will the information that I give be used?

The information will be used to perform a background study that will include a check to determine whether you have any criminal records and/or when required by law if you have been found responsible for substantiated maltreatment of a vulnerable adult or child.
When required, there will be a search of professional boards. Background study data is classified as "private data" and cannot be shared without your consent except as explained in this notice. Your information may also be used by DHS to collect on-going criminal and maltreatment data if it becomes available.

What may happen if I provide the information?

You could be disqualified from positions that require a DHS background study if you are found to have committed certain crimes, been determined responsible for maltreatment of a vulnerable adult or child, or have other records that require a disqualification. If you do not have a disqualifying record, you will be cleared for your job or position.

What if I refuse to provide the information?

You will be disqualified if you refuse to provide information to complete an accurate background study. You will not be able to work in a position that requires a DHS background study.

Who will DHS give my information to?

DHS will only share information about you as needed and as allowed or required by law. The identifying information you provide will be shared with the Minnesota Bureau of Criminal Apprehension (BCA) and when required by law the Federal Bureau of Investigation (FBI). If there is reasonable cause to believe that other agencies may have information related to a disqualification, your identifying information may also be shared with:

- county attorneys, sheriffs, and agencies;
- courts and juvenile courts;
- local police;
- the Office of the Attorney General; and,
- agencies with criminal record information systems in other states.

What information will DHS share with the entity that requested my background study?

The entity that requested the background study will be notified of your background study determination.

If you are disqualified, the entity will not be told the reason unless you were disqualified for refusing to cooperate with the background study or for substantiated maltreatment of a minor or vulnerable adult.

What other entities might DHS share information with?

Information about your Background study may be shared with:

- the Minnesota Department of Health;
- the Minnesota Department of Corrections;
- the Office of the Attorney General, and;
- health-related licensing boards.

What if my disqualification is set aside?

If you request reconsideration of your disqualification and your disqualification is set aside, the entity that requested the background study will be informed of the reason(s) for your disqualification unless the law states otherwise. DHS will provide information about the decision to set aside your disqualification if the entity requests it.

Unless prohibited by law, your name and the reason(s) for your disqualification will become public data if your set aside is for:

- a child care center or a family child care provider licensed under chapter 245A; or,
- an offense identified in section 245C.15, subdivision 2.

For future background studies submitted by entities that provide the same type of services as the services you were set aside for, the set aside will apply unless:

- you were disqualified for an offense in section 245C.15, subdivision 1 or 2; or,
- DHS receives additional information indicating that you pose a risk of harm; or,
- your set aside was limited to a specific person receiving services.

In addition, those entities will be informed of the reason(s) for your disqualification unless prohibited by law.

Will my fingerprints be kept?

DHS and the BCA will not keep your fingerprints. If an FBI check is required for your background study, the FBI may keep your fingerprints and may use them for other purposes in accordance with state and federal law.

What information can the fingerprint and photo site view and keep?

The fingerprint and photo site can view identifying information to verify your identify. The fingerprint and photo site will not keep your fingerprints, photo, or most other information. The fingerprint and photo site can keep your name and the date and time your fingerprints were recorded and sent, for auditing and billing purposes.

Who can see my photo?

Your photo will be kept by DHS. If you provide your social security number to allow your background study to be transferable to future entities, your photo will be available to those entities to verify your identity.

What are my rights about the information you have about me?

- You may ask if we have information about you and request in writing to get copies. You may have to pay for copies.
- You may give other people permission to see and have copies of private information about you.
- You may ask (in writing) for a report that lists the entities that submitted a background study request on you.
- You may ask in writing that the information used to complete your background study be destroyed. The information will be destroyed if you have:

  (1) not been affiliated with any entity for the previous two years; and,
  (2) no current disqualifying characteristic(s).

Please send all written requests to:

Minnesota Department of Human Services
Background Studies Division
NETStudy 2.0 Coordinator
PO Box 64242
St. Paul, MN 55164-0242

How long will DHS keep my background study information?

DHS will destroy:

- your photo when you have not been affiliated with an entity for two years.
- any background data collected on you after two years following your death or 90 years after your date of birth, except when readily available data indicates that you are still living.

What is the legal authority for DHS to conduct background studies?

Background studies are completed by DHS according to the requirements in Minnesota Statutes, chapter 245C or other authorizing state law.

What if I think my privacy rights have been violated?

You may report a complaint if you believe your privacy rights have been violated. If you think that the Minnesota Department of Human Services violated your privacy rights, you may send a written complaint to the Minnesota Department of Human Services, Privacy Official at:

Minnesota Department of Human Services
Privacy Official
PO Box 64998
St. Paul, MN 55164-0998

DEPARTMENT OF HUMAN SERVICES

Minnesota law requires some background studies conducted by the Department of Human Services (DHS) to include a fingerprint-based Federal Bureau of Investigation (FBI) record check. The FBI requires that you be provided the following Privacy Act Statement if a FBI record check is conducted as part of your DHS background study.

FBI Privacy Act Statement

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

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

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

Your Rights

You have the right to directly obtain your FBI record and to work with the FBI to correct your record if it is wrong. You are not required to do this, but if you want to you must send your fingerprints and a fee to the FBI. Information about the process is on the FBI's web site at https://www.fbi.gov/services/cjis/identity-history-summary-checks

If your background study results in a disqualification, you will be provided with information about how to ask DHS for reconsideration of the determination. At that time, you may inform DHS that the information used was wrong (this is a correctness review) and/or that the disqualification should not apply (this is a risk of harm review).

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310 - HOUR RULE ACKNOWLEDGEMENT

(MN Stat. 256B.0659, subd. 11 (a)(10))

A personal care assistant must "be limited to providing and being paid for up to 310 hours per month of personal care assistance services regardless of the number of recipients being served or the number of personal care assistance provider agencies enrolled with…" (MN Stat. 256B.0659, Subd. 11 (a) (10)).

Please read, carefully consider, and initial each section below.

_____ I understand and agree that I cannot work as a Personal Care Assistant in the State of Minnesota more than 310 hours per calendar month. I further understand that the 310 hours per calendar month are a total of ALL PCA hours worked at ALL agencies with ALL clients I serve COMBINED.

_____ I understand and agree that it is my responsibility to monitor my PCA hours worked, so that I do not exceed the 310 hours per calendar month.

_____ I understand that any hours worked beyond 310 calendar hours per month for ALL CLIENTS combined and for ALL agencies combined, are not eligible for payment of wages. I further understand that Metropolitan Community Services has the right to recover those wages I am not entitled to, that were paid to me for hours submitted on timesheets that were in violation of the above MN Statutes.

_____ I understand that it is my responsibility to notify Metropolitan Community Services if my scheduled hours will violate this law so that my agency will have adequate time to find PCA coverage for the remaining shifts in the day or month that I am not eligible to work.

Employee Name	Employee Signature	Date

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EMPLOYEE CONFIDENTIALITY AGREEMENT

All patient protected health information (PHI – which includes patient medical and financial information), employee records, financial and operating data of Metropolitan Community Services and any other information of a private or sensitive nature are considered confidential. Confidential information should not be read or discussed by any employee unless pertaining to his or her specific job requirements. Examples of inappropriate disclosures include:

- Employees discussing or revealing PHI or other confidential information to friends or family members.
- Employees discussing or revealing PHI or other confidential information to other employees without a legitimate need to know.
- The disclosure of a patient's presence in the office, hospital, or other medical facility, without the patient's consent, to an unauthorized party without a legitimate need to know, and that may indicate the nature of the illness and jeopardize confidentiality.
- Using patient information for marketing purposes without express permission from Metropolitan Community Services and patient.

The unauthorized disclosure of PHI or other confidential information by employees can subject each individual employee and the practice to civil and criminal liability. Disclosure of PHI or other confidential information to unauthorized persons, or unauthorized access to, or misuse, theft, destruction, alteration, or sabotage of such information, is grounds for immediate disciplinary action up to and including termination.

ACKNOWLEDGEMENT

I have been trained and understand the HIPAA Privacy information. I agree with the duties, obligations, responsibilities, and conditions for maintaining the privacy and confidentiality of patient information described in the training.

I hereby acknowledge, by my signature below, that I understand that the PHI, other confidential records, and data which I learn or have access to in the course of my employment with Metropolitan Community Services is to be kept confidential, private, and secure, and that maintaining confidentiality, privacy, and security of PHI and other confidential records and data is a condition of my employment. Such information shall not be disclosed to anyone under any circumstances, except to the extent necessary to fulfill my job requirements.

As an employee of Metropolitan Community Services, I understand that I must maintain the privacy and confidentiality of any and all confidential patient information to which I have access in the course of carrying out my work. I will maintain confidentiality of such information, regardless of its source and in any and all formats (i.e., paper, magnetic, computer, conversations, film, etc.). If I have reason to believe that there is any breach of patient confidentiality, I will immediately notify my supervisor or other appropriate responsible party. I understand that my duty to maintain confidentiality, privacy, and security continues even after I am no longer employed.

I have been trained in the Health Insurance Portability and Accountability Act (HIPAA) privacy and security policies and procedures of Metropolitan Community Services and am familiar with the guidelines in place at Metropolitan Community Services pertaining to the use and disclosure of patient PHI or other confidential information. Approval should first be obtained before any disclosure of PHI or other confidential information not addressed in the guidelines and policies and procedures of Metropolitan.

Community Services. I also understand that the unauthorized use or disclosure of patient PHI and other confidential or proprietary information of Metropolitan Community Services is grounds for disciplinary action, up to and including immediate dismissal and/or civil and/or criminal penalties.

By signing below, I certify that I have read the above information. Any questions concerning these policies have been discussed. My signature also certifies my understanding of an agreement with the above policies. A photocopy of this document is as valid as the original.

Employee Name	Employee Signature	Date

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ACKNOWLEDGEMENT OF MN STAT. § 268.095

An applicant who, without good cause, fails to affirmatively request any additional job assignments after completion of a job assignment for a staffing service employer, shall be considered to have quit employment. (Minn. Stat. 268.095, subd. 2(e)).

I have read the above statute and understand that my eligibility for unemployment may be affected if I do not request another job assignment from Metropolitan Community Services after completing my current assignment. I understand that I must notify Human Resources within 5 days of completing my current job assignment. I also understand that I may be required to attend any updating Training Session so that I may be given a new job assignment. I understand I must be ready and willing to accept new job assignment.

By signing below, I certify that I have read the above information. Any questions concerning these policies have been discussed. My signature also certifies my understanding of an agreement with the above policies. A photocopy of this document is as valid as the original.

Employee Name	Employee Signature	Date

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OVERTIME POLICY

Non-exempt employees are not authorized to work more than 40 hours in any work week without the prior approval of their supervisor/office staff. When overtime is unavoidable, it must be approved in advance and should be managed as efficiently and economically as possible. Overtime privileges may be revoked at any time at the Agency sole discretion. Failure to obtain prior written approval for overtime prohibited by this policy and may lead to disciplinary action including possible termination.

I have reviewed all aspects of this policy, have carefully read, and fully understand all provisions of this policy.

Employee Name	Employee Signature	Date

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FRAUD AND ABUSE DISCLAIMER

Upon successful completion of a background study, you will be provided with training materials on fraud and abuse as relating to your employment. Please use the following form, "FRAUD AND ABUSE ACKNOWLEDGEMENT," to document your completion of the training.

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FRAUD AND ABUSE POLICY

POLICY

Metropolitan Community Services (hereinafter "MCS") is committed to providing care and service in compliance with all applicable rules and regulations. The agency will comply with the requirements and obligations related to Fraud and Abuse under state and federal laws. As part of the commitment, MCS has established and will maintain a Corporate Compliance Program that includes a Fraud and Abuse program.

Employees and contractors are expected to immediately report any potential false, inaccurate, or questionable claims to their supervisors, the Fraud and Abuse Coordinator or the Compliance Officer according to this policy.

Agency is prohibited by law from retaliating in any way against any employee or contractor who reports a perceived problem, concern or fraud and abuse issue in good faith.

Examples of potential false claims may include the following when they are done intentionally and knowingly:

- Claiming reimbursement for services that have not been rendered.
- Characterizing the service differently than the service provided
- Billing for services that are not medically necessary.
- Failing to provide medically necessary services/items.
- Forging or altering prescriptions and improperly obtaining prescriptions for controlled substances.

PURPOSE

- To provide guidance regarding the agency's responsibilities under the DRA, the State False Claims acts, and any contracts with payers.
- To inform employees about the protections under the laws and contracts, and the roles of these laws to prevent and detect fraud, waste, and abuse in Federal and State Programs.

PROCEDURE

Agency shall develop a comprehensive internal Fraud and Abuse Program, as part of its Compliance Program to prevent and detect program violations.

Employees and contractors must immediately report any false, inaccurate, or questionable claims or actions as well as questions, concerns or potential Fraud or Abuse to:

- Immediate supervisor
- Agency Fraud and Abuse Coordinator and/or Agency Compliance Officer

All activity reported related to this policy will be investigated in accordance with the agency fraud and abuse program.

Agency will not discriminate or retaliate against any employee or contractor for reporting a potentially fraudulent activity or for cooperating in any government or law enforcement authority's investigation or prosecution.

If it is determined that the Agency submitted claims in error, MCS will make every effort to recover improper payments or funds misspent due to fraudulent or abusive actions by the agency or its contractors.

RESPONSIBILITY AND ACCOUNTABILITY

Employees and Contractors: All agency employees and contractors are responsible for reporting any potential false, inaccurate, or questionable claims or actions as well as questions, concerns of potential fraud or abuse.

Internal Fraud and Abuse team: Group of individuals representing billing, clinical, quality improvement, medical records is responsible for ensuring that all reported suspected Fraud or Abuse are fully investigated and if appropriate, are reported to proper authorities

Compliance Officer: The Compliance Officer has oversight for the Fraud and Abuse Program, including but not limited to policies/procedures and communications. The Compliance Officer will communicate with the Management Team, Governing Body, and Professional Advisory Committee as needed but at least annually as part of the annual agency evaluation.

References:
Deficit Reduction Act of 2005, (Pub. L. 109-171)
False Claims Act 31 USC sect. 3279-3733
Agency Non-Retaliation Policy

The following is a summary of the Federal False Claims laws and whistleblower protections.

The Federal False Claims Act

The Federal False Claims Act (FCA) helps the Federal government combat fraud and recovers losses resulting from fraud in Federal programs. A person or entity may violate the FCA by knowingly:

- Submitting a false claim for payment
- Making or using a false record or statement to obtain payment for a false claim.
- Conspiring to make a false claim or get one paid.
- Making or using a false record to avoid payments owed to the Government.

Knowingly means that a person:

- Has actual knowledge of the information.
- Acts in deliberate ignorance of the truth or falsity of the information.
- Acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

Medicaid and Medicare Violations

Violations of Medicare laws and the Medicare Fraud and Abuse Statute also constitute violations of the False Claims Act. Home Health Care agencies that seek and receive reimbursement for Medicare and Medicaid funds are Government contractors subject to the False Claims Act. Billing for services not rendered or misrepresenting the type of services rendered can trigger liability under the False Claims Act.

False Statements of Contract Compliance

Violations of contract terms or of statutes and regulations that are often required by Government contracts and set forth in what might otherwise be termed "boilerplate" sections of contracts, may be sufficient to violate the False Claims Act. Knowing presentation of claim for payment can be deemed equivalent to a false certification of compliance with such laws, rules, and regulations. If federal funding is conditioned on compliance with these contract provisions, such misconduct gives rise to a viable False Claims Act case. It should be remembered that claims may be false, and the law violated, even though goods or services provided fulfill other contract specifications.

The FCA imposes penalties of $5,500 to $11,000 per claim plus three times the amount of damages to the Government for FCA violations. Lawsuits must be filed by the later of either (1) three years after the violation was discovered by the federal official responsible for investigating violations (but no more than ten years after the violation was committed, or (2) six years after the violation was committed.

False Claims Act Whistleblower Employee Protections

In 1986, Congress added anti-retaliation protections to the False Claims Act. These provisions, which did not exist previously, are contained in 31 U.S.C. Sec. 3730(h):

Any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of his employer or others in furtherance of an action under this section, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under this section, shall be entitled to all relief necessary to make the employee whole.

The protection against retaliation extends to whistleblowers whose allegations could legitimately support a False Claims Act case even if the case is never filed. The statute of limitations for Sec. 3730(h) claims is 6 years in most jurisdictions.

The whistleblower plaintiff is entitled to reinstatement with seniority, double back pay, interest, special damages sustained as a result of discriminatory treatment, and attorney's fees and costs. There is federal jurisdiction for these whistleblower claims. To establish a Sec. 3730(h) retaliatory discharge claim, the whistleblower must engage in conduct protected by the False Claims Act. Second, the courts require a showing that the defendant has some notice of the protected conduct that the whistleblower was either taking action in furtherance of a qui tam action or assisting in an investigation or actions brought by the Government. Finally, the whistleblower must show that the termination was in retaliation for the protected activities. A False Claims Act qui tam case can include whistleblower claims and other legal claims based upon other state and federal laws.

Federal Whistleblower Protection Laws

Unlike the False Claims Act, which allows a whistleblower to file a lawsuit in federal court, many of the federal whistleblower laws do not permit a whistleblower to go directly to court, but instead are to be pursued "administratively." Congress designed many of these laws so that an individual, with or without an attorney, may make a simple complaint or "charge" of retaliatory discrimination to a federal government agency. If not resolved administratively, an administrative law judge may preside over the evidentiary hearing that will take place. Some retaliation and whistleblower statutes are relatively "hollow," that is, they prohibit illegal employer retaliation, but do not allow the individual to pursue an administrative charge or file a lawsuit. In legalese, such laws are described as providing no "private cause of action."

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FRAUD AND ABUSE ACKNOWLEDGEMENT

_____ I have received Fraud and Abuse training.

_____ I have reviewed the policy on Fraud and Abuse.

_____ I have been provided information on what is considered fraud and abuse.

_____ I understand that acts of fraud and/or abuse may result in termination from my position.

Employee Name	Employee Signature	Date

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CLIENTS HOSPITALIZED OR OTHERWISE NOT RECEIVING SERVICES AT HOME

As an employee of METROPOLITAN COMMUNITY SERVICES, I have been informed that when clients are hospitalized, I cannot turn in timecards for those days even if I am at the hospital with the client. When clients are hospitalized, payment is made to the hospital for their care and the home care provider cannot bill for any services.

I also understand that if my client is on vacation or out of town, I cannot claim these hours. If timecards are turned in for these hours, this is fraudulent claims for payment.

In both situations listed above, documenting that services were provided in the home is against agency policy, against the Federal/State regulations and is considered falsifying records. Violation of these regulations is grounds for termination.

I acknowledge that I have been informed of these policies and I understand that I may not claim these hours as hours worked. I am to notify the office when my client is not available to receive services at home.

Employee Name	Employee Signature	Date

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FIRST DATE OF SERVICE

As an employee of METROPOLITAN COMMUNITY SERVICES, I have been informed that First Date of Service is client specific and must be prior authorized by the agency. First Date of Service for a client may not occur PRIOR to a meeting with a Qualified Professional/Designated Coordinator.

I acknowledge that I have been informed of these policies and I understand that I may not claim ANY hours PRIOR to a meeting with QP/DC as hours worked.

Employee Name	Employee Signature	Date

METROPOLITAN COMMUNITY SERVICES

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JOB DESCRIPTION: PERSONAL CARE ASSISTANT

POSITION SUMMARY

The Personal Care Assistant performs personal care services for recipients living in the community. The Personal Care Assistant works within the guidelines of a care plan established by the recipient/responsible party, the PHN and the Qualified Professional.

QUALIFICATIONS

1. Be at least sixteen (16) years of age.
2. Must have successfully completed mandatory PCA/CFSS Standardized Training and passed test with a score of 80% or greater.
3. Must provide a demonstrated ability to the qualified professional that he/she is capable of providing personal care services by accurately following a client care plan.
4. Be able to work with little direct supervision, make appropriate judgments and know how and when to report changes in the client's condition to the qualified professional.
5. Have demonstrated dependability, tact, and the ability to follow orders.
6. Have good physical and mental health.
7. Have U.S. Citizenship or evidence of alien work permit.
8. Have passed a criminal background check.

ESSENTIAL FUNCTIONS/AREAS OF ACCOUNTABILITY

1. Bowel and bladder care.
2. Skin care, including prophylactic routine and palliative measures documented in the Plan of Care.
3. Range of motion exercises.
4. Respiratory assistance.
5. Assist with transferring, turning, and positioning of client.
6. Assist with medications (normally self-administered).
7. Application and maintenance of prosthetics and orthotics.
8. Cleaning of equipment.
9. Assistance with food, nutrition, and diet activities.
10. Accompany client to obtain medical diagnoses or treatment.
11. Provide services necessary to maintain client's personal health and safety.
12. Assist client to complete daily living skills such as personal/oral hygiene.
13. Assist with incidental household services.

Personal Care Assistant May Not:

1. Provide services except as employee of an enrolled provider agency.
2. Provide services not outlined in the plan of personal care services.
3. Provide services that are not supervised by the recipient/responsible party.
4. Provide person care services to clients for whom they are legal guardians.
5. Perform sterile procedures.
6. Give injections of fluids into veins, muscles, or skin.

PHYSICAL/ENVIRONMENTAL DEMANDS

The information below is intended to describe the general context/requirements needed to perform this job. During a typical workday, this position requires the activities listed. It is not to be considered as an exhaustive statement of duties, responsibilities, or requirements and does not limit the assignment of additional duties.

Physical Activities Required for this Position

- Sitting
- Stationary Standing
- Walking on a variety of surfaces
- Ability to be mobile
- Crouching (bend at knees)
- Kneeling/Crawling
- Stooping (bending at waist)
- Twisting (knees/waist/neck)
- Turning/Pivoting
- Climbing
- Balancing
- Grasping
- Reaching Overhead
- Reaching Extension
- Pinching
- Pushing/Pulling (maximum 100 lbs)
- Lifting/Carrying (maximum 100 lbs)
- Other

Sensory Activities

- Talking in person
- Talking on the telephone
- Hearing in person
- Hearing on telephone
- Vision for close work
- Other (specify):

Environmental Considerations

- Driving a car in all weather conditions
- Providing services in variety of environments
- Potential for exposure to infectious disease
- Ability to manage clinical equipment
- Other

Note: Employees must not transport clients in personal vehicles for insurance liability reasons.

I have read and understand the above job description of the Personal Care Assistant.

PCA Name	Signature	Date

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JOB DESCRIPTION: HOMEMAKER

POSITION SUMMARY

The Homemaker performs services that help a person manage general cleaning and household activities. There are three homemaker services:

- Homemaker/cleaning
- Homemaker/home management
- Homemaker/assistance with activities of daily living (ADLs)

The Homemaker works within the guidelines of the assignment sheet established by the recipient/responsible party and the Qualified Professional.

QUALIFICATIONS

1. Be at least sixteen (16) years of age.
2. Must provide a demonstrated ability to the qualified professional that he/she is capable of providing services by accurately following a client care plan.
3. Be able to work with little direct supervision, make appropriate judgments and know how and when to report changes in the client's condition to the qualified professional.
4. Have demonstrated dependability, tact, and the ability to follow orders.
5. Have good physical and mental health.
6. Have U.S. Citizenship or evidence of alien work permit.
7. Have passed a criminal background check.

ESSENTIAL FUNCTIONS/AREAS OF ACCOUNTABILITY

1. Provide home cleaning and laundry services
2. Provide assistance with home management activities as needed. Home management activities may include assistance with:
    - Arranging for transportation
    - Laundry
    - Meal preparation
    - Shopping for food, clothing and household supplies
    - Simple household repairs
3. Monitor the person's wellbeing while in the home, including home safety
4. While onsite, provide assistance with ADLs as needed. Assistance with ADLs includes assistance with the following:
    - Ambulating
    - Bathing
    - Dressing
    - Eating
    - Grooming
    - Toileting

Homemaker May Not:

1. Provide services except as employee of an enrolled provider agency.
2. Provide services not outlined in the assignment sheet
3. Provide services that are not supervised by the recipient/responsible party.

PHYSICAL/ENVIRONMENTAL DEMANDS

The information below is intended to describe the general context/requirements needed to perform this job. During a typical workday, this position requires the activities listed. It is not to be considered as an exhaustive statement of duties, responsibilities, or requirements and does not limit the assignment of additional duties.

Physical Activities Required for this Position

- Sitting
- Stationary Standing
- Walking on a variety of surfaces
- Ability to be mobile
- Crouching (bend at knees)
- Kneeling/Crawling
- Stooping (bending at waist)
- Twisting (knees/waist/neck)
- Turning/Pivoting
- Climbing
- Balancing
- Grasping
- Reaching Overhead
- Reaching Extension
- Pinching
- Pushing/Pulling (maximum 100 lbs)
- Lifting/Carrying (maximum 100 lbs)
- Other

Sensory Activities

- Talking in person
- Talking on the telephone
- Hearing in person
- Hearing on telephone
- Vision for close work
- Other (specify):

Environmental Considerations

- Driving a car in all weather conditions
- Providing services in variety of environments
- Potential for exposure to infectious disease
- Ability to manage clinical equipment
- Other

Note: Employees must not transport clients in personal vehicles for insurance liability reasons.

I have read and understand the above job description of the Homemaker.

Homemaker Name	Signature	Date

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JOB DESCRIPTION
DIRECT SUPPORT PROFESSIONAL (DSP)

A direct support professional (hereinafter "DSP"), is a person who assists an individual with a disability to lead a self-directed life and contribute to the community, assists with activities of daily living if needed, and encourages attitudes and behaviors that enhance community inclusion.

QUALIFICATIONS

- Be at least eighteen (18) years of age.
- High school diploma, GED, or equivalent.
- Valid driver's license.
- Have passed a criminal background check.
- Have U.S. Citizenship or evidence of alien work permit.
- Must have successfully completed mandatory Training and passed test with a score of 70% or greater.
- Must provide a demonstrated ability to the Designated Coordinator/Designated Manager that he/she is capable of providing services by accurately following a client care plan.
- Be able to work with little direct supervision, make appropriate judgments and know how and when to report changes in the client's condition to the Designated Coordinator/Designated Manager.
- Have demonstrated dependability, tact and the ability to follow orders.
- Have good physical and mental health.
- Have good communication skills (verbally and written) with all levels of personnel, internal and external to the company.
- Ability to handle physical aspects of job, including bending, stooping, lifting, pushing, pulling, reaching, and walking for periods of time

ESSENTIAL FUNCTIONS/AREAS OF ACCOUNTABILITY

As a DSP, you will be responsible for providing direct care to those with intellectual and developmental disabilities and elderly persons in a community setting, following a plan and working within the hours authorized. Duties may include:

- Performing personal care tasks, including assistance with basic personal hygiene and grooming, bathing, dressing, eating, and ambulation, transfers, positioning, and toileting, medical monitoring, and health care related tasks.
- Providing interventions intended to address cognitive issues and challenges important to the person.
- Providing services intended to help the person adopt ways to meet his or her needs. Some of the examples include encouraging the person's self-sufficiency, reducing the person's reliance on human assistance, developing and demonstrating cuing or reminder tools (e.g., calendars, lists), providing verbal, visual and/or touch guidance to help the person complete a task, helping the person understand written assistive technology directions or instructions from the manufacturer or health professional so the person can maintain independence.
- Performing home management functions such as assistance with cleaning, meal planning/preparation, and shopping for household/personal needs, assistance with budgets and money management, assistance with communications (e.g., sorting mail, accessing email, placing phone calls, scheduling appointments), providing transportation (only if authorized by Designated Coordination or Designated Manager), cueing, guidance, supervision, training or instructional support to complete routine household care and maintenance, providing tenancy support and advocacy.
- Providing training, assistance, support and/or guidance with budgeting and assistance to manage money, cooking, meal planning and nutrition, encouraging and implementing healthy lifestyle skills and practices, and providing assistance with household chores, including minor household maintenance activities.
- Ensuring client safety and maintaining a safe environment.
- Coordinating or implementing changes to mitigate environmental risks in the home.

- Providing reminders about and assistance with exercises and other health maintenance/improvement activities
- Providing medication assistance (e.g., medication refills, reminders, administration, and/or preparation)
- Monitoring the person's health according to written instructions from a licensed health professional and reporting changes in client's condition or family situation to administrators and supervisors.
- Using medical equipment devices or adaptive technology according to written instructions from a licensed health professional.
- Collaboration with the person to arrange health care (e.g., physical, mental, chemical), meaningful activities, social services, meetings, and appointments.
- Encouraging self-help activities.
- Helping the person access activities, services and resources that facilitate meaningful community integration and participation, helping with navigating community resource use and access
- Helping the person develop and/or maintain his or her informal support system.
- Documenting services provided.
- Other duties as assigned.

PHYSICAL DEMANDS

This position may require lifting (up to 75 lbs.), reaching, kneeling, bending, stretching, stooping, wiping, standing, transferring (up to 75 lbs.), stretching, walking, pushing, pulling, and partial or complete assistance with activities of daily living without assistance from another healthcare worker or significant other. This position requires spending most of the workday standing and walking, with occasional sitting.

TRANSPORTATION OF CLIENTS

Providing transportation when it is integral to community engagement goals and community resources and/or when informal supports are not available. Must be prior authorized.

Note. This job description reflects management's assignment of duties and does not restrict nor limit the duties that may be assigned.

I have read and understand the above job description of the DSP.

DSP Name	Signature	Date

DEPARTMENT OF LABOR AND INDUSTRY

Employee notice

1. Employee: Address:
Phone number: Email address:
Date employment began:
2. Legal name of employer: Main office/principal place of business address:
Phone number: Email address:
Operating name of employer (if different):
Mailing address (if different):
3. Employment status (exempt or non-exempt):
☐ Employee is exempt from: ☐ minimum wage ☐ overtime ☐ other provisions of Minnesota Statutes 177
Legal basis for exemption:
☐ Employee is non-exempt (entitled to overtime, minimum wage, other protections under Minn. Stat. 177)
4. Rate or rates of pay
Paid by: Hour ☐ Shift ☐ Day ☐ Week ☐ Salary ☐ Piece ☐ Commission ☐ Other method ☐
Overtime is owed after: hours
Allowances claimed:
$ per meal for meal allowance (max = 60% of one hour of adult minimum wage per meal)
$ per day for lodging allowance (max = 75% of one hour of adult minimum wage per day) (or fair market value)
5. Leave benefits available:
☐ Sick leave ☐ Paid vacation ☐ Other paid time off
How benefits are accrued: Number of hours _____ or days _____ per ☐ year ☐ month ☐ per pay period ☐ per hours worked
Terms of use:
6. Deductions that may be made from employee's pay and amounts:
7. Number of days in the pay period: Regularly scheduled payday:
Date employee will receive first payment of wages earned:
8. Other information relevant to this position:
I, the employee, have received a copy of this notice: ☐ Yes ☐ No
Employer signature Date Employee signature Date

This document contains important information about your employment. Check the box at left to receive this information in this language.

☐	Spanish/Español	Este documento contiene información importante sobre su empleo. Marque la casilla a la izquierda para recibir esta información en este idioma.
☐	Hmong/Hmoob	Daim ntawv no muaj cov xov tseem ceeb hais txog thaum koj ua hauj lwm. Khij lub npauv ntawm sab laug yog koj xav tau cov xov tseem ceeb no txhais ua lus Hmoob.
☐	Vietnamese/Việt ngữ	Tài liệu này chứa thông tin quan trọng về việc làm của quý vị. Đánh dấu vào ô bên trái để nhận thông tin này bằng Việt ngữ.
☐	Simp. Chinese/简体中文	本文件包含与您的雇用相关的重要信息。勾选左边的方框将接收以这种语言提供的信息。
☐	Russian/русский	Данный документ содержит важную информацию о вашем трудоустройстве. Отметьте галочкой квадрат слева для получения этой информации на данном языке.
☐	Somali/Soomaali	Dukumentigan waxaa ku qoran macluumaad muhiim ah oo ku saabsan shaqadaada. Calaamadi sanduuqan haddii aad rabto inaad macluumaadkan ku hesho luqaddan.
☐	Laotian/ພາສາລາວ	ເອກະສານນີ້ມີຂໍ້ມູນທີ່ສຳຄັນກ່ຽວກັບການຈ້າງງານຂອງທ່ານ. ກວດເບິ່ງກ່ອງທີ່ຢູ່ເບື້ອງຊ້າຍເພື່ອຮັບຂໍ້ມູນນີ້ໃນພາສານີ້.
☐	Korean/한국어	이 문서에는 귀하의 고용 형태에 관련된 중요한 정보가 담겨있습니다. 이 언어로 이 정보를 받기를 원하시면 왼쪽 상자에 체크하여 주세요.
☐	Tagalog/Tagalog	Ang dokumentong ito ay nagtataglay ng mahalagang impormasyon tungkol sa iyong pagtatrabaho. Lagyan ng tsek ang kahon sa kaliwa upang matanggap ang impormasyong ito sa wikang ito.
☐	Oromo/Oromoo	Waraqaan kun waayee hojii keetii odeeffannoo barbaachisoo ta'an qabatee jira. Saaxinnii karaa bitaatti argamu kana irratti mallattoo godhi yoo afaan Kanaan barreeffama argachuu barbaadde.
☐	Amharic/አማርኛ	ይህ ዶኩመንት አቀጣጠሮን በሚመለከት አስፈላጊ መረጃ የያዘ ነው። ይህንን ዶኩመንት በስተግራ በኩል ባለው ቋንቋ ተተርጉሞ እንዲሰጦት ከፈለጉ በዛው በስተግራ በኩል ባለው ሳጥን ውስጥ ምልክት ያድርጉ።
☐	Karen / ကညီကျိာ်	လာ်ဘိလာ်မီတခါးအံၤဟာ်ဃုာ်တာ်ဂ့ၢ်တာ်ကျိးအကါနီဉ်လ၊အဘဉ်ယးဒီးနတာ်ဖံးတာ်မၤန္ဉာ်လီၤ. တိၤနီဉ်တာ်ဒ၊လ၊အခုဉ်တကပၤလ၊တာ်ကဒီးန္ဉာ်တာ်ဂ့ၢ်တာ်ကျိးလ၊ကျိာ်တခါးအံၤအဂီၢ်တက့ၢ်.
☐	Arabic/ العربية	يحتوي هذا المستند على معلومات مهمة حول عملك. ضع علامة في المربع على اليمين للحصول على هذه المعلومات في هذه اللغة.

Translation providers approved by the Minnesota Department of Administration

Betmar Languages, Inc. 6260 Hwy. 65 N.E. Minneapolis, MN 55432 763-572-9711 best@betmar.com	**The Bridge World Language Center, Inc.** 110 Second Street S., #308 Waite Park, MN 56387 320-259-9239 mini@bridgelanguage.com	**Fox Translation Services** 1152 Mae Street, #122 Hummelstown, PA 17033 866-369-1646 or 407-733-3720 dina@foxfoxcasemanagement.com
Global Translation and Interpreter 913 E. Franklin Ave., #206 Minneapolis, MN 55404 612-722-1244 sandor@globaltranslations.com	**Latin American Translators Network, Inc.** 1720 Peachtree Street N.W., #532 Atlanta, GA 30309 800-943-5286, ext. 8641, translations@latn.com 800-943-5286, ext. 8620, idenis@latn.com	**Latitude Prime, LLC** 80 S. Eighth Street, #900 Minneapolis, MN 55402 888-341-9080, ext. 501 elle@latitude.com
Lingualinx Language Solutions, Inc. 433 River Street, #6001 Troy, NY 12180 518-388-9000 abartlett@lingualinx.com	**Prisma International, Inc.** 1128 Harmon Place, #310 Minneapolis, MN 55403 612-349-3111 jromano@prisma.com	**Swits, LTD** 110 S. Third Street Delavan, WI 53115 262-740-2590 translations@swits.us

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WAGE PAYMENT AUTHORIZATION FORM

Last Name	First Name	Middle Name

I choose to receive payment for wages worked as:

- ◯ Direct Deposit (Complete Section 1); or
- ◯ Paper Check (Complete Section 2)

Section 1: DIRECT DEPOSIT

Type of Account:

- ◯ Checking
- ◯ Savings

Financial Institution ("Bank") Name: _____

Routing #: _____

Account #: _____

One of the following is required to process this enrollment:

- Voided check with name imprinted (no starter checks); **or**
- Bank letter or specification sheet (the signature of your local bank representative MUST be included).

Certain accounts may have restrictions on deposits and withdrawals. Check with your bank for more information specific to your account.

_____ I authorize the Metropolitan Community Services (the "Company" or "Employer") to deposit my wages/salary (and appropriate debit and adjustment entries), into the bank account specified above. I agree that direct deposit transactions I authorize comply with all applicable law. My signature below indicates that I am agreeing that I am either the account holder or have the authority of the account holder to authorize my employer to make direct deposits into the named account. If Company deposits funds erroneously into my account, I authorize Company to debit my account for an amount not to exceed the original amount of the erroneous credit. If the above is unsuccessful, the Company will notify me and request the return of those funds within three (3) working days. Funds not voluntarily returned by me will be deducted in full of my next direct deposit(s).

Section 2: PAPER CHECK

I request my paycheck to be mailed to:

Address		
City	State	Zip Code

_____ I understand that I must update my address on file each time it changes. I further understand that Metropolitan Community Services is NOT responsible for U.S. Postal Service delays. A $35.00 fee will be charged to the employee to stop payment on the lost/stolen check.

Employee Signature: _____ Date: _____

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PAYROLL SCHEDULE 2024

No.	Working Period	Timecards must be received by Thursday	Pay Day (Friday)
1	12/04/2023 - 12/17/2023	12/21/2023	01/05/2024
2	12/18/2023 - 12/31/2023	01/04/2024	01/19/2024
3	01/01/2024 - 01/14/2024	01/18/2024	02/02/2024
4	01/15/2024 - 01/28/2024	02/01/2024	02/16/2024
5	01/29/2024 - 02/11/2024	02/15/2024	03/01/2024
6	02/12/2024 - 02/25/2024	02/29/2024	03/15/2024
7	02/26/2024 - 03/10/2024	03/14/2024	03/29/2024
8	03/11/2024 - 03/24/2024	03/28/2024	04/12/2024
9	03/25/2024 - 04/07/2024	04/11/2024	04/26/2024
10	04/08/2024 - 04/21/2024	04/25/2024	05/10/2024
11	04/22/2024 - 05/05/2024	05/09/2024	05/24/2024
12	05/06/2024 - 05/19/2024	05/23/2024	06/07/2024
13	05/20/2024 - 06/02/2024	06/06/2024	06/21/2024
14	06/03/2024 - 06/16/2024	06/20/2024	07/05/2024
15	06/17/2024 - 06/30/2024	07/04/2024	07/19/2024
16	07/01/2024 - 07/14/2024	07/18/2024	08/02/2024
17	07/15/2024 - 07/28/2024	08/01/2024	08/16/2024
18	07/29/2024 - 08/11/2024	08/15/2024	08/30/2024
19	08/12/2024 - 08/25/2024	08/29/2024	09/13/2024
20	08/26/2024 - 09/08/2024	09/12/2024	09/27/2024
21	09/09/2024 - 09/22/2024	09/26/2024	10/11/2024
22	09/23/2024 - 10/06/2024	10/10/2024	10/25/2024
23	10/07/2024 - 10/20/2024	10/24/2024	11/08/2024
24	10/21/2024 - 11/03/2024	11/07/2024	11/22/2024
25	11/04/2024 - 11/17/2024	11/21/2024	12/06/2024
26	11/18/2024 - 12/01/2024	12/05/2024	12/20/2024

Our Office is Closed On:

Date	Day	Holiday	Date	Day	Holiday
January 1, 2024	Monday	New Year's Day	September 2, 2024	Monday	Labor Day
May 27, 2024	Monday	Memorial Day	November 28, 2024	Thursday	Thanksgiving Day
June 19, 2024	Wednesday	Juneteenth	November 29, 2024	Friday	Thanksgiving Friday
July 4, 2024	Thursday	Independence Day	December 25, 2024	Wednesday	Christmas Day

- ❖ You are responsible for ensuring that MCS receives your complete timecards in a timely manner. We DO NOT accept faxed/emailed timecards.
- ❖ Timecards received after the above deadlines will not be processed until the next scheduled payday. Payroll will only "back pay" late timecards up to four (4) weeks past the deadline.
- ❖ Direct Deposit is available to all employees. MCS is not responsible for any checks lost in the mail. A $30.00 fee will be charged to the employee to stop payment on the lost/stolen check.
- ❖ If your check is lost or stolen: Contact us immediately so that we can stop payment and issue a new check. This process takes approximately 3-5 days.
- ❖ If you do not have direct deposit, you may pick up your check at our office. Checks are available for a pickup every other Thursday, between 2:00 pm and 4:30 pm.
- ❖ If you are having someone pick up your check for you, they will need a written authorization signed by you and they will have to present their photo ID.

Minimum Essential Coverage (MEC) Plan Participation Agreement

This form is used to communicate enrollment in a Minimum Essential Coverage (MEC) Plan. Complete information on eligibility, effective dates, and allowable expenses can be found in the Summary Plan Description, provided to you by your employer.

Member Information

First Name | MI | Last Name | Social Security Number *(required)*

Member Mailing Address *(PO Box, Apartment, Lot or Unit No.)* | City | State | Zip Code

Company Name | Member Email Address *(required)* | Plan Coverage Level: Single ☐ Family ☐

Type of Enrollment

☐ New Hire ☐ Open Enrollment ☐ Qualified Status Change Event Hire Date _____ Effective Date _____

Covered Individuals *(Please list only the eligible family member(s), including yourself, that you wish to enroll in the MEC Plan)*

Name (Last, First, MI) * *(please print legibly)*	**SSN *** *(privacy protected)*	**DOB *** *(mm/dd/yyyy)*	**Gender ***	**Relationship ***	**Primary Insurance Carrier** *(if covered by insurance plan other than this employer's)*
	(see above)		☐ M ☐ F	☑ Self	
			☐ M ☐ F	☑ Dependent Child	
			☐ M ☐ F	☑ Dependent Child	
			☐ M ☐ F	☑ Dependent Child	
			☐ M ☐ F	☑ Dependent Child	
			☐ M ☐ F	☑ Dependent Child	

*** Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) requires Flyte Human Capital Management to report specific enrollment data to the Centers for Medicare & Medicaid Services (CMS). The above information is required for your (and your family's) enrollment in the Plan and is used for financial reporting and to verify your identity, in compliance with federal and state law.**

Participation Waiver *(Please check the box below only if you wish to waive participation in the Plan)*

☐ I do NOT wish to participate in this tax-free, employer sponsored Plan.

Certification & Acknowledgement

I understand that my coverage can only be changed during the open enrollment period of the MEC or if I have a Qualified Change affecting my eligibility or the eligibility of my covered family members. I was offered the ability to opt-out of the Plan entirely and I have checked the box above if I have chosen to do so.

Signature of Member *Please be advised - unsigned forms cannot be processed.* | Date

Signature of Payroll / HR Officer | Name of Payroll / HR Officer (printed) | Date

7900 Excelsior Blvd. Suite 200 • Hopkins MN 55343
Phone: 952-658-8995 • Fax 952-777-2263
www.mcsmn.com

EMPLOYEE HANDBOOK ACKNOWLEDGMENT

I understand that this Handbook describes important information about the Organization.

I, _____ (Employee Name), acknowledge that on _____(date), I received a copy of Metropolitan Community Services' Handbook ("Handbook") and that I read it, understood it and agree to comply with it. I understand that Metropolitan Community Services has the maximum discretion permitted by law to interpret, administer, change, modify or delete the rules, regulations, procedures and benefits contained in the Handbook at any time with or without notice. No statement or representation by a supervisor or manager or any other employee, whether oral or written, can supplement or modify this Handbook. Changes can only be made if approved in writing. I also understand that any delay or failure by Metropolitan Community Services to enforce any rule, regulation, procedure contained in the Handbook will not constitute a waiver of Metropolitan Community Services' right to do so in the future.

I furthermore acknowledge that I have entered into my employment relationship with the Organization voluntarily and acknowledge that the relationship is one of "at-will" employment. I understand that neither this Handbook nor any other communication by a management representative or any other employee, whether oral or written, is intended in any way to create a contract of employment. I understand that, unless I have a written employment agreement signed by an authorized Metropolitan Community Services representative, I am employed at will and this policy does not modify my at-will employment status. If I have a written employment agreement signed by an authorized MCS representative and this Handbook conflicts with the terms of my employment agreement, I understand that the terms of my employment agreement will control.

Employee Name	Employee Signature	Date

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STAFF ORIENTATION OUTLINE & SIGN OFF

1. **Welcome to METROPOLITAN COMMUNITY SERVICES**
   - Mission Statement – Philosophy
   - Overview of Agency operations and services
     - ❖ Organizational structure
     - ❖ Various disciplines (personnel within each)
     - ❖ Overview of functions and coordination between services
     - ❖ Medical Assistance regulations -- frequently used terminology
   - Contract Agreement, if applicable

2. **Orientation to PCA Program Requirements**
   - Home Care Bill of Rights
   - Client Complaints
   - Office of Ombudsman
   - Vulnerable Adult/Child, including reporting requirements
   - Emergency Procedures (Handling emergencies and use of emergency services)
   - Review of the types of home care services employee will provide and scope of services agency provides

3. **Introduction and review of agency policies and procedures related to providing services**
   - Safety practices for clients and employees
   - Infection control
   - Employee misconduct
   - Employee Training requirements
   - HIPAA
   - Fraud and Abuse

4. **Orientation to Clinical and Written Procedures**
   - Position description and ADA requirements
   - General Administrative Policies
   - Client Care plan and documentation (time sheets)
     - ❖ Care Conferences/ Supervisory visits
     - ❖ Chart format -- various forms used within chart

5. **Agency Personnel Policies**
   - Review employee handbook
   - Review payroll requirements

6. **Complete Necessary Forms for Payroll and Regulatory Requirements**
   - W-4
   - I-9
   - Proof of PCA / CFSS Training
   - Employee Injury Report procedures
   - EEO Compliance

During this orientation program, I have received information, explanation, and training on the topics listed above.

Employee Name	Employee Signature	Date