MCS EMPLOYMENT APPLICATION & FORMS

Fill out the forms truthfully. Applicants should hold full responsibilities for all the information filled out on application forms.

Fill out the form completely and accurately. All items of the forms should be filled out. If nothing to declare, "N/A" should be filled in. Please do not leave any item blank without any reason.

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EMPLOYEE FACE SHEET

PERSONAL INFORMATION

Last Name	First Name	Middle Name
DOB	SSN	Languages Spoken
Address		
City	State	Zip Code
Phone Number	E-Mail	

EMERGENCY CONTACT INFORMATION

Name		Relationship to you
Address		
City	State	Zip Code
Phone Number	E-Mail	

FOR OFFICE USE ONLY

ALL APPLICANTS

☐ Employment Application	☐ Overtime Policy	☐ Copy of Social Security Card
☐ BCG Study Authorization Form	☐ W-4	☐ If Applicable, copy of a Green Card
☐ BCG Clearance	☐ W-4 MN	☐ If Applicable, copy of an Emp. Auth.
☐ Employee Confidentiality Agreement	☐ I-9	☐ MEC
☐ Acknowledgement: MN Stat. §268.095	☐ Direct Deposit Authorization	☐ HIPPA Training
☐ Acknowledgement: Employee Handbook	☐ Copy of Voided Check / Bank Lttr	☐ Fraud, Waste, Abuse Training
☐ Notice of Pay Rate	☐ Copy of Driver's License / State ID	☐ Bloodborne Pathogens Training

ADDITIONAL DOCUMENTS FOR PCAs/HMKs

☐ Ind. PCA Enrollment App. (DHS-4469)	☐ Job Description: PCA	☐ Acknowledgement: 275/310 Hour Limit
☐ Provider Agreement (DHS-4611)	☐ Job Description: HMK	☐ PCA/CFSS Certificate

ADDITIONAL DOCUMENTS FOR DSPs

☐ VAMR Certificate	☐ If Applicable, CPR Certificate	☐ DSP Job Description
☐ Maltreatment of Minors Training	☐ First Aid Training	☐ Copies of any Licenses / Certificates

ADDITIONAL DOCUMENTS FOR QPs

☐ QP Acknowledgement	☐ Resume	☐ Steps for Success Pre-Test
☐ RN License	☐ Diploma for Non-Licensed QP	

OTHER

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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 persons 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.

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 a 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;
- previous home addresses, city, county, and states of residence for the last five years;
- sex and date of birth;
- driver's license or other identification number, and;
- fingerprints and a photograph.

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 have been found responsible for substantiated maltreatment of a vulnerable adult or child. Background study data is classified as "private data" and cannot be shared without your consent except as explained in this notice.

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 to work.

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 and in some cases 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 Bureau of Criminal Apprehension will not keep your fingerprints. However, if an FBI check is required for your background study, the Federal Bureau of Investigation (FBI) will keep your fingerprints and may use them for other purposes.

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 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 a 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. Background studies are authorized under Minnesota Statutes, sections 256B.0943, subdivision 5a; 256B.0659, subdivision 11(a)(3); 241.021, subdivision 6(a);144.057, subdivision 1; 518.165, subdivision 4, and 524.5-118;

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

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310 - HOUR RULE ACKNOWLEDGEMENT

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

Employee Name:_____

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 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 to 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 is made. 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 Signature:_____ Date:_____

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ACKNOWLEDGEMENT OF MN STAT. § 268.095

Employee Name:_____

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 Signature:_____ Date:_____

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OVERTIME POLICY

Employee Name:_____

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 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 ACKNOWLEDGEMENT

Employee Name:_____

_____ 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 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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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.

Employee Name:_____

Employee Signature:_____ Date:_____

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Phone: 952-658-8995 • Fax 952-777-2263
www.mcsmn.com

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.

Employee Name:_____

Employee Signature:_____ Date:_____

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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 Signature:_____ Date:_____

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STAFF ORIENTATION OUTLINE & SIGN OFF

Employee Name:_____

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 Signature:_____ Date:_____

Minimum Essential Coverage (MEC) Plan Participation Agreement

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

Single ☐ Family ☐

Company Name | Member Email Address | Plan Coverage Level

Type of Enrollment

☐ New Hire ☐ Plan Open Enrollment ☐ Qualified Status Change Event (forward with the Employee Profile and Benefit Plan Change Form)

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 *** *(Spousal coverage may not be available)*	**Primary Insurance Carrier** *(if covered by insurance plan other than this employer's)*
	(see above)		☐ M ☐ F	☑ Self	
			☐ M ☐ F	☐ Spouse/Partner ☐ Dependent Child	
			☐ M ☐ F	☐ Spouse/Partner ☐ Dependent Child	
			☐ M ☐ F	☐ Spouse/Partner ☐ Dependent Child	
			☐ M ☐ F	☐ Spouse/Partner ☐ Dependent Child	
			☐ M ☐ F	☐ Spouse/Partner ☐ 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

Save Print Email Reset

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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	Other Last Names Used *(if any)*

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

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Save Print Email Reset

Employment Eligibility Verification

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

USCIS Form I-9
OMB No. 1615-0047
Expires 10/31/2022

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear 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.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

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

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

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

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

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

Examples of many of these documents appear in the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

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

DHS ENROLLMENT FORMS

A person who wants to become a PCA worker must enroll with the DHS as an individual MHCP PCA provider after passing a background study.

A PCA worker who is age 16-17 must be employed by only one PCA provider agency responsible for compliance with current labor laws.

Minnesota Department of **Human Services**

Dear Agency Representative,

As an agency that provides services to Minnesota Health Care Programs (MHCP) recipients, you must submit this enrollment application and provider agreement for each individual personal care assistant (PCA). This will:

- Assign a Unique Minnesota Provider Identifier (UMPI) to the PCA
- Allow you to bill us for the services the PCA provides

To enroll PCAs with us, the individual PCA must:

1. Read and understand the Privacy Notice
2. Pass the Background Study (BGS)* per PCA program requirements and be affiliated to the agency's BGS facility ID
3. Successfully complete and pass the required PCA training competency test
4. Meet the provider screening requirements
5. Correctly complete the application
6. Sign the application
7. Read and sign the MHCP Provider Agreement - Individual Support Worker (PCA, CDCS and CSG) (DHS-4611)

A new DHS BGS must be completed if the PCA has not been continuously employed with your agency.

*Complete a DHS BGS by logging in to the NetStudy website at https://bgs.dhs.state.mn.us/a/login.asp and follow directions.

More information is on the MHCP Provider webpage at www.dhs.state.mn.us/provider.

Fax the application and agreement to 651-431-7465.

MHCP accepts only faxed applications and agreements.

Minnesota Department of **Human Services**

DHS-4469-ENG 11-16

Minnesota Health Care Programs (MHCP)

Individual PCA Enrollment Application

Complete this form online, print and then fax to MHCP. Complete at least all bolded fields to enroll an individual PCA. We will return incomplete forms to you.

◉ New hire (requires new background study and completion of PCA training)

◯ Rehire (requires new background study and completion of PCA training) – PREVIOUS EMPLOYMENT END DATE: _____

◯ Previously used for managed care organization (MCO) claims only (new background study not required)

Individual PCA Information

PROVIDER TYPE 38 – INDIVIDUAL	**LEGAL NAME (FIRST)**	**FULL MIDDLE NAME**	**LAST NAME**	**SOCIAL SECURITY NUMBER**

ADDRESS (RESIDENTIAL ADDRESS ONLY – DO NOT ENTER A PO BOX)	**CITY**	**STATE**	**ZIP CODE**

COUNTY OF RESIDENCE	PHONE NUMBER	**DATE OF BIRTH**	**UMPI** (if requesting reinstatement)

INDIVIDUAL PCA TRAINING DATE PASSED: _____ CERTIFICATION NUMBER: _____	**Is the individual 18 years old or older?** ◯ Yes ◯ No* *May affiliate with only one agency
If previously used for MCO only claims, has this individual maintained continuous employment with your agency? ◯ Yes ◯ No	**BGS NUMBER or APPLICATION ID**

Individual PCA Provider Statement

I have reviewed and certify the information provided above is true and correct to the best of my knowledge. **I will notify the Minnesota Department of Human Services Provider Enrollment of any additions or changes to the information.**

By signing this form, I acknowledge I have read and understand the Application and Background Study Privacy Notice. I also authorize the Minnesota Department of Human Services to use the information collected about me according with the Privacy Notice.

NAME OF PCA (print or type)	**SIGNATURE OF PCA**	**DATE SIGNED**

Group Affiliation Information

You have the option to affiliate or enroll the individual PCA named above, if 18 years old or older, with other agencies you directly own without completing another application and agreement. Do you want to affiliate the above named individual PCA with any other agencies you own? ◯ Yes ◯ No (If yes, enter information below.)

ORGANIZATION OR AGENCY NAME	AGENCY NPI OR UMPI	STUDY ID

Agency Information

AGENCY NAME	AGENCY NPI OR UMPI	AGENCY FAX NUMBER

AGENCY PERSONNEL COMPLETING FORM	AGENCY SIGNATURE

Next Steps

Read, sign and date the MHCP Provider Agreement - Support Worker (PCA, CDCS and CSG) (DHS-4611), and return it with this application.

Fax the application and agreement to 651-431-7465. Only faxed requests will be processed.

Clear Form

DEPARTMENT OF HUMAN SERVICES

DHS-4611-ENG 2-21

MINNESOTA HEALTH CARE PROGRAMS (MHCP)

Individual Support Worker (CDCS, CSG, PCA, CFSS) Provider Agreement

As a participating provider in Minnesota Health Care Programs (MHCP) administered by the Minnesota Department of Human Services (DHS), the provider agrees to:

A. Submit documentation to your affiliated agency that fully discloses the extent of services provided to individuals under these programs. The documentation must be legible and meet the requirements of Minnesota Statutes, section 256B.0659, subdivision 12 for all individual support workers in Consumer Directed Community Supports (CDCS), Consumer Support Grant (CSG), Personal Care Assistance (PCA), and Community First Services and Supports (CFSS) .

B. Furnish DHS, the secretary of the U.S. Department of Health and Human Services (DHHS), or the Minnesota Medicaid Fraud Control Unit with such information as it may request regarding payments claimed for services provided under these programs.

C. Comply with all federal and state statutes and rules relating to the delivery of services to individuals and to the submission of claims for such services.

D. Accept as payment in full, amounts paid in accordance with schedules established by DHS, except where payment by the member has been authorized by DHS.

E. Make full disclosure of any conviction(s) of program crimes as required by the Code of Federal Regulations, title 42, section 455.106.

F. Comply with all federal statutes, implementing regulations and guidance prohibiting discrimination on the basis of race, color, national origin, sex, age, religion and disability in any program or activity receiving federal financial assistance from DHHS; and to comply with the Minnesota Human Rights Act.

G. Provide services to members of the same scope and quality as would be provided to the general public, within MHCP guidelines.

H. Comply with the provisions of any fully executed agreement or addendum required by DHS, which is incorporated herein by reference.

I. Comply with the advance directive requirements as required by the Code of Federal Regulations, title 42, sections 489.100 and 417.436.

J. Properly handle and safeguard protected information collected, created, used, maintained, or disclosed on behalf of DHS. For purposes of this agreement, “protected information” means data subject to any of the following laws:

1. The Minnesota Government Data Practices Act (MGDPA), Minnesota Statutes, chapter 13, section 13.46 ("welfare data");
2. The Minnesota Health Records Act, sections 144.291 and 144.298;
3. The Health Insurance Portability and Accountability Act (“HIPAA”), including but not limited to the requirements of the Privacy Rule and the Security Regulations, the Code of Federal Regulations, title 45, parts 160 and 164, subparts A and E.
4. Federal law and regulations that govern the use and disclosure of substance abuse treatment records, the United States Code, title 42, section 290dd-2 and the Code of Federal Regulations, title 42, sections 2.1 to 2.67; and

Electronic initials accepted.

DIRECT SUPPORT WORKER INITIALS	
NAME OF SUPPORT WORKER	UMPI

5. Any other applicable state and federal statutes, rules, and regulations affecting the collection, storage, use and dissemination of private or confidential information.

K. Comply with the laws described in section J. This includes the provider:

1. Not using or further disclosing protected information created, collected, received, stored, used, maintained or disseminated in the course or performance of this agreement other than as necessary to perform its obligations under this Provider Agreement, or as required by law, either during the period of this agreement or after. See, respectively, the Code of Federal Regulations, title 45, sections 164.502(b) and 164.514(d), and Minnesota Statutes, 13.05 subdivision 3.
2. Using appropriate administrative, physical, and technical safeguards to prevent use or disclosure of the protected information other than as provided for by this agreement and to ensure the confidentiality, integrity, and availability of any electronic protected health information (PHI) that it creates, receives, maintains, or transmits on behalf of DHS. The provider will not transmit PHI over the Internet or any other unsecure or open communications channel unless such information is encrypted or otherwise safeguarded using procedures no less stringent than those described in the Code of Federal Regulations, title 45, section 164.312. If the provider stores or maintains PHI in encrypted form, the provider shall, at DHS' request, promptly provide DHS with the key or keys to decrypt such information. The provider shall not forward previously encrypted data to any other party, unless otherwise required by this agreement.
3. Mitigating, to the extent practicable, any harmful effects known to the provider of a use, disclosure, or breach of security with respect to protected information by the provider in violation of this agreement.

L. Agree that this agreement may be immediately terminated at the discretion of DHS if it determines that the provider has violated a material term of the agreement, including but not limited to, non-compliance by the provider with the HIPAA Privacy Rule and Security Standards. If termination is not feasible, DHS shall report the breach to the Secretary of DHHS.
Upon termination of this agreement, all of the protected information provided by DHS to the provider, or created or received by the provider on behalf of DHS, that the provider still maintains in any form, including information that is in the hands of subcontractors or agents of the provider, shall be destroyed or returned to DHS, and the provider shall retain no copies of such information. If it is infeasible to return or destroy the information, the provider shall provide DHS notification of the conditions that make return or destruction infeasible, and shall extend the protections of this agreement to such information and limit further use and disclosure of such information to those purposes that make return or destruction infeasible, for as long as the provider maintains the information.

M. Agree that any ambiguity in this agreement shall be resolved to permit DHS to comply with HIPAA, MDGPA, and other applicable state and federal statutes, rules, and regulations affecting the collection, storage, use and dissemination of private or confidential information and other state and federal laws and regulations.

Upon signature, this Provider Agreement supersedes and replaces all former Provider Agreements the provider has with DHS.

An individual applicant must personally sign the Provider Agreement. Sign and date this form, initial page 1, and return both page 1 and page 2 of this agreement.

Check if signing electronically:

☐ I am signing this form electronically. My name as typed in the signature field is my legally binding signature. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (Minnesota Statutes 325L.02(h), 325L.05 and 325L.08)

NAME OF SUPPORT WORKER (TYPE OR PRINT)	TITLE
SIGNATURE OF SUPPORT WORKER	DATE

Keep a copy of the Provider Agreement for your files and upload the original form using the online Minnesota Provider Screening and Enrollment (MPSE) portal, or fax to 651-431-7465.

Agreement Summary

As an individual support worker, you are providing health care services to individuals. We require your enrollment in the Minnesota Health Care Programs (MHCP) and to be listed as the rendering provider on the claim so that you are represented as the person who provided the services. Knowing that a qualified individual provided the service ensures the safety of the people that the Minnesota Department of Human Services (DHS) serves. It also allows DHS to perform auditing and tracking of services which protects against double-billing and other types of fraud. Before enrollment is approved, MHCP must make certain that:

1. There is no legal or other reason why you shouldn't provide these services,
2. You understand what is necessary to properly provide these services, and
3. You understand the need to protect the privacy of the people you care for.

To help ensure that each of these conditions is met, MHCP requires that you agree to the terms in the attached Provider Agreement. In general, this agreement requires that you:

A. Provide documents to your employer about the services you provide.

B. Provide documents to MHCP or other state and federal agencies related to the services you provide, when requested.

C. Comply with federal and state laws about the services you provide.

D. Accept payment made to your employer as payment in full for the services you provide. You cannot ask for nor accept additional payment from the member.

E. Disclose any criminal convictions you have related to Medicare, Medicaid, or title XX services.

F. Not discriminate against individuals because of their race, color, national origin, sex, age, religion or disability when you provide these services.

G. Provide the same quality of service to persons receiving public assistance as those who don't receive such assistance.

H. If you are enrolled to provide and bill for other services, you must continue to follow the requirements of the agreement you signed when you enrolled for those services. The terms of that agreement are different than the terms in the attached agreement.

I. Comply with federal requirements about advance directives. An advance directive is written instruction, such as a living will, to give a patient control over medical treatment decisions.

J. Properly protect private information about the people to whom you provide services, especially their health information.

K. Don't disclose the private information of someone for whom you provide services, unless it is needed for your work. This includes not discussing someone's private information unless your job requires it. Also, ensure that the information could not be accessed by someone who does not have permission to see it. This includes not leaving paperwork out where others can see it, and not sending private information over the internet.

L. Understand that this agreement may be canceled if you violate its terms. If this agreement is canceled, you must properly dispose of any private information you have about the people you serve so that it is not discovered by someone who does not have permission to see it.

M. Understand that by signing this agreement, you are agreeing to protect any private information you come in contact with in your job. When you protect private information, you are complying with federal and state laws, and you help DHS comply with these laws, as well.

This is a basic description of the terms of this agreement.

By signing this agreement, you are agreeing to be legally bound by all of its terms. If you have questions about it, you should get answers to them before signing this agreement. If you need or want legal advice, you should contact your own attorney. For more information, call 651-431-2700.

Save Print Email Reset

PAYROLL FORMS

As you may know, Form W-4 is used to determine your withholding allowances based on your unique situation so that we can withhold the correct federal/state income tax from your pay. To complete the W-4 properly, you'll need to go through the personal allowance worksheet to ensure you're not paying too much or too little taxes come tax time!

You should consider completing a new Form W-4 when your personal or financial situation changes.

Save | Print | Email | Reset

Form **W-4**
(Rev. December 2020)
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

2021

Step 1: Enter Personal Information

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

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **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 accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ► ☐

TIP: To be accurate, submit a 2021 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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 Dependents

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

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

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

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

► _____ **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)
Metropolitan Community Services 7900 Excelsior Blvd., Suite 200, Hopkins, MN 55343		46-1868140

General Instructions

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2021 if you meet both of the following conditions: you had no federal income tax liability in 2020 **and** you expect to have no federal income tax liability in 2021. You had no federal income tax liability in 2020 if (1) your total tax on line 24 on your 2020 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, 29, and 30), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2021 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2022.

Your privacy. If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

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

1. Expect to work only part of the year;

2. Have dividend or capital gain income, or are subject to additional taxes, such as Additional Medicare Tax;

3. Have self-employment income (see below); or

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

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

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

Specific Instructions

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

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

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

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

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

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2021 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

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 2021 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:
- $25,100 if you're married filing jointly or qualifying widow(er)
- $18,800 if you're head of household
- $12,550 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 possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

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

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

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

Married Filing Jointly or Qualifying Widow(er)

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$190	$850	$890	$1,020	$1,020	$1,020	$1,020	$1,020	$1,100	$1,870	$1,870
$10,000 - 19,999	190	1,190	1,890	2,090	2,220	2,220	2,220	2,220	2,300	3,300	4,070	4,070
$20,000 - 29,999	850	1,890	2,750	2,950	3,080	3,080	3,080	3,160	4,160	5,160	5,930	5,930
$30,000 - 39,999	890	2,090	2,950	3,150	3,280	3,280	3,360	4,360	5,360	6,360	7,130	7,130
$40,000 - 49,999	1,020	2,220	3,080	3,280	3,410	3,490	4,490	5,490	6,490	7,490	8,260	8,260
$50,000 - 59,999	1,020	2,220	3,080	3,280	3,490	4,490	5,490	6,490	7,490	8,490	9,260	9,260
$60,000 - 69,999	1,020	2,220	3,080	3,360	4,490	5,490	6,490	7,490	8,490	9,490	10,260	10,260
$70,000 - 79,999	1,020	2,220	3,160	4,360	5,490	6,490	7,490	8,490	9,490	10,490	11,260	11,260
$80,000 - 99,999	1,020	3,150	5,010	6,210	7,340	8,340	9,340	10,340	11,340	12,340	13,260	13,460
$100,000 - 149,999	1,870	4,070	5,930	7,130	8,260	9,320	10,520	11,720	12,920	14,120	15,090	15,290
$150,000 - 239,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,830	14,030	15,230	16,190	16,400
$240,000 - 259,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,830	14,030	15,270	17,040	18,040
$260,000 - 279,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,870	14,870	16,870	18,640	19,640
$280,000 - 299,999	2,040	4,440	6,500	7,900	9,230	10,470	12,470	14,470	16,470	18,470	20,240	21,240
$300,000 - 319,999	2,040	4,440	6,500	7,940	10,070	12,070	14,070	16,070	18,070	20,070	21,840	22,840
$320,000 - 364,999	2,720	5,920	8,780	10,980	13,110	15,110	17,110	19,110	21,190	23,490	25,560	26,860
$365,000 - 524,999	2,970	6,470	9,630	12,130	14,560	16,860	19,160	21,460	23,760	26,060	28,130	29,430
$525,000 and over	3,140	6,840	10,200	12,900	15,530	18,030	20,530	23,030	25,530	28,030	30,300	31,800

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$440	$940	$1,020	$1,020	$1,410	$1,870	$1,870	$1,870	$1,870	$2,030	$2,040	$2,040
$10,000 - 19,999	940	1,540	1,620	2,020	3,020	3,470	3,470	3,470	3,640	3,840	3,840	3,840
$20,000 - 29,999	1,020	1,620	2,100	3,100	4,100	4,550	4,550	4,720	4,920	5,120	5,120	5,120
$30,000 - 39,999	1,020	2,020	3,100	4,100	5,100	5,550	5,720	5,920	6,120	6,320	6,320	6,320
$40,000 - 59,999	1,870	3,470	4,550	5,550	6,690	7,340	7,540	7,740	7,940	8,140	8,150	8,150
$60,000 - 79,999	1,870	3,470	4,690	5,890	7,090	7,740	7,940	8,140	8,340	8,540	9,190	9,990
$80,000 - 99,999	2,000	3,810	5,090	6,290	7,490	8,140	8,340	8,540	9,390	10,390	11,190	11,990
$100,000 - 124,999	2,040	3,840	5,120	6,320	7,520	8,360	9,360	10,360	11,360	12,360	13,410	14,510
$125,000 - 149,999	2,040	3,840	5,120	6,910	8,910	10,360	11,360	12,450	13,750	15,050	16,160	17,260
$150,000 - 174,999	2,220	4,830	6,910	8,910	10,910	12,600	13,900	15,200	16,500	17,800	18,910	20,010
$175,000 - 199,999	2,720	5,320	7,490	9,790	12,090	13,850	15,150	16,450	17,750	19,050	20,150	21,250
$200,000 - 249,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,820	20,930	22,030
$250,000 - 399,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,820	20,930	22,030
$400,000 - 449,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,910	21,220	22,520
$450,000 and over	3,140	6,250	8,830	11,330	13,830	15,790	17,290	18,790	20,290	21,790	23,100	24,400

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$820	$930	$1,020	$1,020	$1,020	$1,420	$1,870	$1,870	$1,910	$2,040	$2,040
$10,000 - 19,999	820	1,900	2,130	2,220	2,220	2,620	3,620	4,070	4,110	4,310	4,440	4,440
$20,000 - 29,999	930	2,130	2,360	2,450	2,850	3,850	4,850	5,340	5,540	5,740	5,870	5,870
$30,000 - 39,999	1,020	2,220	2,450	2,940	3,940	4,940	5,980	6,630	6,830	7,030	7,160	7,160
$40,000 - 59,999	1,020	2,470	3,700	4,790	5,800	7,000	8,200	8,850	9,050	9,250	9,380	9,380
$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,850	11,050	11,250	11,520	12,320
$80,000 - 99,999	1,880	4,280	5,710	7,000	8,200	9,400	10,600	11,250	11,590	12,590	13,520	14,320
$100,000 - 124,999	2,040	4,440	5,870	7,160	8,360	9,560	11,240	12,690	13,690	14,690	15,670	16,770
$125,000 - 149,999	2,040	4,440	5,870	7,240	9,240	11,240	13,240	14,690	15,890	17,190	18,420	19,520
$150,000 - 174,999	2,040	4,920	7,150	9,240	11,240	13,290	15,590	17,340	18,640	19,940	21,170	22,270
$175,000 - 199,999	2,720	5,920	8,150	10,440	12,740	15,040	17,340	19,090	20,390	21,690	22,920	24,020
$200,000 - 249,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,880	24,980
$250,000 - 349,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,880	24,980
$350,000 - 449,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,900	25,200
$450,000 and over	3,140	6,840	9,570	12,160	14,660	17,160	19,660	21,610	23,110	24,610	26,050	27,350

Save | Print | Email | Reset

DEPARTMENT OF REVENUE

2021 W-4MN, Minnesota Employee Withholding Allowance/Exemption Certificate

Employees

Complete Form W-4MN so that your employer can withhold the correct Minnesota income tax from your pay. Consider completing a new Form W-4MN each year or when your personal or financial situation changes.

Employee's First Name and Initial	Last Name	Employee's Social Security Number

Permanent Address

City | State | ZIP Code

Marital Status *(Check one):*

- ☐ Single; Married, but legally separated; or Spouse is a nonresident alien
- ☐ Married
- ☐ Married, but withhold at higher Single rate

Read instructions on back. Complete Section 1 OR Section 2, then sign and give the completed form to your employer.
Do not complete both Section 1 and Section 2. Completing both sections will make the form invalid.

☐ **Section 1 — Determining Minnesota Allowances**

A Enter "1" if no one else can claim you as a dependent . . . . . **A** _____

B Enter "1" if any of the following apply: . . . . . **B** _____

- You are single and have only one job
- You are married, have only one job, and your spouse does not work
- Your wages from a second job or your spouse's wages are $1500 or less

C Enter "1" if you are married. You may choose to enter "0" if you are married and have either a working spouse or more than one job. *(Entering "0" may help you avoid having too little tax withheld.)* . . . . . **C** _____

D Enter the number of dependents (other than your spouse or yourself) you will claim on your tax return. . . . **D** _____

E Enter "1" if you will use the filing status Head of Household *(see instructions)*. . . . . **E** _____

F **Total number of allowances claimed**. Add steps A through E.
If you plan to itemize deductions on your 2021 Minnesota income tax return, you may also complete the Itemized Deductions and Additional Income Worksheet. . . . . **F** _____

☐ **Section 2 — Exemption From Minnesota Withholding**

Complete Section 2 if you claim to be exempt from Minnesota income tax withholding *(see Section 2 instructions for qualifications)*. If applicable, check one box below to indicate why you believe you are exempt:

☐ **A** I meet the requirements and claim exempt from both federal and Minnesota income tax withholding

☐ **B** Even though I did not claim exempt from federal withholding, I claim exempt from Minnesota withholding, because:

- I had no Minnesota income tax liability last year
- I received a refund of all Minnesota income tax withheld
- I expect to have no Minnesota income tax liability this year

☐ C All of these apply:

- My spouse is a military service member assigned to a military location in Minnesota
- My domicile (legal residence) is in another state
- I am in Minnesota solely to be with my spouse. My state of domicile is _____

☐ **D** I am an American Indian that resides and works on a reservation

☐ **E** I am a member of the Minnesota National Guard or an active duty U.S. military member and claim exempt from Minnesota withholding on my military pay

☐ **F** I receive a military pension or other military retirement pay as calculated under U.S. Code, title 10, sections 1401 through 1414, 1447 through 1455, and 12733, and I claim exempt from Minnesota withholding on this retirement pay

Minnesota Allowances and Additional Withholding

1 **Minnesota Allowances.** Enter Step F from Section 1 above or Step 10 of the Itemized Deductions Worksheet . . **1** _____

2 Additional Minnesota withholding you want deducted each pay period *(see instructions)* . . . . . **2** _____

I certify that all information provided in Section 1 ***OR*** *Section 2 is correct. I understand there is a $500 penalty for filing a false Form W-4MN.*

Employee's Signature | Date | Daytime Phone Number

Employees: Give the completed form to your employer.

Employers

See the employer instructions to determine if you must send a copy of this form to the Minnesota Department of Revenue. If required, enter your information below and mail this form to the address in the instructions. (Incomplete forms are considered invalid.) We may assess a $50 penalty for each required Form W-4MN not filed with us. Keep a copy for your records.

Name of Employer	Federal Employer ID Number (FEIN)	Minnesota Tax ID Number
Metropolitan Community Services	46-1868140	2866341

Address	City	State	ZIP Code
7900 Excelsior Blvd., Suite 200	Hopkins	MN	55343

DEPARTMENT OF REVENUE

Form W-4MN Employee Instructions

Complete this form for your employer to calculate the amount of Minnesota income tax to be withheld from your pay.

When should I complete Form W-4MN?

Complete Form W-4MN if any of these apply:

- You begin employment
- You change your filing status
- You reasonably expect to change your filing status in the next calendar year
- Your personal or financial situation changes
- You claim exempt from Minnesota withholding (see Section 2 instructions for qualifications)

If you have not had sufficient Minnesota income tax withheld from your wages, we may assess penalty and interest when you file your state income tax return.

Note: Your employer may be required to submit a copy of your Form W-4MN to the Minnesota Department of Revenue. You may be subject to a $500 penalty if you provide a false Form W-4MN.

What if I have completed federal Form W-4?

If you completed a 2021 Form W-4, you must complete Form W-4MN to determine your Minnesota withholding allowances.

What if I am exempt from Minnesota withholding?

If you claim exempt from Minnesota withholding, complete only Section 2 of Form W-4MN and sign the form to validate it. If you complete Section 2, you must complete a new Form W-4MN by February 15 in each following year.

You cannot claim exempt from withholding if all of these apply:

- Another person can claim you as a dependent on their federal tax return
- Your annual income exceeds $1,100
- Your annual income includes more than $350 of unearned income

What if I am a nonresident alien for U.S. income taxes?

If you are a nonresident alien, you are not allowed to claim exempt from withholding. You will check the single box for marital status regardless of your actual marital status and may enter one personal allowance on Step A. Enter zero on steps B, C, and E.

If you are resident of Canada, Mexico, South Korea, or India, and are allowed to claim dependents, you may enter the number of dependents on Step D.

Section 1 — Minnesota Allowances Worksheet

Complete Section 1 to find your allowances for Minnesota withholding tax. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

If you expect to owe more income tax for the year than will be withheld, you can claim fewer allowances or request additional Minnesota withholding from your wages. Enter the amount of additional Minnesota income tax you want withheld on line 2 of Section 1.

Nonwage Income

Consider making estimated payments if you have a large amount of "nonwage income." Nonwage income (other than tax-exempt income) includes interest, dividends, net rental income, unemployment compensation, gambling winnings, prizes and awards, hobby income, capital gains, royalties, and partnership income.

Two Earners or Multiple Jobs

If your spouse works or you have more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4MN. Usually, your withholding will be more accurate when all allowances are claimed on the Form W-4MN for the highest paying job and zero allowances are claimed on the others.

Head of Household Filing Status

You may claim Head of Household as your filing status if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself, your dependents, and other qualifying individuals. Enter "1" on Step E if you may claim Head of Household as your filing status on your tax return.

What if I itemize deductions on my Minnesota return or have other nonwage income?

Use the Itemized Deductions and Additional Income Worksheet to find your Minnesota withholding allowances. Complete Section 1 on page 1, then follow the steps in the worksheet on the next page to find additional allowances.

Section 2 — Minnesota Exemption

Your employer will not withhold Minnesota taxes from your pay if you are exempt from Minnesota withholding. You cannot claim exempt from withholding if all of these apply:

- Another person can claim you as a dependent on their federal tax return
- Your annual income exceeds $1,100
- Your annual income includes more than $350 of unearned income

Continued

Itemized Deductions and Additional Income Worksheet

1 Enter an estimate of your 2021 Minnesota itemized deductions. For 2021, you may have to reduce your itemized deductions if your income is over $199,850 ($99,925 for Married Filing Separately). . . . . _____

2 Enter one of the following based on your filing status: . . . . . _____
   a. $25,050 if Married Filing Jointly
   b. $18,800 if Head of Household
   c. $12,525 if Single or Married Filing Separately

3 Subtract step 2 from step 1. If zero or less, enter 0 . . . . . _____

4 Enter an estimate of your 2021 additional standard deduction (from page 11 of the Form M1 instructions) . . . . . _____

5 Add steps 3 and 4 . . . . . _____

6 Enter an estimate of your 2021 taxable nonwage income . . . . . _____

7 Subtract step 6 from step 5. If zero, enter 0. If less than zero, enter the amount in parentheses. . . . . _____

8 Divide the amount on step 7 by $4,350. If a negative amount, enter in parentheses. Do not include fractions . . . . . _____

9 Enter the number on step F of Section 1 on page 1 . . . . . _____

10 Add step 8 and 9 and enter the total here. If zero or less, enter 0. Enter this amount on line 1 of page 1. . . . . _____

Box A

Check box A of Section 2 to claim exempt if all of these apply:

- You meet the requirements to be exempt from federal withholding
- You had no Minnesota income tax liability in the prior year and received a full refund of Minnesota tax withheld
- You expect to have no Minnesota income tax liability for the current year

Box B

Check box B of Section 2 if you are not claiming exempt from federal withholding, but meet the second and third requirements for box A.

Box C

Check box C in Section 2 to claim exempt if all of these apply:

- You are the spouse of a military member assigned to duty in Minnesota
- You and your spouse are domiciled in another state
- You are in Minnesota solely to be with your active duty military spouse member

Boxes D-F

If you receive income from the following sources, it is exempt from Minnesota withholding. Your employer will not withhold Minnesota tax from that income when you check the appropriate box in Section 2.

- **Box D:** You receive wages as a member of an American Indian tribe living and working on the reservation of which you are an enrolled member.
- **Box E:** You receive wages for Minnesota National Guard (MNG) pay or for active duty U.S. military pay. MNG and active duty U.S. military members can claim exempt from Minnesota withholding on these wages, even if they are taxable federally. For more information, see Income Tax Fact Sheet 5, Military Personnel.
- **Box F:** You receive a military pension or other military retirement pay calculated under U.S. Code title 10, sections 1401 through 1414, 1447 through 1455, and 12733. You may claim exempt from Minnesota withholding on this income even if it is taxable federally.

Note: You may not want to claim exempt if you (or your spouse if filing a joint return) expect to have other forms of income subject to Minnesota tax and you want to avoid owing tax at the end of the year.

If you complete Section 2, you must complete a new Form W-4MN by February 15 in each following year.

Nonresident Alien

If you are a nonresident alien for federal tax purposes, do not complete Section 2.

Additional Minnesota Withholding

If you would like an additional amount of tax to be deducted per payment period, enter the amount on line 2. Do not enter a percentage of the payment you want to be deducted.

Use of Information

All information on Form W-4MN is private by state law. It cannot be given to others without your consent, except to the Internal Revenue Service, to other states that guarantee the same privacy, and by court order. Your name, address, and Social Security Number are required for identification. Information about your allowances is required to determine your correct tax. We ask for your phone number so we can call if we have a question.

Questions?

- Website: www.revenue.state.mn.us
- Email: withholding.tax@state.mn.us
- Phone: 651-282-9999 or 1-800-657-3594 (toll-free)

Employer instructions are on the next page.

Form W-4MN Employer Instructions

Form W-4MN Requirement

Federal Form W-4 will not determine withholding allowances used to determine the amount of Minnesota withholding. Employees completing a 2021 Form W-4 will need to complete 2021 Form W-4MN to determine the appropriate amount of Minnesota withholding.

Lock-In Letters

Internal Revenue Service (IRS) Letter 2800C tells you when the IRS believes your employee may have filed an incorrect federal Form W-4. If you receive this letter, you must provide the Minnesota Department of Revenue with a copy of the employee's Form W-4MN. We will verify the number of allowances that the employee may claim for Minnesota purposes. Continue using the Form W-4MN you were using at the time you received Letter 2800C from the IRS, until we notify you to change the amount of allowances on the employee's Form W-4MN. If the employee has not completed a Form W-4MN, have them complete the form and use the allowances calculated on that form until notified by the department.

Use the amount on line 1 of page 1 for calculating the withholding tax for your employees.

When does an employee complete Form W-4MN?

Employees complete Form W-4MN when they begin employment or when their personal or financial situation changes.

How should I determine Minnesota withholding for an employee that does not complete Form W-4MN?

If an employee does not complete Form W-4MN and they have a federal Form W-4 (from 2019 or prior years) on file, use the allowances on their federal Form W-4. Otherwise, withhold Minnesota tax as if the employee is single with zero withholding allowances.

What if my employee claims to be exempt from Minnesota withholding?

If your employee claims exempt from Minnesota withholding, they must complete Section 2 of Form W-4MN. They must provide you with a new Form W-4MN by February 15 of each year. If you are paying an employee for wages that are exempt from withholding, such as Medicaid Waiver Payments or wages to H-2A visa workers, do not send us Form W-4MN.

When do I need to submit copies of a Form W-4MN to the department?

You must send copies of Form W-4MN to us if any of these apply:

- The employee claims more than 10 Minnesota withholding allowances
- The employee checked box A or B under Section 2, and you reasonably expect the employee's wages to exceed $200 per week
- You believe the employee is not entitled to the number of allowances claimed

You do not need to submit Form W-4MN to us if the employee is asking to have additional Minnesota withholding deducted from their pay.

We may assess a $50 penalty for each Form W-4MN you do not file with us when required.

Mail Forms W-4MN to:

Minnesota Department of Revenue
Mail Station 6501
600 N. Robert St.
St. Paul, MN 55146-6501

What if my employee is a resident of a reciprocity state?

If your employee is a resident of North Dakota or Michigan and they do not want you to withhold Minnesota tax from their wages, they must complete Form MWR, *Reciprocity Exemption/Affidavit of Residency*. They must complete a Form MWR by February 28 of each year, or within 30 days after they begin working or change their permanent residence. See Withholding Fact Sheet 20, *Reciprocity - Employee Withholding,* for more information.

What is an invalid Form W-4MN?

A Form W-4MN is considered invalid if any of these apply:

- There is any unauthorized change or addition to the form, including any change to the language certifying the form is correct
- The employee indicates in any way the form is false by the date they provide you with the form
- The form is incomplete or lacks the necessary signatures
- Both Section 1 and Section 2 were completed
- The employer information is incomplete

What if I receive an invalid form?

Do not use the invalid form to calculate Minnesota income tax withholding. Have the employee complete and submit a new Form W-4MN. If the employee does not give you a valid form, and you have an earlier Form W-4MN from them, use the earlier form to calculate their withholding.

If a valid Form W-4MN is not completed by the employee, withhold taxes as if the employee is single and claiming zero withholding allowances.

What if my employee is a nonresident alien of the United States?

If the wages to this employee are subject to income tax withholding, you will use Table 1 and the procedure under **Withholding Adjustment for Nonresident Alien Employees** in IRS Publication 15-T to determine the correct Minnesota withholding tax. Do not use this procedure for nonresident alien students from India and business apprentices from India. See IRS Notice 1392 for special instructions and withholding exceptions.

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

WAGE PAYMENT AUTHORIZATION FORM

Employee Name:_____ Phone #:_____

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:

Street Address:_____

City/State/Zip:_____

_____ 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 $30.00 fee will be charged to the employee to stop payment on the lost/stolen check.

Employee Signature:_____ Date:_____

METROPOLITAN COMMUNITY SERVICES

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

PAYROLL SCHEDULE 2021

No.	Working Period	Timecards must be received by	Pay Day (Friday)
1	12/07/2020 - 12/20/2020	12/24/2020	01/08/2021
2	12/21/2020 - 01/03/2021	01/07/2021	01/22/2021
3	01/04/2021 - 01/17/2021	01/21/2021	02/05/2021
4	01/18/2021 - 01/31/2021	02/04/2021	02/19/2021
5	02/01/2021 - 02/14/2021	02/18/2021	03/05/2021
6	02/15/2021 - 02/28/2021	03/04/2021	03/19/2021
7	03/01/2021 - 03/14/2021	03/18/2021	04/02/2021
8	03/15/2021 - 03/28/2021	04/01/2021	04/16/2021
9	03/29/2021 - 04/11/2021	04/15/2021	04/30/2021
10	04/12/2021 - 04/25/2021	04/29/2021	05/14/2021
11	04/26/2021 - 05/09/2021	05/13/2021	05/28/2021
12	05/10/2021 - 05/23/2021	05/27/2021	06/11/2021
13	05/24/2021 - 06/06/2021	06/10/2021	06/25/2021
14	06/07/2021 - 06/20/2021	06/24/2021	07/09/2021
15	06/21/2021 - 07/04/2021	07/08/2021	07/23/2021
16	07/05/2021 - 07/18/2021	07/22/2021	08/06/2021
17	07/19/2021 - 08/01/2021	08/05/2021	08/20/2021
18	08/02/2021 - 08/15/2021	08/19/2021	09/03/2021
19	08/16/2021 - 08/29/2021	09/02/2021	09/17/2021
20	08/30/2021 - 09/12/2021	09/16/2021	10/01/2021
21	09/13/2021 - 09/26/2021	09/30/2021	10/15/2021
22	09/27/2021 - 10/10/2021	10/14/2021	10/29/2021
23	10/11/2021 - 10/24/2021	10/28/2021	11/12/2021
24	10/25/2021 - 11/07/2021	11/11/2021	11/26/2021
25	11/08/2021 - 11/21/2021	11/25/2021	12/10/2021
26	11/22/2021 - 12/05/2021	12/09/2021	12/24/2021

OUR OFFICE IS CLOSED ON:

New Year's Day	Friday, January 1, 2021	Thanksgiving Day	Thursday, November 25, 2021
Memorial Day	Monday, May 31, 2021	Day after Thanksgiving	Friday, November 26, 2021
Independence Day	Monday, July 5, 2021	Christmas Day	Friday, December 24, 2021
Labor Day	Monday, September 6, 2021	New Year's Eve	Friday, December 31, 2021