Attendant Application

Open applications will be accepted without ID, however, when completing the second half of the application or a full application you must submit either 1 document from List A or a document from List B AND List C identified on the list of acceptable documents attached to the Form I-9. Documents presented must be original documents, no copies will be accepted.

Date: ______________

Employer/Consumer (print):

________________________________________

Employee/Attendant (print):

________________________________________

Are you related to your employer? Yes _______ No _______

How are you related?

☐ Parent
☐ Child
☐ Sibling
☐ Grandchild
☐ Cousin
☐ Other _______________

* Please note that an employer (consumer) cannot employ a spouse.
Consumer Directed Services
Attendant Application

Personal Data  
Date: ____________

Name: ____________________________________________________________

Address: __________________________________________________________

Street address  City  State  Zip  

Phone: (home) __________ (cell) __________ message phone: __________

Your mode of transportation: Own car _____ Bus _____ other _____

Some Consumers may have allergies—do you smoke?  □ Yes  □ No

Have you lived in Missouri for the last five (5) years? If no what other states have you lived in?

____________________________________________________________________

Do you have any criminal convictions, findings of guilt, pleas of guilty and or pleas of nolo contendere except minor traffic offenses?  □ Yes  □ No

If “yes”, describe offense and when it occurred:

____________________________________________________________________

Have you ever been an attendant for the CDS Program?  □ Yes  □ No

How did you learn about this position?

____________________________________________________________________

Have you ever worked with persons with disabilities?  □ Yes  □ No

Are you a Certified Nursing Assistant (CNA)?  □ Yes  □ No

Please check boxes you have experience in:

Personal Care
☐ Bathing/grooming
☐ Dressing
☐ Toileting
☐ Mobility
☐ Transferring
☐ Hoyer lift
☐ Assist with ambulation

Other plan of care tasks
☐ General housecleaning (vacuuming, dusting)
☐ Laundry
☐ Meal Preparation
☐ Meal clean-up
☐ Assist with eating
☐ Shopping for someone
☐ Transporting consumer Dr. or to shop

Other experience not mentioned:

____________________________________________________________________
Employment History (most recent first)

Company Name: ___________________________ Phone:________________________
Address: ___________________________ Phone:________________________
Dates of employment (from) _______ (to) _______ Position: ________________
Duties: ___________________________ Reason for leaving: ___________________________
Are you eligible for re-hire? □ Yes □ No If No explain why: ___________________________

Company Name: ___________________________ Phone:________________________
Address: ___________________________ Phone:________________________
Dates of employment (from) _______ (to) _______ Position: ________________
Duties: ___________________________ Reason for leaving: ___________________________
Are you eligible for re-hire? □ Yes □ No If No explain why: ___________________________

Do you wish for your previous employers to be contacted? □ Yes □ No

References
Please list three personal references not related to you.

Name: ___________________________ Relationship: ___________________________
Address: ___________________________ Phone: ___________________________

Name: ___________________________ Relationship: ___________________________
Address: ___________________________ Phone: ___________________________

Name: ___________________________ Relationship: ___________________________
Address: ___________________________ Phone: ___________________________

I certify that the answers given herein are true and complete to the best of my knowledge.
I understand that if I transport a consumer in my car I take on the assumption of liability.
By signing this application, I give consent to a pre-employment criminal record check & a closed
record check pursuant to section 610.210.RSMo.

Applicant signature ___________________________ Date ___________________________

Midland Empire Resources for Independent Living accepts job applications for attendant
positions as a service to consumers who may need an attendant. MERIL is not the employer or
independent contractor for or with consumers or attendants. Attendants are responsible for
negotiating working relationships with individual consumers, including discussion of
responsibility for payment of taxes, etc.
<table>
<thead>
<tr>
<th>Medicaid</th>
<th>Attendant Care Contract</th>
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<td>Non-Public Entity OHCDS</td>
<td>[Services to be Subcontracted by Center for Independent Living]</td>
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<td>Organized Health Care Delivery System</td>
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<td>Home and Community Based Services</td>
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A. **Consumer/Employer’s Name:**

B. **Attendant/Employee’s Name:**

C. **Date of Contract:**

**ATTENDANT CARE CONTRACT**

This Attendant Care Contract ("Contract") is made by the Center for Independent Living and the Attendant/Employee identified in line B. above [who will be employed by the Consumer/Employer identified in line A. above] as of the Date of Contract specified in line C. above.

1. **Definitions and responsibilities.** In order to make this Contract more easily understood, certain terms are defined and various responsibilities are described as follows:

   a.) The term **"Consumer/Employer"** means the individual identified in line A. above who requires attendant care services in his/her home. Hereafter, the Consumer/Employer will be referred to as **"Consumer."** Consumer is the employer of the Attendant/Employee and as such is responsible for directing, managing, scheduling (within the parameters of authorized service hours), and supervising the Attendant/Employee. Consumer is responsible for reviewing all timesheets connected with Attendant/Employee’s hours of service for accuracy, and Consumer is responsible for promptly forwarding the same to CIL. Consumer, through the fiscal intermediary, will pay the Attendant/Employee for services authorized in Consumer’s Plan of Care and by this Contract. Consumer will not pay Attendant/Employee for any services not authorized in Consumer’s Plan of Care, and will make no supplemental payments to Attendant/Employee. Consumer will not pay Attendant/Employee for hours in excess of those authorized in Consumer’s Plan of Care and in the documents furnished to Consumer by CIL.

   b.) The term **"Attendant/Employee"** means the individual identified in line B. above who, as a party to this Contract, agrees to provide attendant care services to Consumer in Consumer’s home. Hereafter, the
Attendant/Employee will be referred to as “Attendant.” Attendant shall have and maintain the qualifications, credentials, certifications, licenses, and/or training (“qualifications”) necessary to perform the attendant care services described and authorized in Consumer’s Plan of Care before rendering any attendant care services to Consumer. Attendant is not entitled to be paid until and unless he/she has met/maintained all qualifications for rendering attendant care services. Attendant agrees that he/she will accept as payment in full for the services described and authorized in Consumer’s Plan of Care the payments he/she receives pursuant to this Contract. He/she will not seek additional or supplemental payments from Consumer or others acting on behalf of Consumer nor will he/she accept additional or supplemental payments from Consumer or others acting on behalf of Consumer.

c.) The term “attendant care services” or “attendant care” means those services that Consumer needs to have provided to him/her within his/her home in order to achieve independent living within the community. Attendant care services may include but are not limited to helping Consumer with eating, dressing, meal preparation, toileting, bathing, grooming, transferring, and specific health maintenance tasks, as well as some incidental housekeeping tasks that insure Consumer’s health and safety, like grocery shopping and laundry. The attendant care services that Attendant will perform will be described and authorized in the Consumer’s Plan of Care. A copy of the pertinent parts of the Plan of Care will be provided to Attendant.

d.) The term “Center for Independent Living” means the agency signing this Contract. Hereafter, the Center for Independent Living will be referred to as “CIL.” It is recognized as a vendor of Consumer-Directed Services and enrolled as an Organized Health Care Delivery System with the Department of Social Services, Division of Medical Services. CIL is authorized to provide administrative support to Consumer. CIL is authorized to enter into payroll service contracts with payroll service companies to provide fiscal intermediary services as set forth below.

e.) The term “fiscal intermediary” means a payroll service company, under contract with CIL, retained to perform “fiscal intermediary services”—those services that an employer must generally perform in connection with paying his/her employee. These include calculating the amount that an employee is to be paid, writing payroll checks (or making direct deposits), withholding and paying state and federal income taxes to the appropriate authorities, withholding and paying Social Security (FICA) and Medicare payments and/or employer’s portions as is required by law or regulation and paying them to the appropriate authorities, and making unemployment/workers compensation insurance payments, as well as withholding/paying those amounts as may be required by law or regulation from time-to-time. The fiscal intermediary will provide Attendant with a written summary of all
deductions and payments made. The fiscal intermediary will prepare and provide Consumer and Attendant with end-of-year tax information and forms within the time prescribed by law, such as W-2’s, so that Consumer and Attendant may comply with all tax filing requirements. The fiscal intermediary will maintain copies of all records required by law or regulation for tax and other purposes, and these shall be the official records documenting the employer/employee (Consumer/Attendant) relationship.

2. **Purpose and background information.** The purpose of this Contract is to allow Consumer to interview, hire, direct, manage, schedule (within the parameters of authorized service hours), supervise, and discharge his/her Attendant. CIL is a vendor of Consumer-Directed Services and as such it is authorized by the Missouri Department of Health and Senior Services to provide administrative support for Consumer-Directed Services. CIL may contract with payroll service companies to act as fiscal intermediary. The fiscal intermediary will act as an agent for and provide payroll services for Consumer, as explained herein.

Consumer will employ Attendant to work in Consumer’s home, at the direction and under the supervision of Consumer, to provide the attendant care services described and authorized in Consumer’s Plan of Care. Because of the work arrangement contemplated in this Contract, Attendant is an employee of Consumer for purposes of the federal Fair Labor Standards Act, and not an independent contractor. It is, therefore, necessary that Consumer withhold and pay all income taxes required by law, as well as all other withholdings or payments that employers generally make in connection with employees in order to comply with applicable laws and regulations.

The fiscal intermediary will perform fiscal intermediary services as described above and prepare and write payroll checks to Attendant on behalf of Consumer.

3. **Basis for payment.** Attendant agrees to perform the attendant care services described and authorized in Consumer’s Plan of Care at an initial rate equal to $9.45/hour, which rate may be increased from time-to-time with or without notice to Attendant. Attendant will be paid only for those services described and authorized in Consumer’s Plan of Care, and no others. Medicaid will provide funds to the fiscal intermediary to pay Attendant for authorized attendant care services actually performed for Consumer. Attendant is not permitted to work in excess of the number of hours authorized during a given month. If he/she does so, he/she will not be paid for those hours through this Contract. Attendant is not permitted to off-set excess hours in one month against scheduled hours in another month, even if this is agreeable to Consumer. Attendant understands that he/she is not entitled to nor will he/she receive as part of his/her payment hereunder, or otherwise, any “fringe” benefits, such as health insurance, sick leave, paid personal days, paid vacations, paid holidays, and the like.
4. Method of payment. CIL will provide Consumer with documents authorizing payment for the services described and authorized in Consumer’s Plan of Care. The documents will set forth: a) the maximum number of hours to be worked during a specific time period; b) the rate of compensation in effect for the services; and, c) the applicable time period for performance of the attendant care services. CIL will also provide Consumer with timesheets to record the services performed by Attendant and the time spent in service. The completed timesheets are the basis for payment to Employee.

Payroll will be processed bi-weekly. At the end of each payroll period, Consumer will review and approve the completed timesheet and forward the same to CIL. Timesheets must be received by CIL within three (3) calendar days of the end of a payroll period in order to be included in the next payroll. If CIL does not receive the timesheets within the prescribed time, then payment will not be processed until the next payroll, and Attendant’s payment will be delayed.

It is imperative that Consumer and Attendant accurately record and report services and hours. Falsification or misrepresentation on any timesheet constitutes fraud. Payments made on behalf of Consumer as a result of inaccurate timesheets will be recouped from Attendant and/or Consumer. Any incidents of apparent fraud may be reported to Medicaid and/or other appropriate authorities.

5. Conditions and understandings of Contract. The quality, appropriateness, and timeliness of the attendant care services rendered and reimbursed through this Contract are subject to evaluation, through inspection or other means, by CIL. In addition, for so long as Medicaid funds are used, in whole or in part, to pay Attendant, the Missouri Department of Social Services and the U.S. Department of Health and Human Services, and/or its/their designee(s), have the right to evaluate, through inspection or other means, the attendant care services rendered and reimbursed hereunder.

Attendant understands and agrees that he/she is not an employee of CIL. Attendant will not represent to anyone that he/she is an employee of CIL.

Attendant understands and agrees that he/she is not an employee of the State of Missouri or any department, unit, agency, or subdivision thereof. Attendant will not represent to anyone that he/she is an employee of the State of Missouri or any department, unit, agency, or subdivision thereof.

Attendant understands and agrees that pursuant to this Contract, he/she is employed solely by Consumer.
Attendant understands and agrees that this Contract is non-exclusive. Consumer may enter into one or more other Attendant Care Contracts with other attendants. Consumer may terminate this Contract with Attendant and such termination will have no effect on other non-terminated contracts which will remain in full force and effect.

Similarly, Attendant may enter into one or more Attendant Care Contracts with other consumers. Termination of one or more of such other Attendant Care Contract(s) with other consumer(s) does not automatically terminate this Contract.

Attendant understands and agrees that this Contract does not guarantee him/her any specific number of hours of work or any hours at all.

Attendant understands and agrees that he/she may not act as Consumer’s personal representative in matters regarding medical treatment, financial, and/or budgetary decision making, unless Attendant is Consumer’s legal guardian, agent under power of attorney, conservator, or representative payee, and is acting within the scope of his/her legal authority.

6. Liability for work related injury/illness. Attendant understands and agrees that Attendant and/or Consumer is/are solely responsible for any injuries or illness Attendant sustains while providing attendant care services and/or acting within the scope of his/her employment, and that neither CIL nor the State of Missouri has any liability for such injuries or illness.

7. Direction and supervision of consumer. Attendant understands and agrees that he/she will perform the attendant care services specified in Consumer’s Plan of Care in Consumer’s home under the direction and supervision of Consumer, in a manner reasonably satisfactory to Consumer, on such dates and at such times as agreed upon by Attendant and Consumer; however, the service time shall not exceed the number of hours authorized for service.

8. Termination for cause. Attendant understands and agrees that Consumer may establish reasonable standards for employment and performance and may discharge Attendant for violation of the same. Attendant understands that Consumer may discharge Attendant for cause with or without prior notice to Attendant. Consumer’s discharge of Attendant for cause is a termination of this Contract for cause.

9. Termination by Attendant. Attendant may terminate this Contract, with or without cause, upon 30-days written notice to Consumer and CIL of his/her intention to terminate.

10. Contract term. If this Contract has not been previously terminated, it shall terminate one year from the Date of Contract specified in line C. above, or it shall
be renewed as set forth herein. On or before the end of the Contract term, CIL will review this Attendant Care Contract. If CIL determines that Attendant is employed by Consumer at the end of the Contract term and the terms of this Contract are met, then this Contract shall automatically renew for a consecutive one-year term unless Consumer has informed CIL that he/she no longer wishes to employ Attendant or Attendant has informed CIL that he/she no longer wishes to work for Consumer. This Contract may be renewed for successive consecutive one-year terms if the terms of this Contract are met, Attendant continues to be employed by Consumer, and neither Consumer nor Attendant have told CIL that he/she wishes to discontinue the employment relationship. If, at the time of review, CIL determines that Attendant is no longer employed by Consumer, this Contract shall terminate. Notwithstanding the foregoing sentence, if at the time of review, CIL determines that Attendant is not presently working for Consumer but is likely to be re-employed in the immediate future, then CIL, in its sole discretion, may renew this Contract for a one-year term commencing with the date of re-employment. It may be renewed again for successive consecutive one-year terms upon the conditions set forth in this paragraph and in this Contract.

11. **Confidentiality.** Attendant understands that Consumer is entitled to have his/her personal and health care information treated with confidentiality. Attendant agrees to protect and maintain Consumer’s confidentiality. Under no circumstances will Attendant will discuss or disclose Consumer’s personal or health care information without legal authorization to do so. Consumer’s right to confidential treatment of personal and health care information survives the termination of this Contract.

12. **Non-discrimination.** The parties to this Contract agree that they and each of them will refrain from discrimination on the basis of race, religion, nationality, sex, age, familial status, color, handicap, or any other basis not permitted by law.

13. **Miscellaneous provisions.** This Contract shall be interpreted in accordance with and governed by the laws of the State of Missouri. The place of contract is the county where CIL has its principal offices.

The invalidity or unenforceability of any portion or provision of this Contract shall not effect, impair, or render unenforceable any other portion or provision. It is intended that each provision herein that is invalid or unenforceable as written be valid and enforceable to the fullest extent possible.

Under no circumstances may Attendant assign his/her obligations, duties, or rights pursuant to or connected with this Contract to any other person or entity.

All understandings, agreements, offers, representations, and/or writings made by the parties to this Contract prior to the Date of Contract specified in line C. above
are hereby merged in this Contract and are of no force and effect unless specifically set forth in this Contract.

The captions in this Contract are for convenience only and are not to be construed as substantive parts of this Contract.

This Contract may not be modified except by a writing signed and dated by both parties except 1) the Contract may be renewed pursuant to paragraph 10 above without an additional writing and 2) Attendant's compensation for services may be increased from time-to-time as authorized by law or regulation without notice or a writing signed by both parties.

At the time of termination of this Contract, whether for cause, end of term, or otherwise, Attendant agrees to promptly deliver to CIL any and all records, materials, directives, memos, or other documents that pertain to this Contract, Consumer, or CIL, including but not limited to all originals and/or copies of Consumer's Plan of Care (in whole or in part), confidential Consumer information, medical care directions and/or physician/medical care instructions, medical records, health care information, behavioral plans, CIL training materials, completed or incomplete timesheets, and the like, except that Attendant may retain Attendant’s payroll records and tax information.

At the time of termination of this Contract, whether for cause, end of term, or otherwise, Attendant agrees to promptly provide Consumer with current timesheet information so that the last payroll for Attendant may be completed.

BY SIGNING BELOW YOU ACKNOWLEDGE YOU HAVE READ THIS CONTRACT, YOU ACCEPT IT, AND AGREE TO ITS TERMS.

Center for Independent Living:

BY: ___________________________ (sign)

____________________________________________________
(Print name and title)

Attendant:

_____________________________ (sign)

____________________________________________________
(Print name)

END OF DOCUMENT
Personal Care Attendants
Background Checks

I, the undersigned, understand in order to work as a personal care attendant for a consumer of the CDS Program must register with the Family Care Safety Registry as described in Missouri Statute 210.900RSMo. I understand background checks, which include any discrepancies, could be cause for me to file a “Good Cause Waiver” and forward the positive results to MERIL, before employment as a personal care attendant can begin.

I currently have no discrepancies on my background including listings with the Missouri Highway Patrol, Missouri Department of Social Services, Missouri Department of Health and Senior Services, Missouri Department of Mental Health.

________________________________________
Applicant Name (PRINT)

________________________________________
Applicant Signature

/   /   
Date

I currently HAVE a discrepancy on my background.

☐ I have received and completed a “Good Cause Waiver” form

________________________________________
Applicant Name (PRINT)

________________________________________
Applicant Signature

/   /   
Date
November 9, 2005

MEMORANDUM FOR VENDORS OF CONSUMER DIRECTED SERVICES

From: Brenda F. Campbell, Interim Director  
Division of Senior and Disability Services  

Subject: Sex Offender Registry

The division asks vendors under contract with the Department of Health and Senior Services for consumer-directed services to urge attendants to check the Missouri Sex Offender Registry to determine whether any of an attendant’s consumers are on the registry. This enables attendants to make informed decisions with regard to contact with consumers. The registry may be accessed at:

http://www.mshp.dps.mo.gov/MSHPWeb/PatrollDivisions/CRID/SOR/SORPage.html

Vendors should notify DHSS if they receive any reports by attendants of any inappropriate contact by consumers.

Questions may be submitted to the in-home services contracts e-mail address at:
ihscontracts@dhss.mo.gov.

BFC/MW

Distribution List: 4
HUMAN RIGHTS CHECKLIST

This checklist is to be INITIALED and SIGNED by each attendant that a consumer hires, acknowledging they fully understand the Personal Care Attendant Program and their responsibilities to their employer.

____ 1. The consumer of this Personal Care Attendant Program is the employer of each attendant they hire.

____ 2. Any conflict the attendant may have with the consumer (the attendant’s employer), should be discussed immediately with them, unless it is an abusive situation, then the attendant should discuss the conflict with the IL Mentor.

____ 3. The consumer is the expert in matters of how he or she chooses to live his or her life. The attendant should not tell the consumer how to live, but the attendant will not be expected to do things that violate his or her human rights or value structure. If discussion between the attendant and the consumer does not solve the problem, the attendant should not take the job with this consumer.

____ 4. The consumer depends on attendants in order to lead a normal life. **The attendant will give a minimum of two hours notice if he/she is not able to work on a certain day or it will be necessary to be late.** If the employer has more than one attendant, the attendants should exchange phone numbers and indicate a willingness to switch shifts (with the employer’s approval) in case of need. **If something happens on the way to work, call right away.**

____ 5. The attendant should give the consumer at least a two-week notice before terminating employment. It is the consumer’s responsibility to inform MERIL when an attendant has quit their job or has given notice to quit.

____ 6. Open communication is required of both parties at all times.

____ 7. The attendant should try to develop a sense of initiative and willingness. For example, to clean behind furniture or to be able to do what needs to be done without necessarily being told each time. This should be discussed with your employer.

____ 8. This a consumer-directed program. The attendant should not attempt to “take over,” violating the employer’s desires, methods or lifestyle.

____ 9. Discussion between the consumer and the attendant should be made before the attendant implements a new idea.

____ 10. The consumer participates in the evaluation process for the program and is given a Plan of Care. The attendant is to follow the Plan of Care. If the consumer needs changes made to the Plan of Care, he or she should contact MERIL so a re-evaluation may be scheduled.

____ 11. MERIL must be notified immediately should a consumer be hospitalized. The attendant will not be paid for time the consumer is in the hospital.

____ 12. Before beginning employment, the attendant must have received training on proper procedure for time sheets and have been informed of what circumstances constitute Medicaid Fraud.

____ 13. I understand that the CDS program is for consumers with disabilities and as an employee of a consumer I understand information about my employer is confidential and should not be shared with others.

____ 14. I understand if I become aware of abuse or neglect of the consumer I work for I am responsible to report this to MERIL or DHSS. I understand how to make this report.

Attendant Signature: ____________________________ Date: ____________
MANDATORY—PLEASE COMPLETE FOR DIRECT DEPOSIT

I would like my wages/salary deposited to the bank account attached.

Checking-Bank Name ____________________________________________

Bank address __________________________________________________

OR

Savings- Bank Name ____________________________________________

Bank address __________________________________________________

*For checking or saving attach only a voided check or specification sheet that includes bank routing number and account number. Deposit tickets or handwritten account information will not accepted.

EMPLOYEE—REQUIRED INFORMATION (Please Print)

Employee Name ________________________________________________

Social Security No. ___ ___/ ___/ ___ ___ ___

Employer (consumer) Name ______________________________________

I hereby authorize my employer, ___________________________(hereinafter COMPANY), to deposit any amounts owed me by initiating credit entries to my account at the financial institution (hereinafter BANK) indicated above. Further, I authorize BANK to accept and to credit any credit entries indicated by COMPANY to my account. In the event that 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. For my convenience, I request that MERIL directly deposit my wages/salary earned from my employer, into my bank account. I understand that deposit of my earnings into my account by MERIL may be an advance of funds on behalf of my employer, which is subject to the successful collection of these funds by MERIL from my employer’s bank. If, within 30 days of MERIL making the deposit into my account, my employer does not make available to MERIL the funds that were advanced to make the deposit into my account, I authorize MERIL to charge my account to recover said advance. I agree to hold MERIL harmless from loss and to indemnify it, limited to the amount of deposit. This authorization is to remain in full force and effect until COMPANY and BANK have received written notice from me of its termination in such time and in such manner as to afford COMPANY and BANK a reasonable opportunity to act on it.

Employee Signature ____________________________ Date —/—/—

CANCEL DIRECT DEPOSIT

Employee Signature ____________________________ Date _//_/

(Please complete a new form for change in bank accounts)

Please attach voided check here
Personal Care Attendant Health and Safety

General Information regarding Universal Precautions & Infection Control

Good hand washing and other general infection control techniques should be exercised when handling body fluids to prevent infection with non-blood borne pathogens.

DO’S AND DON'TS OF UNIVERSAL PRECAUTIONS:
DO wash your hands with soap, running water, and friction prior to patient contact, immediately following client contact, between clients, and after removing gloves. Wash hands immediately after contact with blood or any body fluids to which Universal Precautions apply.
DO wear gloves when coming in contact with blood, body fluids containing visible blood, and other body fluids to which Universal Precautions apply.
DO protect yourself from potentially infected material by wearing gloves if you have any minor cuts, scratches, or dermatitis of the hands.
DO clean all blood and body fluids spills promptly. Use detergent and water followed by a disinfecting solution consisting of 1 part household bleach to 10 parts water.
DO treat all linen and clothing soiled with blood or body fluids (to which Universal Precautions apply) as infected.
DO wear gloves when removing such linen or clothing.
DO place the soiled articles into a plastic bag and later wash the articles in hot water (160 degrees Fahrenheit) with detergent for 25 minutes.

Do not reuse gloves

What body fluids do Universal Precautions apply to?: Universal Precautions apply to all blood and other body fluids containing visible blood. Universal Precautions also apply to: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid, amniotic fluid, and mucous membranes.

What body fluids do Universal Precautions not apply to?: Universal Precautions do not apply to feces, nasal secretions, sputum, sweat, tears, urine, and vomitus, unless they contain visible blood. Universal Precautions also do not apply to human breast milk although HIV and HBV have been isolated in breast milk. Gloves may be worn in situations where exposures to breast milk might be frequent (ie: breast milk banking).

Each consumer on the CDS Program is responsible to provide materials for infection control and universal precautions.

Signature: __________________________ Date: __________
Attendant name: __________________________
MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
FAMILY CARE SAFETY REGISTRY
WORKER REGISTRATION

REGISTRATION TYPE (Check all that apply. Complete column on right only if Long Term Care/Personal Care selected from left.)

☐ Adoptive Parent
☐ Child Care
☐ Foster Parent/Family Member of Foster Parent
☐ County Office:
☐ Hospital
☐ Long Term Care/Personal Care (Please choose subcategory at right) ☐
☐ Mental Health/Psychiatric Hospital
☐ Voluntary (Select voluntary if no other registration type applies.)

A one-time registration fee of $14.00 applies to all categories except Foster Parents. Foster Parents must list the Children's Division county office.

Register only once. If you believe you have already registered, check our website at www.health.mo.gov/safety/fcsr or call, toll free, 866-422-6872.

SOCIAL SECURITY NUMBER (Mail copy of card with form.)

PERSONAL INFORMATION (Provide all names you have used, starting with most recent. Include legal names and nicknames.)

LAST NAME
FIRST NAME
MIDDLE NAME
SUFFIX (Jr., Sr., II, III)

MAIDEN NAME (IF APPLICABLE)
PRIOR NAMES USED (IF APPLICABLE, LIST FIRST AND LAST NAMES.)
DATE OF BIRTH (MM-DD-YYYY)

GENDER ☐ M ☐ F

CONTACT INFORMATION

MAILING ADDRESS (ENTER YOUR STREET ADDRESS OR POST OFFICE BOX. THIS ADDRESS MUST BE DIFFERENT FROM EMPLOYER ADDRESS.)

CITY
STATE
ZIP CODE
COUNTY

TELEPHONE
EMAIL ADDRESS (REQUIRED)
COUNTRY (COMPLETE ONLY IF OUTSIDE U.S.)

EMPLOYER ASSOCIATED WITH THIS REGISTRATION (Complete either left or right column, not both.)

☐ My current/potential child care, long term care or mental health care employer is:

☐ No Employer, because I am a(n):

☐ Adoptive Parent
☐ Foster Parent/Family Member
☐ Home Child Care Provider
☐ Private Pay/Private Duty
☐ Student
☐ Volunteer
☐ Other (Explain: )

EMPLOYER NAME

EMPLOYER ADDRESS

EMPLOYER CITY
STATE
ZIP

EMPLOYER TELEPHONE
EMPLOYER CONTACT NAME
EMPLOYER CONTACT TITLE

REGISTRATION AGREEMENT

The information provided is complete and accurate to the best of my knowledge. I understand it is unlawful to withhold or falsify information required on this form. I grant my permission for the Missouri Department of Health and Senior Services (DHSS) to obtain any and all background information authorized by law to process this request. Furthermore, I authorize the DHSS to release the fact that I am a registrant in the Family Care Safety Registry (FCSR) and any related background information to the requester of the FCSR for employment purposes only, as provided in §210.921, subsection 1, subdivisions (1) and (2), RSMo. For purposes of the FCSR, “employment purposes” includes direct employer/employee relationships, prospective employer/employee relationships, and screening and interviewing of persons or facilities by those persons contemplating the placement of an individual in a child care, elder care or personal care setting. I understand that if I dispute the information contained in the FCSR I have the right to appeal the accuracy of the transfer of information to the FCSR within thirty (30) days of receiving the results of the background screening.

NOTICE: The FCSR may choose to deposit the check enclosed electronically as an ACH debit entry to my designated bank account. I understand that my signature below authorizes my financial institution to deduct this payment from my account. In the event that DHSS or its subcontractor is unable to secure funds from my account or I provide insufficient or inaccurate information regarding my account, my obligation to the DHSS will remain unpaid and further collection action may be taken by the DHSS or its subcontractor, including, but not limited to, returned check fees.

SIGNATURE OF APPLICANT
DATE OF SIGNATURE (MUST BE WITHIN SIX MONTHS OF SUBMISSION.)

MO 590-2421 (12-18)

REV. 12/18
WHAT IS THE FAMILY CARE SAFETY REGISTRY?
The Family Care Safety Registry (FCSR), administered by the Missouri Department of Health and Senior Services (DHSS), provides families and employers with a method to obtain background screening information. The Registry, through various state agencies, offers several resources to screen child care, long term care and mental health workers:

- State criminal history and sex offender registry records maintained by the Missouri State Highway Patrol
- Child abuse/neglect records maintained by the Missouri Department of Social Services
- The Employee Disqualification List maintained by the Missouri Department of Health and Senior Services
- The Employee Disqualification Registry maintained by the Missouri Department of Mental Health
- Child care facility licensing records maintained by the Missouri Department of Health and Senior Services
- Foster parent records maintained by the Missouri Department of Social Services

WHO HAS TO REGISTER?
Any person hired on or after January 1, 2001, as a child care worker or elder care worker, hired on or after January 1, 2002, as a personal care worker, or hired on or after January 1, 2009, as a mental health worker, as provided in §210.906, RSMo, is required to make application for registration in the Family Care Safety Registry within fifteen (15) days of the beginning of employment. Such person who fails to submit a completed registration form to the DHSS without good cause, as determined by the department, is guilty of a class B misdemeanor. Employees and volunteers from non-state and/or federally regulated entities are NOT REQUIRED to register with the FCSR.

HOW DO I COMPLETE THE REGISTRATION FORM?
Registration Type – Check at least one box from the left column for type of registration that best describes your worker category. If no other type applies, select “Voluntary.” (A “voluntary registrant” is a person who is not mandated to register with the Family Care Safety Registry pursuant to §210.900 et seq., RSMo.) If you checked Long Term Care / Personal Care, please also make one or more selections from the column on the right for subcategory.

Social Security Number – You must provide your Social Security number pursuant to 19CSR 30-80.030(1). This identifying information, including Social Security number, will be used for internal identification purposes and to conduct background screenings for the resource information listed in paragraph one above.

Personal Information – List your current Last Name, First Name, Middle Name, and any suffix associated with your last name. List any other names by which you may have been known, including maiden names, past married names, and nicknames (attach additional sheets if needed). For identification purposes, list your gender and date of birth.

Contact Information – List your address, city, state, ZIP code, and county. Include your telephone number and email address. We will use this information to notify you of registration results and any background screenings conducted. Email notifications will be encrypted for improved security. To reduce postage costs, the Registry may contact you to request a personal email address if one is not provided.

Employer Associated with this Registration - If you are currently employed by or are seeking employment with a child care or long term care provider, please list the facility name, address, telephone number, and contact person. If registration is not for employment purposes, make a selection from column on right. The employer entered in this section will not receive a copy of the registration notification. Employers eligible to use the Registry for caregiver screenings must make a separate request for your background information.

Registration Agreement – Sign and date the registration form. Your signature will authorize the Family Care Safety Registry to conduct the background screening outlined in §210.903.2, RSMo and to provide the information to requesters for employment purposes, as provided in §210.921.1, RSMo.

WHERE DO I SEND MY REGISTRATION FORM?
Send your completed registration form and photocopy of Social Security card and required fee to the Missouri Department of Health and Senior Services, ATTN: Fee Receipts, P.O. Box 570, Jefferson City, MO 65102. If you have questions, please call the Registry using the toll-free telephone number, 866-422-6872.

WHEN WILL I KNOW THE RESULTS OF MY BACKGROUND SCREENING?
After the background screening has been completed, you will be notified in writing of the results that will be recorded in the Family Care Safety Registry. You will also be notified in writing each time background screening information is provided. The notification will contain the name and address of the person who made the request and the background information disclosed. The person making the request will be informed that information will be released for employment purposes only, pursuant to §210.921.1, RSMo. Any person using Registry information for any other purpose is guilty of a class B misdemeanor. In addition, state agencies can request information for licensure or regulatory purposes. Prior to disclosing information, the Registry obtains the name and address of the requester, and determines that the request is for employment or regulatory purposes. To ensure you receive these notifications, it will be important for you to notify the Family Care Safety Registry when you have a change in your contact information. Notify the Family Care Safety Registry of changes in personal or contact information using the toll-free telephone number, 866-422-6872, by email to fcsr@health.mo.gov, or by mail to FCSR, PO Box 570, Jefferson City, MO 65102.

WHAT IF I DON’T AGREE WITH THE RESULTS OF MY BACKGROUND SCREENING?
As provided in §210.912, RSMo, you have the right to appeal the information transferred to the Family Care Safety Registry. Your right to appeal is limited to the accuracy of the transfer of information from the state agency that maintains the background information and does not include a right to appeal the accuracy of the substance of the information transferred. An appeal must be filed in writing to the Office of the Director, Missouri Department of Health and Senior Services, P.O. Box 570, Jefferson City, MO, 65102, within 30 days of receiving the results of the background screening determination. An administrative appeal shall be set within 30 days of the filing of the appeal and a decision shall be made within 60 days. This right to appeal is in addition to any other appeal rights granted by state law.

WHAT INFORMATION WILL BE DISCLOSED BY THE FAMILY CARE SAFETY REGISTRY?
Disclosure of background information on a person registered in the Family Care Safety Registry will be limited. If the person is registered, the Registry worker will disclose whether the person’s name is listed in any of the background checks pursuant to §210.903, subsection 2, RSMo, and if so, which one(s). Specific information will be disclosed by the Registry pursuant to §210.921, subsection 1, subdivision (2).
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.

Step 1: Enter Personal Information

<table>
<thead>
<tr>
<th>(a) First name and middle initial</th>
<th>Last name</th>
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<table>
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<tr>
<th>(b) Social security number</th>
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</table>

<table>
<thead>
<tr>
<th>(c) Single or Married filing separately</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married filing jointly (or Qualifying widow(er))</td>
</tr>
<tr>
<td>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)</td>
</tr>
</tbody>
</table>

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 online estimator, 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 2020 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 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

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.

(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.

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

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)

For Privacy Act and Paperwork Reduction Act Notice, see page 3.
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 get 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.

Exemption from Withholding. You may claim exemption from withholding for 2020 if you meet both of the following conditions: you had no federal income tax liability in 2019 and you expect to have no federal income tax liability in 2020. You had no federal income tax liability in 2019 if (1) your total tax on line 16 on your 2019 Form 1040 or 1040-SR is zero (or less than the sum of lines 18a, 18b, and 18c), 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 2020 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 16, 2021.

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 the 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 1 Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.

Step 3. Step 3 of Form W-4 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 2020 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.

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.

   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.

   c Add the amounts from lines 2a and 2b and enter the result on line 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.

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).

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

1 Enter an estimate of your 2020 itemized deductions (from Schedule A (Form 1040 or 1040-SR)). Such deductions may include qualified home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income.

2 Enter:

   • $24,800 if you're married filing jointly or qualifying widow(er)
   • $18,650 if you're head of household
   • $12,400 if you're single or married filing separately

3 If line 1 is greater than line 2, subtract line 2 from line 1. If line 2 is greater than line 1, enter “-0-”.

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040 or 1040-SR)). See Pub. 505 for more information.

5 Add lines 3 and 4. Enter the result here and in Step 4(b) of Form W-4.

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 6102(2) and 6108 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. You 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)

<table>
<thead>
<tr>
<th>Higher Paying Job Annual Taxable Wage &amp; Salary</th>
<th>Lower Paying Job Annual Taxable Wage &amp; Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>$0 - 9,999</strong></td>
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<td>$525,000 and over</td>
<td>$3,140</td>
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</tbody>
</table>

## Single or Married Filing Separately

<table>
<thead>
<tr>
<th>Higher Paying Job Annual Taxable Wage &amp; Salary</th>
<th>Lower Paying Job Annual Taxable Wage &amp; Salary</th>
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</thead>
<tbody>
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<tr>
<td>$400,000 - 449,999</td>
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</table>

## Head of Household

<table>
<thead>
<tr>
<th>Higher Paying Job Annual Taxable Wage &amp; Salary</th>
<th>Lower Paying Job Annual Taxable Wage &amp; Salary</th>
</tr>
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<tbody>
<tr>
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<tr>
<td>$450,000 and over</td>
<td>$3,140</td>
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</tbody>
</table>
# Missouri Department of Revenue

## Employee's Withholding Certificate

This certificate is for income tax withholding and child support enforcement purposes only. Type or print.

<table>
<thead>
<tr>
<th>Full Name</th>
<th>Social Security Number</th>
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<tbody>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Address (Number and Street or Rural Route)</th>
<th>City or Town</th>
<th>State</th>
<th>ZIP Code</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

1. **Filing Status:** Check the appropriate filing status below.
   - Single or Married Spouse Works or Married Filing Separate
   - Married (Spouse does not work)
   - Head of Household

2. **Additional withholding:** If you expect to have a balance due (as a result of interest income, dividends, income from a part-time job, etc.) on your tax return, you may request your employer to withhold an additional amount of tax from each pay period. To calculate the amount needed, divide the amount of the expected tax by the number of pay periods in a year. Enter the additional amount to be withheld each pay period on line 2. 

3. **Reduced withholding:** If you expect to receive a refund (as a result of itemized deductions, modifications or tax credits) on your tax return, you may direct your employer to only withhold the amount indicated on line 3. Your employer will not use the standard calculations for withholding. You may designate an amount that is too low, it could result in you being under withheld. If you enter the amount to be withheld instead of the standard calculation. If no amount is indicated on line 3, the standard calculations will be used.

4. **Exempt Status:** Select the proper reason you are claiming an exemption from withholding below and indicate EXEMPT on line 4.
   - I am exempt because I had a right to a refund of all Missouri income tax withheld last year and expect to have no tax liability this year. A new MO W-4 must be completed annually if you wish to continue the exemption.
   - I am exempt because I meet the conditions set forth under the Servicemember Civil Relief Act, as amended by the Military Spouses Residency Relief Act and have no Missouri tax liability.
   - I am exempt because my income is earned as a member of any active duty component of the Armed Forces of the United States and I am eligible for the military income deduction.

Under penalties of perjury, I certify that the information provided on this form is true and accurate.

**Employee's Signature (Form is not valid unless you sign it)**

**Date (MM/DD/YYYY)**

**Employer's Name**

**Employer's Address**

**City**

**State**

**ZIP Code**

**Date Services for Pay First Performed by Employee (MM/DD/YYYY)**

**Federal Employer I.D. Number**

**Missouri Tax Identification Number**

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**Notice To Employer:**

Within 20 days of hiring a new employee, send a copy of Form MO W-4 to the Missouri Department of Revenue, P.O. Box 3340, Jefferson City, MO 65105-3340 or fax to (573) 526-8079.


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**Notice To Employee:**

Return complete form to your Employer. Consider completing a new Form MO W-4 each year and when your personal or financial situation changes.

Visit our online withholding calculator: [https://mytax.mo.gov/trpt/portal/home/withholding-calculator](https://mytax.mo.gov/trpt/portal/home/withholding-calculator).

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**Items to Remember:**

- Employees must complete a new form if their filing status changes or to adjust the amount of withholding.
- If you are claiming an "Exempt" status due to the Military Spouses Residency Relief Act you must provide one of the following to your employer: Leave and Earnings Statement of the non-resident military servicemember, Form W-2 issued to the nonresident military servicemember, a military identification card, or specific military orders received by the servicemember. You must also provide verification of residency such as a copy of your state income tax return filed in your state of residence, a property tax receipt from the state of residence, a current drivers license, vehicle registration or voter ID card. For additional assistance in regard to Military, visit the department's website [https://dor.mo.gov/military/](https://dor.mo.gov/military/).
- Additional information can be found at [https://dor.mo.gov/business/withhold](https://dor.mo.gov/business/withhold).

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**Mail to:** Taxation Division

**P.O. Box 3340**

**Phone:** (573) 522-0967

**Fax:** (573) 526-8079

**Jefferson City, MO 65105-3340**

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Form MO W-4 (Revised 12-2019)
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.)

<table>
<thead>
<tr>
<th>Last Name (Family Name)</th>
<th>First Name (Given Name)</th>
<th>Middle Initial</th>
<th>Other Last Names Used (if any)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address (Street Number and Name)</td>
<td>Apt. Number</td>
<td>City or Town</td>
<td>State</td>
</tr>
<tr>
<td>Date of Birth (mm/dd/yyyy)</td>
<td>U.S. Social Security Number</td>
<td>Employee’s E-mail Address</td>
<td>Employee’s Telephone Number</td>
</tr>
</tbody>
</table>

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:

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
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").

<table>
<thead>
<tr>
<th>List A</th>
<th>List B</th>
<th>List C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identity and Employment Authorization</td>
<td>Document Title</td>
<td>Document Title</td>
</tr>
<tr>
<td></td>
<td>Issuing Authority</td>
<td>Issuing Authority</td>
</tr>
<tr>
<td></td>
<td>Document Number</td>
<td>Document Number</td>
</tr>
<tr>
<td></td>
<td>Expiration Date (if any) (mm/dd/yyyy)</td>
<td>Expiration Date (if any) (mm/dd/yyyy)</td>
</tr>
<tr>
<td></td>
<td>Document Title</td>
<td>Document Title</td>
</tr>
<tr>
<td></td>
<td>Issuing Authority</td>
<td>Issuing Authority</td>
</tr>
<tr>
<td></td>
<td>Document Number</td>
<td>Document Number</td>
</tr>
<tr>
<td></td>
<td>Expiration Date (if any) (mm/dd/yyyy)</td>
<td>Expiration Date (if any) (mm/dd/yyyy)</td>
</tr>
</tbody>
</table>

Additional Information

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

<table>
<thead>
<tr>
<th>Last Name of Employer or Authorized Representative</th>
<th>Title of Employer or Authorized Representative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Today's Date (mm/dd/yyyy)</td>
<td></td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>Last Name (Family Name)</th>
<th>First Name (Given Name)</th>
<th>Middle Initial</th>
<th>Date (mm/dd/yyyy)</th>
</tr>
</thead>
</table>

B. Date of Rehire (if applicable)

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Document Number</th>
<th>Expiration Date (if any) (mm/dd/yyyy)</th>
</tr>
</thead>
</table>

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.

Signature of Employer or Authorized Representative

<table>
<thead>
<tr>
<th>Today's Date (mm/dd/yyyy)</th>
<th>Name of Employer or Authorized Representative</th>
</tr>
</thead>
</table>

Form I-9 10/21/2019
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.

<table>
<thead>
<tr>
<th>LIST A</th>
<th>Documents that Establish Both Identity and Employment Authorization</th>
<th>LIST B</th>
<th>Documents that Establish Identity</th>
<th>AND</th>
<th>LIST C</th>
<th>Documents that Establish Employment Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>U.S. Passport or U.S. Passport Card</td>
<td>1.</td>
<td>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</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</td>
<td>2.</td>
<td>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</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>For a nonimmigrant alien authorized to work for a specific employer because of his or her status:</td>
<td>5.</td>
<td>U.S. Military card or draft record</td>
<td>3.</td>
<td>6.</td>
<td>Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal</td>
</tr>
<tr>
<td>a.</td>
<td>Foreign passport; and</td>
<td>6.</td>
<td>Military dependent's ID card</td>
<td>4.</td>
<td>7.</td>
<td>Native American tribal document</td>
</tr>
<tr>
<td>b.</td>
<td>Form I-94 or Form I-94A that has the following:</td>
<td>7.</td>
<td>U.S. Coast Guard Merchant Mariner Card</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1)</td>
<td>The same name as the passport; and</td>
<td>8.</td>
<td>Native American tribal document</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2)</td>
<td>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.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>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</td>
<td>9.</td>
<td>Driver's license issued by a Canadian government authority</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>For persons under age 18 who are unable to present a document listed above:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>10.</td>
<td>School record or report card</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>11.</td>
<td>Clinic, doctor, or hospital record</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>12.</td>
<td>Day-care or nursery school record</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Refer to the instructions for more information about acceptable receipts.