



# NM Self/Participant Direction Employee Employment Packet

This packet contains all the forms you need to enroll as an employee and begin providing services to your participant/member. Please follow all directions in this packet. You will not be paid for services until all forms are completed. Conduent verifies all information, criminal checks, and clears you for hire, and you are notified that you are ready to provide service by your employer.

You must complete and return:

- |  |  |
|--|--|
| <input type="checkbox"/> Employee Information                        | <input type="checkbox"/> Copy of Social Security Card        |
| <input type="checkbox"/> Employee Information & Qualification Form   | <input type="checkbox"/> Payroll Information Worksheet       |
| <input type="checkbox"/> Employee Agreement                          | <input type="checkbox"/> IRS Form W-4                        |
| <input type="checkbox"/> Attestation Form                            | <input type="checkbox"/> New Mexico W-4 (Optional)           |
| <input type="checkbox"/> Employee Transportation Appendix (Optional) | <input type="checkbox"/> Pay Selection & Direct Deposit Form |
| <input type="checkbox"/> U.S. CIS Form I-9                           | <input type="checkbox"/> Timesheet                           |
| <input type="checkbox"/> I-9 Supporting documentation                | <input type="checkbox"/> Mileage Sheet                       |

We encourage you to use the checklist above as a final review before you return the forms. Failure to return these forms will delay enrollment. Note: To fill out the forms in this PDF packet on your computer before printing, complete the Employee Information form first, then review the remaining documents to verify data inserted properly. The other documents, including information on how to complete forms, the payment schedule, and similar instructional forms, are for informational purposes only and do not need to be returned. Send completed forms by fax, email, mail, or in person to Conduent at one of the addresses below.

**Fax: 866.302.6787**

**Email: [docprocessing@conduent.com](mailto:docprocessing@conduent.com)**

**Physical Address:  
1720-A Randolph Rd SE  
Albuquerque, NM 87106**

**Mailing Address:  
PO Box 27460  
Albuquerque, NM 87125-7460**

Should you need any assistance during this process, please contact the Consolidated Customer Service Center (CCSC) at 1.800.283.4465.

We look forward to serving you!



## **Frequently Asked Questions**

Palco serves individuals who participate in the self-directed model by providing various financial, customer support, and informational services. Below are frequently asked questions to help you understand our processes, your requirements, and how to receive assistance.

### **How do I complete forms if I am unable to sign?**

We encourage you to enroll online, as you can sign electronically. However, if you are unable to use the online system, you may either sign with an X or a mark, then have a witness legibly sign the document on the line above the 'witnessed by'.

### **What if I need assistance in completing forms?**

Online enrollment is the easiest method for completing forms. Customer support agents can assist you in gaining credentials to enroll online or in completing forms in this packet. You can reach the Consolidated Customer Service Center (CCSC) at 1.800.283.4465.

### **When can the employee begin providing services?**

Conduent will notify the employer via email (or phone if email is not provided) once all requirements for enrollment have been met. Your employer will notify you when you can begin working. Any work performed prior to that date will not be paid by the program.

### **Can an employee provide services to multiple participants/members?**

Yes. However, an employee must abide by all program rules, especially those regarding overlapping claims for payment of services.

### **What happens if a worker wants to work for another employer?**

Employees may be employed by as many employers as he or she would like. Each time he or she begins working for a new employer, a new employee packet must be completed. However, some requirements may be waived depending on the circumstances, such as providing a copy of Social Security cards or documentation related to receiving direct deposit. Generally, background checks can also transfer, but be sure to check with your program rules to make sure you understand all the requirements.

### **What happens if an employee stops providing services?**

Anytime an employee stops providing service, Conduent must be notified via an Employment Separation Notice, which can be found on our website. (add link) Even after termination, employees should keep Conduent aware of any changes in contact information throughout the year, so that they can send correspondence, such as W-2s, to the correct address.

### **How does an employer change impact existing employees?**

Employees must re-complete some new hire forms, such as the I-9. Conduent will notify you of the requirements. Be sure to complete any required forms so that your pay is not impacted.

### **Can someone correspond with Conduent on my behalf?**

Federal and state privacy laws prevent Conduent from disclosing personal information to unauthorized individuals. Conduent will only correspond with employees about that employee's particular account. Employers may receive all information about the employee's accounts and information about the participant necessary to carry out employer roles. Employers have unlimited access to information on their account.



### **How are timesheets submitted?**

Timesheets must be submitted online. Instructions for online submission will be provided once enrollment is approved. For the Mi Via and Supports Waiver programs, an exception to submission for online timesheets must be submitted to and approved by the State. For Self-Directed Community Benefit, an exception to submission for online timesheets must be submitted to your MCO.

### **When does an employee submit timesheets?**

A payroll schedule shows the deadlines for submitting timesheets and scheduled paydays. The payroll schedule for specific programs can be found at [palcofirst.com](http://palcofirst.com).

### **How will I know if a timesheet was received and approved?**

The online portal will display approval messages in real time. The Employer, Authorized Representative, or Employee may also contact a customer support representative to assist with verifying the status of a timesheet.

### **What if an employee doesn't receive the funds on the scheduled payday?**

For direct deposited payments, please allow sufficient time for the pay to deposit into your account. We recommend allowing 24 hours after payday for the deposit. For paper checks, if you have not received them within 5 days, please contact the Consolidated Customer Service Center at 1.800.283.4465.

### **Will the employee receive a W-2 at year-end?**

W-2s are available January 31. If receiving the W-2 by mail, please allow one week for delivery. All employees receive a W-2. Employees who earn less than the annual domestic service threshold, per IRS Pub. 15 (Circular E), will also receive a refund of over-collected FICA. The employer should encourage their employees to make sure that the correct address and direct deposit information is current with Conduent prior to this date, even if the employee is no longer working.

### **How do I change my information with Conduent?**

The fastest and easiest method is to log into your account and change your information online. Otherwise, you must complete the appropriate form and mail or fax it to Conduent. For name and contact information changes, complete a Change of Information form and attach documentation to show proof of name change which can be driver's license, divorce decree or marriage license. For withholding changes, complete an IRS W-4, or Payroll Information Worksheet. To change payment information, complete a Direct Deposit Authorization. For any other changes, contact customer support.

### **How can Conduent be contacted?**

The Consolidated Customer Service Center representatives are available Monday through Friday, 8:00 a.m. to 5:00 p.m. MT, except state holidays. You may reach them by phone at 1.800.283.4465, fax to 1.866.302.6787 or mail to P.O. Box 27460, Albuquerque, NM 87125-7460. A range of translator and interpreter services are available at your request.



## **Notice of Privacy Practices**

Palco may receive and create records concerning your medical and individually identifiable information (“PHI”) and is required to maintain the privacy and security of your PHI. Please read this notice carefully. If you have questions or concerns, contact the Palco Privacy Officer at [privacy@palcofirst.com](mailto:privacy@palcofirst.com). Palco will only use and disclose your information as allowed by law and as described below:

- **Help manage the health care treatment you receive.** We may disclose your information to provide treatment and administer services, including performing assessments, issuing workers’ compensation and administering similar programs, and recommending services in some situations. We may disclose information to others who implement your health services. We may correspond with you and/or your designated representative (e.g., surrogate employer or authorized user). All emailed correspondence from Palco is encrypted and secure. By emailing Palco with your personal email account, you accept the risk that your correspondence may not be encrypted, nor secure.
- **Run our business, including payment for and administration of your health services.** We may use and disclose your information to receive and issue payment on your behalf and bill Medicaid, Medicare, Managed Care Organizations, the Veterans Administration, or other bodies, as required by your program.
- **Comply with federal and state law, including investigations by the United States Department of Health and Human Services (U.S. DHHS) and law enforcement.** Palco is required by law to comply with investigations by regulatory bodies and issues involving national security. Palco may be required to disclose your information to coroners and other officials at your death.
- **Respond to legal actions and health oversight, such as lawsuits or quality assurance reviews.** Palco may be required to respond to requests, including discovery, subpoenas, audits, and other legal or regulatory matters.

You have the right to:

- **Authorize the use and disclosure of your PHI for reasons not authorized by federal or state law.** Palco will seek your approval to disclose PHI for reasons not required by law, and you may reject disclosure.
- **Receive this notice of privacy practices.** You can request a copy of this notice or view the posting at [palcofirst.com](http://palcofirst.com), in enrollment packets, and in program manuals, as applicable. Palco can change the terms of this notice at any time. Changes will apply to all of your medical records. Direct complaints to the Privacy Officer or the U.S. DHHS.
- **Review and receive copies of your records and a list of disclosures.** Requests must be on a Request for Sensitive Records form. We will provide you with a copy or summary within 10 days of receiving your request. We may charge a reasonable, cost-based fee for collection of the records, including postage and labor. Palco may reject some requests if required by law.
- **Request amendments to your records.** Requests must be on a Request to Amend Sensitive Information form. We will provide you with a copy or summary or a rejection within 15 days of receiving your request.
- **Request information in an alternate format or restrict access on your records.** Requests must be in writing on a Request for Additional Privacy. We will provide you with a copy or summary within 15 days of receiving your request. We may reject or terminate the request in certain limited cases and will notify you of rejections and terminations.
- **Be notified in case of a breach of your sensitive information.** You will be notified within 60 days by the Privacy Officer.
- **Choose someone to act on your behalf with regard to your records.** You must complete the appropriate forms and information to designate Authorized Users in order for those individuals to communicate with Palco on your behalf.



# PALCO PAYMENT SCHEDULE - 2024

## New Mexico Self-Direction Program

Service Period		Faxed Timesheets Due by 12 am	Online Timesheets Due by 12 pm	Payments Made by Palco by 5pm
SATURDAY		SATURDAY	TUESDAY	FRIDAY
Start Date	End Date	Deadline	Deadline	Paid On
December 16, 2023	December 29, 2023	December 30, 2023	January 2, 2024	January 12, 2024
December 30, 2023	January 12, 2024	January 13, 2024	January 16, 2024	January 26, 2024
January 13, 2024	January 26, 2024	January 27, 2024	January 30, 2024	February 9, 2024
January 27, 2024	February 9, 2024	February 10, 2024	February 13, 2024	February 23, 2024
February 10, 2024	February 23, 2024	February 24, 2024	February 27, 2024	March 8, 2024
February 24, 2024	March 8, 2024	March 9, 2024	March 12, 2024	March 22, 2024
March 9, 2024	March 22, 2024	March 23, 2024	March 26, 2024	April 5, 2024
March 23, 2024	April 5, 2024	April 6, 2024	April 9, 2024	April 19, 2024
April 6, 2024	April 19, 2024	April 20, 2024	April 23, 2024	May 3, 2024
April 20, 2024	May 3, 2024	May 4, 2024	May 7, 2024	May 17, 2024
May 4, 2024	May 17, 2024	May 18, 2024	May 21, 2024	May 31, 2024
May 18, 2024	May 31, 2024	June 1, 2024	June 4, 2024	June 14, 2024
June 1, 2024	June 14, 2024	June 15, 2024	June 18, 2024	June 28, 2024
June 15, 2024	June 28, 2024	June 29, 2024	July 2, 2024	July 12, 2024
July 29, 2024	July 12, 2024	July 13, 2024	July 16, 2024	July 26, 2024
July 13, 2024	July 26, 2024	July 27, 2024	July 30, 2024	August 9, 2024
July 27, 2024	August 9, 2024	August 10, 2024	August 13, 2024	August 23, 2024
August 10, 2024	August 23, 2024	August 24, 2024	August 27, 2024	September 6, 2024
August 24, 2024	September 6, 2024	September 7, 2024	September 10, 2024	September 20, 2024
September 7, 2024	September 20, 2024	September 21, 2024	September 24, 2024	October 4, 2024
September 21, 2024	October 4, 2024	October 5, 2024	October 8, 2024	October 18, 2024
October 5, 2024	October 18, 2024	October 19, 2024	October 22, 2024	November 1, 2024
October 19, 2024	November 1, 2024	November 2, 2024	November 5, 2024	November 15, 2024
November 2, 2024	November 15, 2024	November 16, 2024	November 19, 2024	November 29, 2024
November 16, 2024	November 29, 2024	November 30, 2024	December 3, 2024	December 13, 2024
November 30, 2024	December 13, 2024	December 14, 2024	December 17, 2024	December 27, 2024
December 14, 2024	December 27, 2024	December 28, 2024	December 31, 2024	January 10, 2025

Late time submissions and mistakes may result in late payment!

### 2024 Office Closures

- |   |   |
|---|---|
| New Year's Day - Monday, January 1*             | Labor Day - Monday, September 2*                |
| Martin Luther King, Jr Day – Monday, January 15 | Columbus Day – Monday, October 14               |
| President's Day – Monday, February 19           | Veterans Day – Monday, November 11              |
| Memorial Day - Monday, May 27*                  | Thanksgiving - Thursday-Friday, November 28-29* |
| Juneteenth Day – Wednesday, June 19             | Christmas - Tuesday-Wednesday, December 24-25*  |
| Independence Day - Thursday, July 4*            |   |

\* Palco Office Closures

## Instructions for Employee Forms

Please use the instructions below to complete the attached forms to become a worker through the self-directed program.

- The **Employee Information** is used to enroll the worker in the program and associate him or her with the employer and participant. Complete the entire form. Sign and date the highlighted fields. Please make sure your employer signs and dates as well.
- The **Employee Information & Qualification** notifies you of your duties associated with being a worker on the self-direction program. Please read this form carefully and initial where indicated to make sure that you understand and will comply with the information therein. Sign and date all the highlighted fields.
  - Complete the Employee Information box at the top of page.
  - Sign and date the bottom of the page.
- The **Employment Agreement** is used to inform the employee of all requirements that they must agree to in order to become an employee in this program. The employee must read this form carefully and make sure that you understand and comply with the information therein.
  - Complete the Employee Information box at the top of the page.
  - Mark all applicable boxes.
  - Initial the bottom right of each page as indicated.
  - Both the employer and Employee must sign and date the bottom of the last page.
- The **Provider Attestation** must be completed for any residential or non-residential HCBS provider, who offers self-directed services in a setting where individuals live and/or receive HCBS, must comply with the following CMS Final Rule Requirements. Information at the bottom of page 2 must be completed and the provider (employee) must sign and date. HCBS providers will need to adhere to the Employee Agreement and qualifications requirements of the program by completing and submitting a Provider attestation form annually to Conduent to remain compliant with the HCBS Setting Rule requirements.
- The **Appendix to Employee Agreement** (optional) is required to be completed if the employee is required to drive the participant as their job function or part of their assigned tasks. Copies of the employee's valid NM driver's license, current proof of insurance and current vehicle registration must be attached. The employee information is completed at the top of the page and the employer must sign and date the bottom of the page.

Note: To fill out the forms in this PDF packet on your computer, complete this Data Form **and** the top of the next form first, then review the remaining documents to verify data inserted properly before printing.



## Employee Information

Complete this form entirely to begin the enrollment process as an employee in the self-direction program. Completion of this form does not constitute a hiring by the employer.

PARTICIPANT INFORMATION	
Full Name	ID/Last 4 of SSN

EMPLOYER INFORMATION	
Full Name	ID/Last 4 of SSN

EMPLOYEE (APPLICANT) INFORMATION			
First Name	Middle Name	Last Name	
Social Security Number	Email ( <b>REQUIRED</b> )	Date of Birth (mm/dd/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Do you share a residence with the participant? <input type="checkbox"/> No <input type="checkbox"/> Yes. Please specify who owns or rents the residence: _____			
Physical Address (Street Address, Including Apt. #, CANNOT BE A PO BOX)			
City	State	Zip	County
Mailing Address (Street Address, Including Apt. #) – <i>if different than the physical address</i>			
City	State	Zip	County
Phone1	Phone2	Preferred Method of Communication <input type="checkbox"/> Email <input type="checkbox"/> Mail <input type="checkbox"/> Phone / Voicemail	

\_\_\_\_\_  
**Employee Printed Name**

\_\_\_\_\_  
**Employer Printed Name**

\_\_\_\_\_  
**Employee Signature**

\_\_\_\_\_  
**Employer Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Date**



## **Employee Information & Qualification**

<b>EMPLOYEE (APPLICANT) INFORMATION</b>	
Full Name	ID/Last 4 of SSN

As an employee in self-direction, you must agree to the following terms of employment:

- You understand that the participant, or his or her surrogate, is your employer. Neither Palco, nor program/state administrators, is your employer.
- This position is paid as an employee and not as an independent contractor.
- This document does not create an anticipation of, nor a contract of, employment.
- To adhere to all federal, state, local, and program laws, regulations, policies, and requirements throughout my employment. This includes staying current on information provided to me about the program throughout my employment.
- To accurately complete all enrollment documentation to ensure that you meet the program's eligibility requirements for providing services and is not prohibited in any manner from providing services.
- Employees agree to adhere to the Employee Agreement and qualifications requirements of the SDCB program by completing and submitting a Provider attestation form annually to Conduent to remain compliant with the HCBS Setting Rule requirements.
- That my employment is contingent upon many factors, including successful completion and/or passing of required background checks, training, and credentialing.
- Employees are responsible for providing Conduent and Employer of Record (EOR) a copy of the criminal background checks and screenings rendering Self-Directed Personal Care Services. Employees/Caregivers will be required to provide the requested documents within 24 business hours of obtaining the results.
- To report any changes in my ability to deliver services, including changes in my background history or qualifications required to perform services under this program.
- Being paid for services through the program is contingent upon the participant's eligibility for the program. Once eligibility terminates, you may no longer be paid through this program.
- Your employer is responsible for payment of services for activities not authorized in or exceeding the limitations established by the budget.
- Funds to pay for services are from public sources, and financial accountability and liability applies to the use of the funds. You understand that submitting false or fraudulent timesheets or submitting timesheets for tasks other than those approved on the authorized budget will be reported to the appropriate authorities for investigation and possible prosecution as fraud.
- That medical and personal information and data about the participant and the employee is confidential. In addition, you have read and agree to the Notice of Privacy Practices.
- That neither Conduent nor program/state administrators are responsible or liable for any negligent acts, work-related injuries, or omissions by me, the employer, participant, other employee or service providers, or authorized representatives.
- To report all critical incidents relating to the participant's health, safety, and welfare, including suspicion of fraud, abuse, or neglect.
- Certificates and rosters of all training completed by Employees (Individual/Vendor) must be provided to Conduent upon completion.



- Employees (Individual/Vendor) must comply with all laws, rules and regulations of the New Mexico corporation Commission for Telecommunications and Security Systems; and comply with all laws, rules, and regulations form the Federal Communications Commission for telecommunications.
- Employees (Individual/Vendor) providing transportation services, must provide a valid New Mexico driver's license, a copy of the no chargeable (at fault) accidents within the previous two years, a copy of no driving while intoxicated convictions within the previous two years, and posses and maintain current insurance policy and registration for each vehicle.

By signing below, you acknowledge that you have read this agreement and accept responsibility as an employee in self-direction, understand their responsibilities and duties associated with that role, and will comply with program policies and requirements. The information provided herein is true and accurate to the best of your knowledge. You further understand and agree that violation of this agreement will result in termination.

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**Employee's Printed Name**

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**Employee Signature**

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**Date**

EN-310000-WIQ-1.0

## Employment Agreement

**Please check the appropriate box to indicate the purpose of the submission of this form.**

- New Employee  
 Employee Pay (Rate) Change

Effective Date of Rate Change \_\_\_\_\_

***Note: Conduent (formerly Xerox) must receive the Employment Agreement at least 15 days before any rate change. Rate changes will become effective at the beginning of the pay period.***

An employee or is hired and supervised directly by the Employer of Record (EOR). The employee or must follow the policies stated in this Agreement. The purpose of this Agreement is to establish the responsibilities of each party. The employee is an employee *at will*. The Self-Direction member/participant served under this Agreement is: (please print)

EMPLOYEE INFORMATION	
Full Name	ID/Last 4 of SSN
PARTICIPANT INFORMATION	
Full Name	ID/Last 4 of SSN
EMPLOYER INFORMATION (If applicable)	
Full Name	ID/Last 4 of SSN

*Under 8.314.6.7 NMAC and 8.308.12 K. NMAC, a Legally Responsible Individual (LRI) is defined as any person who has a duty under state law to care for another person. This category typically includes: the parent (biological, legal, or adoptive) of a minor child; the guardian of a minor child who must provide care to the child; or a spouse. State approval must be obtained in order for an LRI to be paid for providing Self-Direction services.*

**FOR ALL EMPLOYEES**

Is the employee legally responsible for the Self-direction member/participant?

- YES    NO

If the employee is legally responsible for the member/participant, please mark the box that best describes the employee's relationship to the member/participant.

- Parent (biological, legal, or adoptive) of member/participant who is a minor
- Guardian of member/participant who is a minor
- Spouse of the member/participant

If the employee is a Legally Responsible Individual (LRI) for the Self-Direction member/participant, State approval to be a paid provider must be submitted with the employment agreement. If the LRI will be a provider for more than one service, State approval must be submitted for each service.

**Job Duties**

The employer and employee will agree on a specific set of job duties or services to be provided. These duties and services will be developed in compliance with the definitions of Service Standards, and the Centennial Care Managed Care Policy Manual and will be documented on the member/participant's Mi Via Service and Support Plan (SSP) or Self- Directed Community Benefit (SDCB) Care Plan.

**Payment**

The SSP, or SDCB Care Plan start date sets the date from which payments may begin. *The rate of payment and hours/units must not exceed funding within the approved budget's line item.* Only the approved rate will be paid. The employee shall be paid for his/her services at the following hourly rate (From Self-Directed Budget):

**Service Code** \_\_\_\_\_ **Rate \$** \_\_\_\_\_ \*Estimated hours/units \_\_\_\_\_ per  week  month

**Service Code** \_\_\_\_\_ **Rate \$** \_\_\_\_\_ \*Estimated hours/units \_\_\_\_\_ per  week  month

**Service Code** \_\_\_\_\_ **Rate \$** \_\_\_\_\_ \*Estimated hours/units \_\_\_\_\_ per  week  month

**\*Please note that hours/units are an estimate and not fixed. Scheduled work time may change according to member/participant's needs.**

Employee Name	Participant Name
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**Duration of Agreement**

This Agreement will be effective when both parties sign it and in accordance with the date of approval of the service by the Third-Party Assessor (TPA) or Managed Care Organization (MCO). However, it is agreed that services will not be provided until all employment related documents (as outlined in the "Employee Packet") have been received by Conduent (formerly Xerox). Either party may terminate (end) this Agreement and the employment contemplated herein, at any time, and without liability for doing so, by giving the other party *at least 5 (five) working days prior notice except in an emergency situation*. This notice may be given either orally or in writing. It is the responsibility of the EOR and the employee to provide this employment termination information to Conduent by reporting it to the Call Center at 1-800- 286-4465.

**Modification of Agreement**

This Agreement may be changed by agreement of both parties. Modification of the Agreement will require that you submit a new Agreement to Conduent and must include prior approval to ensure that the budget can support the proposed changes. *Signed copies of all new agreements must be provided to Conduent before any changes in rates, units, and so on, can be made.* Changes in rates will NOT be done retroactively. Conduent must receive the Employee Agreement at least 15 days before the effective date of any rate change. If there is an increase in the rate, the new rate must be approved in the member/participant's budget.

**Scheduling of Provider Agency/Vendor/Contractor**

If the employee is **unable** to work at the scheduled time, the employee shall provide at least \_\_\_hours advance notice to the employer so that the employer can find a substitute. (The amount of advance notice should be agreed upon between the employer and employee and noted in the space provided.)

**A change in the scheduled work by the employer or employee must be made at least**

\_\_\_hours in advance. In case of an emergency, the employee will notify the employer or another designated person. This person shall be designated in advance, in writing and be identified to the employee. If an employee is knowingly going to be late, he or she shall notify the employer by telephone. (See note above.)

**Employee Qualifications**

The employee confirms that he/she meets the minimum qualifications for employment as required by the Self-Direction Program and described in the Self-Direction Program regulations (8.314.6 NMAC or 8.308.12 NMAC), the Self-Direction Program Service Standards, and the Centennial Care Managed Care Policy Manual. Qualification, duties and policies of the employee include, but are not limited to:

1. The employee is 18 years of age or older.
2. The employee has the required knowledge, skills, and ability to perform the services specified (stated) in the member/participant's Service and Support Plan (SSP)/budget or SDCB Care Plan.

Employee Name	Participant Name
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3. The employee possesses the experience and background required by the Self-Direction Program for the specific service(s) he or she will provide to the member/participant.
4. The employee has basic math, reading, and writing skills and is able to communicate successfully with the member/participant.
5. An employee who provides transportation for a Self-Direction member/participant, whether as the primary service or as part of providing a separate service, must meet the qualifications for a transportation provider, in addition to other qualifications for employment.
6. The employee holds a valid social security number and is authorized to work in the United States.
7. The employee is willing to submit to a criminal record check. **Criminal record checks are mandatory.** Employee acknowledges that he/she may not begin work until all materials necessary for a criminal background check have been received by Conduent and the EOR has received notification that the employee has successfully passed the initial Consolidated Online Registry (COR) Background Check. After the COR has been completed and the final criminal background check is in process, the employee is employed on a provisional (temporary) basis until the results of the final criminal background check are received by the EOR.
8. Employees are responsible for providing Conduent a copy of the criminal background checks and screenings rendering Self-Directed Personal Care Services. Employees/Caregivers will be required to provide the requested documents within 24 business hours of obtaining the results.
9. Employees agree to adhere to the Employee/Caregiver Agreement and qualifications requirements of the program by completing and submitting a Provider attestation form annually to Conduent to remain compliant with the HCBS Setting Rule requirements.

**Administrative Responsibilities**

1. The employee agrees that federal income, Medicare, Social Security and New Mexico State and local taxes (as applicable) shall be withheld from employee wages per Internal Revenue Service (IRS) and New Mexico Department of Taxation and Revenue requirements.
2. The employee acknowledges and understands that funds available for payment are authorized (allowed) by the Self-Direction New Mexico Self-Directed Medicaid Waiver **in advance** of the work performed. Payment to the employee shall only be made as authorized by the New Mexico Self-Directed Medicaid Waiver according to the approved member/participant SSP/budget or SDCB Care Plan.
3. The employee shall only perform work within the authorized hourly rate as he or she will not be compensated (paid) by the state of New Mexico for work performed in excess of (more than) the authorized amount in the SSP/budget or SDCB Care Plan.
  - a. Effective 9/1/11, any changes to pay for employees must start at the beginning of a pay period. Conduent must receive the Employment Agreement at least 15 days before the effective date of the change. If the employee is going to be given a raise, the new rate must be approved in the member/participant's budget.
4. The employee will not be paid for services that are not performed or time that is not worked.
5. The employee will not be paid for any work performed over the amount authorized and documented in the budget to the employee.
6. Timesheets must be correctly completed and signed *by both* the employer and the employee.

Employee Name	Participant Name
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7. Timesheets are due to Conduent by the employer or employee within one calendar day from the end of the pay period in accordance with the payment schedule (a copy is included in your Employee Packet). Timesheets received after the date in the payment schedule are considered late and may NOT be paid until the following scheduled payment issue date. Timesheets submitted for payment that exceed (go beyond) ninety (90) days after the service was provided cannot be processed or paid according to Medicaid timely-filing requirements.
8. All required documents listed in the Employee Packet must be completed by the employee and sent to Conduent *before* providing any services.
9. The employee is considered a Medicaid provider and must document services and maintain documentation as set forth in the Self-Direction Program Regulations (8.314.6.12 NMAC or 8.308.12 NMAC).
10. The employer will review or has reviewed the Waiver Service Standards or Centennial Care Managed Care Policy with the Employee for those services they are employed to provide.
11. The employer will provide or has provided training to the employee on the reporting requirements set forth in the ABUSE, NEGLECT, EXPLOITATION, AND DEATH REPORTING, TRAINING AND RELATED REQUIREMENTS FOR COMMUNITY PROVIDERS REGULATIONS (7.1.14 NMAC)

**Employment Policies**

1. Payment for services may be in the form of a check or via direct deposit. The employee can change their preference of payment at any time, subject to the processes and timelines outlined in the Direct Deposit Agreement and associated instructions.
2. All paychecks are mailed directly to the employee’s address on file with Conduent or are sent by direct deposit.
3. Employee wages are paid from federal and state funds. Any false claims, statements, documents or concealment (hiding) of material facts will be prosecuted under applicable federal and state laws.
4. The employee agrees to assist the employer by providing the services and performing the activities specified in the member/participant’s Service and Support Plan (SSP) or SDCB Care Plan and as outlined elsewhere in other documents that are related to the employee’s scope of work.
5. The employee agrees to provide employee services as specified by the employer on a schedule mutually agreed upon between the employer and the employee. Occasional variations (changes) in the employee tasks and schedule may occur based on the mutual agreement of both parties.
6. In case of illness, emergency, or an incident that prevents the employee from providing scheduled services to the member/participant/employer; the employee agrees to notify the employer as soon as possible, so that the employer can obtain assistance from another party.

Employee Name	Participant Name
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7. The employee agrees to participate in training to provide employee services, including training to perform any health activities as required by the employer, or as specified in the member/participant's SSP or SDCB Care Plan.
8. The employee agrees to maintain the confidentiality of all information about the member/participant and to respect the member/participant's privacy.
9. The employee agrees to report suspected incidents of abuse, neglect and/or exploitation to either Adult or Child Protective Services, as applicable.
10. The employee understands that this Agreement does not guarantee employment or payment of wages for any time period until all required paperwork is received and logged by Conduent and the EOR has received notification that the employee has successfully passed the Consolidated Online Registry (COR) Background Check.
11. The employee understands that the employee is employed by the employer and **not** the state of New Mexico or Conduent or its subcontractors.
12. The employee and employer acknowledge that the employer is solely responsible for any issue related to employment, hours, wages, and non-payment of wages, including wage claims with the Department of Workforce Solutions.
13. The member/participant/employer's property is not to be used for the employee's personal use, unless mutually agreed upon in writing by both parties prior to the use of the property. All private matters discussed during working times shall be kept confidential.
14. The employee is to be punctual, neatly dressed, and respectful of all family members. The member/participant/employer's telephone may be used only with permission.
15. Misrepresentation (false statement) of time, services, individuals and/or other information is not permitted. If the employer or employee signs a timesheet that is determined to misrepresent information, this may be cause for termination (firing) of the employee, and the member/participant may lose the option of participating in Self- Direction. Additionally, suspected fraud will be reported to the Medicaid fraud unit.
16. Per Medicaid regulations, the Self-Direction Program does not allow payroll hours to exceed forty (40) hours per week for any one employee under one employer (EOR).

**Employer (EOR) Responsibilities**

1. The employer will verify and attest that the employee meets the minimum qualifications for employment as required by the Self-Direction Program and described in the Self- Direction Program regulations (8.314.6 NMAC or 8.308.12 NMAC) and the Self- Direction Program Service Standards and Centennial Care Managed Care Policy Manual.
2. The employer agrees to orient, train, and direct the employee in providing the employee services that are described and authorized (allowed) by the member/participant's service plan or that are requested by the employer.
3. The employer agrees to establish a mutually agreeable schedule for the employee's services, either orally or in writing.

Employee Name	Participant Name
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4. The employer agrees to provide fair notice of changes in the employee's work schedule in the event of unforeseen circumstances or emergencies, but such notice cannot be guaranteed.
5. The employer understands that at any time, the employee can change their preference of payment from check to direct deposit, subject to the processes and timelines outlined in the Direct Deposit Agreement and associated instructions.
6. In consideration of the employee's best efforts to perform his/her job satisfactorily, the employer agrees to authorize completed employee timesheets and to pay the employee according to the predetermined payroll schedule. Net wages will include gross earnings calculated according to the employee's pay rate, minus payroll deductions for the employee's share of applicable state, federal, and local payroll withholdings.
7. The employer agrees that the employee may not begin work until all materials necessary for a criminal background check have been received by Conduent and the employee has successfully passed the Consolidated Online Registry (COR) Background Check. Once the necessary materials have been received by Conduent and the employee has successfully passed the COR Background Check, the employer agrees to select or employ the employee **on an interim (temporary) basis until a final criminal history record check has been completed, for those crimes determined to be disqualifying convictions as stated in NMSA 1978, Section 29-17-3.** The employer has discussed this with the employee and reserves the right to dismiss the employee based on the results of the criminal history record check.

The process for enrolling an employee is as follows:

- a. Pre-hire packet must be properly filled out and sent to Conduent (formerly Xerox). This packet consists of the Department of Health/Division of Health Improvement DOH/DHI Authorization form; copy of a photo ID; 3 fingerprint cards; Fingerprint Reimbursement form (optional).
- b. The COR is completed by Conduent.
- c. If the proposed employee passes the COR, they may begin work on a provisional basis until the full criminal background check is completed.
- d. The Employee Enrollment Packet needs to be completed within 3 days of when the employee begins to work. This packet consists of the Employee Information Form; the Employment Agreement; the Self-Directed Provider Attestation Form, the Declaration of Relationship form; the Federal W-4 Tax Withholding form; the New Mexico State Withholding form; the I-9 form; and the Direct Deposit Authorization form. All documents with the exception of the I-9 form must be sent to Conduent. The I-9 form must be completed and retained (kept) by the EOR.

Employee Name	Participant Name
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- 8. Misrepresentation (false statement) of time, services, individual and/or other information is forbidden. If the employer or employee signs a timesheet that is determined to misrepresent information, this may be cause for termination (firing) of the employee, and the member/participant may lose the option of participating in Self-Direction. Additionally, suspected fraud will be reported to the Medicaid fraud unit.

**Minimum Wage**

This Employment Agreement cannot show a rate that is less than the state minimum wage.

**Mutual Responsibilities**

The parties agree to follow the policies and procedures of the Self-Direction, New Mexico Self-Directed Medicaid Waiver to include the regulations (8.314.6 NMAC or 8.308.12 NMAC), the Service Standards, and Centennial Care Managed Care Policy Manual. The employee and Employer agree to hold harmless, release, and forever discharge the state of New Mexico and Conduent (formerly Xerox) and its subcontractors from any claims and/or damages that might arise out of any action or omissions by the employee, employer, member/participant, or consumer.

The Employer and Employee must sign below to begin an employment relationship through the Self-Direction program. By signing, the employee and the employer listed hereby agree to all qualifications, duties, responsibilities and policies as outlined in this Employment Agreement.

\_\_\_\_\_  
**Employee Printed Name**

\_\_\_\_\_  
**Employer Printed Name**

\_\_\_\_\_  
**Employee Signature**

\_\_\_\_\_  
**Employer Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Date**

Employee Name	Participant Name
---------------	------------------



**SELF-DIRECTED PROVIDER ATTESTATION FORM  
CMS FINAL RULE FOR HCBS**

**Please read the following summary of the Centers for Medicare and Medicaid Services (CMS) Final Rule Requirements for Home and Community Based Services (HCBS) Providers.**

Any residential or non-residential HCBS provider, who offers self-directed services in a setting where individuals live and/or receive HCBS, must comply with the following CMS Final Rule requirements:

- 1) Providers must ensure that settings are integrated in and support full access of individuals to the greater community including:
  - Providing opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources; and
  - Ensuring that individuals receive services in the community, to the same degree of access as individuals not receiving HCBS.
- 2) Providers must ensure that the individual selects from among setting options including non-disability specific settings and options for a private unit in a residential setting. The provider setting must have person-centered service plans that document the options based on the individual's needs and preferences. For residential settings, the person centered plan must document options available for room and board.
- 3) Providers must ensure an individual's rights to privacy, dignity and respect, and freedom from coercion and restraint.
- 4) Providers must ensure settings optimize individual initiative, autonomy, and independence in making life choices, including, but not limited to, daily activities, physical environment, and with whom to interact.
- 5) Provider must ensure settings facilitate individual choice regarding services and supports, and choice regarding who provides them.
- 6) Providers must ensure tenant protections, privacy, and autonomy for individuals receiving HCBS who do not reside in their own private (or family) home.

As a Medicaid enrolled HCBS provider you are required to ensure all aspects of the Final Rule are followed. **HSD/MAD recommends that you read the CMS Final Rule in the Federal Register at the following link to review the details of the CMS Final Rule requirements:**

[https://www.federalregister.gov/documents/2016/10/04/2016-23503/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities?utm\\_campaign=subscription%20mailing%20list&utm\\_source=federalregister.gov&utm\\_medium=email](https://www.federalregister.gov/documents/2016/10/04/2016-23503/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities?utm_campaign=subscription%20mailing%20list&utm_source=federalregister.gov&utm_medium=email)

**I certify that I have carefully read the summary requirements for the Home and Community Based Services above and the CMS Final Rule Requirements in the Federal Register at the link provided above. I attest that my organization/provider setting is in compliance or will be in compliance by March 17, 2022 with the CMS Final Rule Requirements published in the Federal Register.**

**Additionally, I certify that my organization/provider setting will remain in compliance with the CMS Final Rule Requirements published in the Federal Register.**

**(THE APPLYING PROVIDER MUST SIGN AND DATE THIS ATTESTATION FORM).**

**Member/Participant Information**

Member/Participant Name: \_\_\_\_\_

Member/Participant Date of Birth: \_\_\_\_\_

Member/Participant Employer of Record: \_\_\_\_\_

**Provider Information (Vendor or Employee)**

Printed Name: \_\_\_\_\_

Title/Position: \_\_\_\_\_

Social Security Number/Tax ID: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**APPENDIX TO EMPLOYEE AGREEMENT  
CHECKLIST FOR PROVIDERS OF TRANSPORTATION SERVICES  
Self-Direction Medicaid Waiver**

**This form is ONLY required if driving the member is your job function or part of your assigned tasks.**

EMPLOYEE INFORMATION	
Full Name	ID/Last 4 of SSN

**All individuals who provide transportation services of any sort to a Self-Direction participant must possess the following qualifications:**

- Possess a valid New Mexico driver’s license
- Be at least 18 years of age
- Be free of physical or mental impairment that would adversely affect driving performance
- Have no driving while intoxicated (DWI) convictions or chargeable (at fault) accidents within the previous two years
- Possess a current insurance policy and vehicle registration
- Have current CPR/First Aid Certification
- Have a First Aid Kit in the Vehicle *(For Mivia only)*
- Complete Training on Critical Incident, abuse, neglect, and exploitation reporting.

I attest that I have verified that my transportation provider possesses each of these qualifications. (Please complete and sign in ink.)

\_\_\_\_\_  
Employer Printed Name

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

Please attach copies to this form of the following documents from the provider (employee) listed above:

- Valid New Mexico driver’s license
- Current Insurance Policy listing the employee that will be providing transportation
- Current Vehicle Registration of the employee that will be providing transportation
- Driving Records within the previous two years

**These documents are necessary in order to verify if the provider is qualified to perform transportation services within Self-Direction. Without these documents, transportation cannot be provided.**



## Instructions for I-9

The United States Department of Homeland Security, Citizenship, and Immigration Services (CIS) department, requires all U.S. employers and workers to complete the I-9. The purpose is to verify that the applicant worker can be legally employed in the United States. Palco verifies all workers through the U.S. CIS online system.

Use the instructions and checklist below to guide you through completing this form. The applicant worker should complete all fields highlighted in **blue**. The employer should complete all fields highlighted in **yellow**.

### 1. Complete Section 1 at the top of page 1. **Must be completed by the applicant worker.**

- Complete all fields in Section 1. The name here must match the name on your verification documents. (See #3 on this checklist.)

Section 1. Employee Information and Attestation: Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.				
Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	Other Last Names Used (if any)	
Address (Street Number and Name)		Apt. Number (if any)	City or Town	State
				ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address		Employee's Telephone Number

- Select the following box that applies to you.
  - If you select box 3, supply your alien registration or USCIS number.
  - If you select box 4, supply your work expiration date and complete any one of the three fields that follow.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):		
<input type="checkbox"/>	1. A citizen of the United States	
<input type="checkbox"/>	2. A noncitizen national of the United States (See Instructions.)	
<input type="checkbox"/>	3. A lawful permanent resident (Enter USCIS or A-Number)	
<input type="checkbox"/>	4. A noncitizen (other than Item Numbers 2. and 3. above) authorized to work until (exp. date, if any)	
If you check Item Number 4., enter one of these:		
USCIS A-Number	OR	Form I-94 Admission Number
		OR
		Foreign Passport Number and Country of Issuance

- Sign and date.

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

- If necessary, complete the Preparer and/or Translator Certification boxes on page 3.

**2. Complete Section 2 at the bottom of page 1. Must be completed by the employer.**

- Refer to page 2 of the I-9 for appropriate verification documents. Complete all lines associated with the documents provided in the space designated. You must complete one, but not both, of the following two options for submission:
  - One document from List A.
  - One document from List B **and** One document from List C.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)	Additional Information				
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)	<input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.				
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

- Attach copies of the verification documents listed on page 1 of the I-9. The employer must review the worker's verification documents.
- Provide the employee's first day of employment in the space provided. This date must match the date the worker signed on page 1.

**The employee's first day of employment (mm/dd/yyyy):** \_\_\_\_\_

- Complete the next two rows of information in Section 2, including signing and dating the form.

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)
Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code	

- Complete page 4 *only* if the worker had a name or citizenship status change, or if the worker previously worked for the employer within the last three years. If none of these apply, leave page 4 blank.

For more information and assistance on how to complete this form, visit <https://www.uscis.gov/i-9>.



# Employment Eligibility Verification

## Department of Homeland Security

### U.S. Citizenship and Immigration Services

**USCIS**  
**Form I-9**  
OMB No.1615-0047  
Expires 07/31/2026

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

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

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

Last Name (Family Name)		First Name (Given Name)		Middle Initial (if any)	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number (if any)	City or Town	State ZIP Code	
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number		Employee's Email Address		Employee's Telephone Number	
<p><b>I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.</b></p>		Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):				
		<input type="checkbox"/> 1. A citizen of the United States				
		<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)				
		<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)				
		<input type="checkbox"/> 4. A noncitizen (other than <b>Item Numbers 2.</b> and <b>3.</b> above) authorized to work until (exp. date, if any)				
		If you check <b>Item Number 4.</b> , enter one of these:				
		USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance
Signature of Employee				Today's Date (mm/dd/yyyy)		

If a preparer and/or translator assisted you in completing Section 1, that person **MUST** complete the [Preparer and/or Translator Certification](#) on Page 3.

**Section 2. Employer Review and Verification:** Employers or their authorized representative must complete and sign **Section 2** within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	OR	List B	AND	List C
Document Title 1				
Issuing Authority				
Document Number (if any)				
Expiration Date (if any)				
Document Title 2 (if any)	<p><b>Additional Information</b></p>			
Issuing Authority				
Document Number (if any)				
Expiration Date (if any)				
Document Title 3 (if any)	<p><input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.</p>			
Issuing Authority				
Document Number (if any)				
Expiration Date (if any)				

**Certification:** I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.

Last Name, First Name and Title of Employer or Authorized Representative		Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)
Employer's Business or Organization Name		Employer's Business or Organization Address, City or Town, State, ZIP Code	

For reverification or rehire, complete [Supplement B, Reverification and Rehire](#) on Page 4.

## LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.

\* Documents extended by the issuing authority are considered unexpired.

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

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

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
<ol style="list-style-type: none"> <li>1. U.S. Passport or U.S. Passport Card</li> <li>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</li> <li>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</li> <li>4. Employment Authorization Document that contains a photograph (Form I-766)</li> <li>5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole:                             <ol style="list-style-type: none"> <li>a. Foreign passport; and</li> <li>b. Form I-94 or Form I-94A that has the following:                                     <ol style="list-style-type: none"> <li>(1) The same name as the passport; and</li> <li>(2) An endorsement of the individual's status or parole 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.</li> </ol> </li> </ol> </li> <li>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</li> </ol>	OR	<ol style="list-style-type: none"> <li>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</li> <li>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</li> <li>3. School ID card with a photograph</li> <li>4. Voter's registration card</li> <li>5. U.S. Military card or draft record</li> <li>6. Military dependent's ID card</li> <li>7. U.S. Coast Guard Merchant Mariner Card</li> <li>8. Native American tribal document</li> <li>9. Driver's license issued by a Canadian government authority</li> <li style="text-align: center;"><b>For persons under age 18 who are unable to present a document listed above:</b></li> <li>10. School record or report card</li> <li>11. Clinic, doctor, or hospital record</li> <li>12. Day-care or nursery school record</li> </ol>	AND	<ol style="list-style-type: none"> <li>1. A Social Security Account Number card, unless the card includes one of the following restrictions:                             <ol style="list-style-type: none"> <li>(1) NOT VALID FOR EMPLOYMENT</li> <li>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</li> <li>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</li> </ol> </li> <li>2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)</li> <li>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</li> <li>4. Native American tribal document</li> <li>5. U.S. Citizen ID Card (Form I-197)</li> <li>6. Identification Card for Use of Resident Citizen in the United States (Form I-179)</li> <li>7. Employment authorization document issued by the Department of Homeland Security                             <p style="margin-left: 20px;">For examples, see <a href="#">Section 7</a> and <a href="#">Section 13</a> of the M-274 on <a href="https://uscis.gov/i-9-central">uscis.gov/i-9-central</a>.</p> <p style="margin-left: 20px;">The Form I-766, Employment Authorization Document, is a List A, <b>Item Number 4</b>, document, not a List C document.</p> </li> </ol>

### Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.

For receipt validity dates, see the M-274.

<ul style="list-style-type: none"> <li>• Receipt for a replacement of a lost, stolen, or damaged List A document.</li> <li>• Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual.</li> <li>• Form I-94 with "RE" notation or refugee stamp issued to a refugee.</li> </ul>	OR	<p>Receipt for a replacement of a lost, stolen, or damaged List B document.</p>	<p>Receipt for a replacement of a lost, stolen, or damaged List C document.</p>
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\*Refer to the Employment Authorization Extensions page on [I-9 Central](#) for more information.





# Supplement A, Preparer and/or Translator Certification for Section 1

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

**USCIS**  
**Form I-9**  
**Supplement A**  
OMB No. 1615-0047  
Expires 07/31/2026

Last Name ( <i>Family Name</i> ) from <b>Section 1</b> .	First Name ( <i>Given Name</i> ) from <b>Section 1</b> .	Middle initial (if any) from <b>Section 1</b> .
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**Instructions:** This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

**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		Date ( <i>mm/dd/yyyy</i> )	
Last Name ( <i>Family Name</i> )	First Name ( <i>Given Name</i> )		Middle Initial ( <i>if any</i> )
Address ( <i>Street Number and Name</i> )	City or Town	State	ZIP Code

**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		Date ( <i>mm/dd/yyyy</i> )	
Last Name ( <i>Family Name</i> )	First Name ( <i>Given Name</i> )		Middle Initial ( <i>if any</i> )
Address ( <i>Street Number and Name</i> )	City or Town	State	ZIP Code

**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		Date ( <i>mm/dd/yyyy</i> )	
Last Name ( <i>Family Name</i> )	First Name ( <i>Given Name</i> )		Middle Initial ( <i>if any</i> )
Address ( <i>Street Number and Name</i> )	City or Town	State	ZIP Code

**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		Date ( <i>mm/dd/yyyy</i> )	
Last Name ( <i>Family Name</i> )	First Name ( <i>Given Name</i> )		Middle Initial ( <i>if any</i> )
Address ( <i>Street Number and Name</i> )	City or Town	State	ZIP Code



# Supplement B, Reverification and Rehire (formerly Section 3)

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

**USCIS  
Form I-9  
Supplement B**  
OMB No. 1615-0047  
Expires 07/31/2026

Last Name ( <i>Family Name</i> ) from <b>Section 1</b> .	First Name ( <i>Given Name</i> ) from <b>Section 1</b> .	Middle initial (if any) from <b>Section 1</b> .
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**Instructions:** This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the [Handbook for Employers: Guidance for Completing Form I-9 \(M-274\)](#)

Date of Rehire ( <i>if applicable</i> )	New Name ( <i>if applicable</i> )		
Date ( <i>mm/dd/yyyy</i> )	Last Name (Family Name)	First Name (Given Name)	Middle Initial

**Reverification:** If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) ( <i>mm/dd/yyyy</i> )
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**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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.**

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date ( <i>mm/dd/yyyy</i> )
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Additional Information (Initial and date each notation.)

Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire ( <i>if applicable</i> )	New Name ( <i>if applicable</i> )		
Date ( <i>mm/dd/yyyy</i> )	Last Name (Family Name)	First Name (Given Name)	Middle Initial

**Reverification:** If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) ( <i>mm/dd/yyyy</i> )
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**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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.**

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date ( <i>mm/dd/yyyy</i> )
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Additional Information (Initial and date each notation.)

Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire ( <i>if applicable</i> )	New Name ( <i>if applicable</i> )		
Date ( <i>mm/dd/yyyy</i> )	Last Name (Family Name)	First Name (Given Name)	Middle Initial

**Reverification:** If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) ( <i>mm/dd/yyyy</i> )
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**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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.**

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date ( <i>mm/dd/yyyy</i> )
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Additional Information (Initial and date each notation.)

Check here if you used an alternative procedure authorized by DHS to examine documents.

## **Instructions for Employee Payroll Forms**

Please complete the appropriate payroll, IRS, state withholding and additional forms in order to become an employee on the self-directed program. Follow the instructions listed below. All areas highlighted must be signed.

- The **Payroll Information Worksheet** is used to determine any exemptions you qualify for in order for Palco to calculate the proper payroll and payroll tax for you and your employer. Please remember to complete all fields in the Required Information section and sign and date the form. Any missing information could cause a delay in enrollment.
- The **IRS Form W-4** tells Palco how you would like us to calculate and withhold federal income taxes from your paycheck.
  - Complete Box 1 with your name and full address.
  - Write your Social Security Number in Box 2.
  - Make the appropriate selection in Box 3.
  - Select Box 4 if appropriate.
  - Include the total number of dependents you would like to claim in Box 5.
  - Indicate any additional dollar amount to be withheld each pay cycle in Box 6.
  - If you claim any exemption, will write EXEMPT in Box 7.
  - Sign and date the bottom of the form.
- The **Pay Selection and Direct Deposit Authorization Agreement** gives us the authority to pay you via electronic funds transfer
  - Select an option for Request Type at the top of the form.
  - Complete all fields in the Account Information section.
  - Attach one of the following forms of validating documentation:
    - ✓ A voided check (no temporary checks or deposit slip).
    - ✓ A typed letter from your bank on the bank's letterhead with your name, account number and routing number.
    - ✓ For a pre-paid card, send a statement from the card company showing the card is activated and registered. This statement must have your name printed on the card. Generally, you can log into the card company's website and print this form, or if you purchase your pre-paid card directly from a bank, the bank can provide the necessary documentation. **A copy of your card is NOT valid documentation.**
  - Sign and date the bottom of the form.



## Payroll Information Worksheet

As a home care worker in self-direction, your payroll tax withholdings are subject to special tax rules, and your residency may impact your benefits under labor laws. Completing this form accurately will ensure that your taxes and benefits are calculated properly.

REQUIRED INFORMATION	
Employee Name	ID
Employer Name	Participant Name (If different from Employer)

### Select the following box that applies:

- This form is part of your **first-time enrollment** with Palco.
- You are already enrolled with Palco and need to **change** your information

### **Part A: FICA (Social Security and Medicare) Taxes**

The IRS exempts some employers and workers from paying FICA (Social Security and Medicare) taxes.

### Select the appropriate response:

- Non-Exempt.** None of the selections apply.
- Exempt.** I am under 18 and a fulltime student.
- Exempt.** I am a non-resident alien holding a visa for household services.
- Exempt.** I am the spouse of my employer.
- Exempt.** I am the child of my employer and under 21.
- Exempt.** I am the parent of my employer who is an adult. This includes adoptive and stepparents.

### **Exception: If you are the parent of the employer and select any of the following you are non-exempt**

- I am the parent of the employer and I also provide care for my grandchild or step-grandchild in my child's home.
- I am the parent of the employer, and my grandchild or step-grandchild is under 18 or has a physical or mental condition that requires personal care of an adult for at least four weeks in a row during the calendar quarter in which services are performed.
- I am the parent of the employer, and my child (son or daughter) is widowed, divorced, not remarried or living with a spouse who has a mental or physical condition so the spouse cannot care for my grandchild for at least four weeks in a row during the calendar quarter in which services are performed.



**Part B: Unemployment Tax Exemption**

The IRS and State tax agencies exempt some wages from FUTA (Federal Unemployment) or SUTA (State Unemployment) taxes.

**Select the appropriate response:**

- Exempt.** I am the child of my employer and under 21.
- Exempt.** I am the parent of my employer who is an adult. This includes adoptive and stepparents.

**Check this box if you live in the state of Colorado:**  By choosing this, you will be exempt from paying federal unemployment taxes. However, you will be paying state unemployment taxes.

- Exempt.** I am the spouse of my employer.
- Exempt.** I am a non-resident alien holding a visa for household services.
- Non-Exempt.** None of the selections apply.

If any of the information in this document changes at any time, please complete a new document and submit to Palco immediately. Failure to notify Palco may result in a tax bill to you or other employment-related matters from your employer. Palco is not responsible for incorrectly calculating or withholding pay due to your failure to complete and submit a new Payroll Information Worksheet. By signing below, you certify that the information in this document is correct and understand that you have the burden to notify Palco immediately of any changes in this information, and you hold Palco harmless for any incorrect information supplied herein.

\_\_\_\_\_  
**Employee Printed Name**

\_\_\_\_\_  
**Employee Signature**

\_\_\_\_\_  
**Date**

**Please return this form to Conduent via email to [docprocessing@conduent.com](mailto:docprocessing@conduent.com) or via fax to 866.302.6787.**

# 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.**

**2024**

<b>Step 1: Enter Personal Information</b>	(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 <a href="http://www.ssa.gov">www.ssa.gov</a> .
	City or town, state, and ZIP code		
	(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> 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, and when to use the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App).

**Step 2:  
Multiple Jobs  
or Spouse  
Works**

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

Do **only one** of the following.

(a) Use the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App) for most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate

**Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs.** Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

<b>Step 3: Claim Dependent and Other Credits</b>	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 for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . .	<b>3</b>	\$
<b>Step 4 (optional): Other Adjustments</b>	(a) <b>Other income (not from jobs).</b> 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>4(a)</b>	\$
	(b) <b>Deductions.</b> 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 . . . . .	<b>4(b)</b>	\$
	(c) <b>Extra withholding.</b> Enter any additional tax you want withheld each pay period . . . . .	<b>4(c)</b>	\$

<b>Step 5: Sign Here</b>	Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.		
	_____ <b>Employee's signature</b> (This form is not valid unless you sign it.)	_____ <b>Date</b>	

<b>Employers Only</b>	Employer's name and address	First date of employment	Employer identification number (EIN)
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## General Instructions

Section references are to the Internal Revenue Code.

### 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](http://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 2024 if you meet both of the following conditions: you had no federal income tax liability in 2023 **and** you expect to have no federal income tax liability in 2024. You had no federal income tax liability in 2023 if (1) your total tax on line 24 on your 2023 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), 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 2024 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, 2025.**

**Your privacy.** Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

**When to use the estimator.** Consider using the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App) if you:

1. Expect to work only part of the year;
2. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or
3. 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](http://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.

Instead, if you (and your spouse) have a total of only two jobs, you may 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 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. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. 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 2024 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.

# For New Mexico State Withholding Only

Form **W-4**  
 Department of the Treasury  
 Internal Revenue Service

## Employee's Withholding Certificate

**Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.  
 Give Form W-4 to your employer.  
 Your withholding is subject to review by the IRS.**

OMB No. 1545-0074

# 2024

<b>Step 1:</b> <b>Enter Personal Information</b>	<b>(a)</b> First name and middle initial	Last name	<b>(b)</b> Social security number
	Address		<b>Does your name match the name on your social security card?</b> If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to <a href="http://www.ssa.gov">www.ssa.gov</a> .
	City or town, state, and ZIP code		
	<b>(c)</b> <input type="checkbox"/> <b>Single</b> or <b>Married filing separately</b> <input type="checkbox"/> <b>Married filing jointly</b> or <b>Qualifying surviving spouse</b> <input type="checkbox"/> <b>Head of household</b> (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, and when to use the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App).

**Step 2: Multiple Jobs or Spouse Works**

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

Do **only one** of the following.

**(a)** Use the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App) for most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

**(b)** Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

**(c)** If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate

**Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs.** Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

<b>Step 3:</b> <b>Claim Dependent and Other Credits</b>	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 for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . .	<b>3</b>	\$
<b>Step 4 (optional): Other Adjustments</b>	<b>(a) Other income (not from jobs).</b> 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>4(a)</b>	\$
	<b>(b) Deductions.</b> 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 . . . . .	<b>4(b)</b>	\$
	<b>(c) Extra withholding.</b> Enter any additional tax you want withheld each <b>pay period</b> . . . . .	<b>4(c)</b>	\$

<b>Step 5:</b> <b>Sign Here</b>	Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.		
	_____ <b>Employee's signature</b> (This form is not valid unless you sign it.)		_____ <b>Date</b>

<b>Employers Only</b>	Employer's name and address	First date of employment	Employer identification number (EIN)
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# Pay Selection and Direct Deposit Authorization Agreement

HOW WOULD YOU LIKE TO BE PAID? (please select only one option)

## OPTION 1

Money Network Services

*Please Provide a Physical Address Card can be Sent to Below: (No PO BOX)*

Street \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_

\*If you choose the Money Network Services Option, Palco will enroll you with our partners at Fiserv: Money Network Services. Fiserv will send you a Money Network Card in 1-2 weeks and Palco will begin depositing funds directly to the card. Activate your card as soon as it arrives to begin using it. You will receive paper checks during the 1-2 weeks it takes to receive your card.

## OPTION 2

Request Type (check one):

Direct Deposit

New Account Setup

Change in Existing Account

Cancellation

### DIRECT DEPOSIT ACCOUNT INFORMATION

Account Holder's Full Name		ID or Last 4 of SSN
Financial Institution	Routing Number	Account Number
Type of Account (select one): <input type="checkbox"/> Checking <input type="checkbox"/> Savings <input type="checkbox"/> Pre-paid card		

**REQUIRED** The following validating documentation is attached:

Voided check with account holder name printed on the check. *Check cannot be a temporary check*

OR

Official documentation from financial institution listing account holder name, account, and routing number. This includes letters from banks and paperwork from pre-paid cards.

I authorize Palco, Inc. to initiate deposits and debit entries for the purpose of correcting an erroneous deposit to the account indicated herein. In the event Palco is unable to initiate debit entries, I authorize the repayment to Palco from future amounts owed to me. I understand Palco is not responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account. I understand that it is my responsibility to verify the crediting of funds by my financial institution prior to initiating debits against my account. I understand the risks of sharing an account with others, including my employer or worker. Palco is not responsible for any charges I incur from my financial institution. Any changes to my account must be submitted to Palco immediately. This authorization will remain in full force and effect until Palco has received written cancellation in such time and in such manner as to afford Palco and all appropriate financial institutions a reasonable opportunity to act on it.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Please return this form to Conduent via email: [docprocessing@conduent.com](mailto:docprocessing@conduent.com) or via fax 866-302-6787

# 2 WAYS TO GET PAID INSTANTLY

## 1

### Money Network Card

Palco has partnered with Money Network<sup>®</sup> Service, one of the largest card companies in the country, to offer consumers a **FREE** Money Network Card, which works just like a bank card. To see more benefits of the Money Network Card, **see the Money Network Card page**.

→ You can use your Money Network Card anywhere Visa Debit<sup>®</sup> or Debit Mastercard<sup>®</sup> are accepted.

## 2

### Direct Deposit

A direct deposit transfers funds automatically into an existing bank account. This means that once a worker links their account electronically, money will be deposited directly into that account.

→ Workers can receive their payments directly into any bank account of their choice!

Using these methods of payment in place of a paper check ensures a worker receives their payment on pay day the moment the funds are available! No hassling with paper checks getting lost in the mail or having to wait in line at the bank!

Sign up for Direct Deposit or request your free Money Network Card today by submitting a **Pay Selection Form**. **See the Pay Selection and Direct Deposit Authorization Agreement** for more details.

*To ensure quick and accurate payment, use Palco's CONNECT online timesheet and reporting portal to enter time electronically, error free, and submit it to Palco instantly. CONNECT is a allows you to monitor the time submission process from start through payment. .*



# Money Network<sup>®</sup>

## *Get more from your money*

The Money Network<sup>®</sup> Service gives you the Savings, Convenience & Service *you deserve.*



### More Savings

- ✓ No activation fee
- ✓ Get cash at surcharge-free ATMs
- ✓ Mobile App<sup>2</sup> for money management
- ✓ Use or cash Money Network<sup>®</sup> Checks



### More Benefits

- ✓ Receive all or a portion of your wages faster than a paper check<sup>3</sup> with direct deposit
- ✓ Make purchases anywhere Visa<sup>®</sup> Debit Cards or Debit Mastercard<sup>®</sup> is accepted
- ✓ Access to tools to set aside money for a rainy day



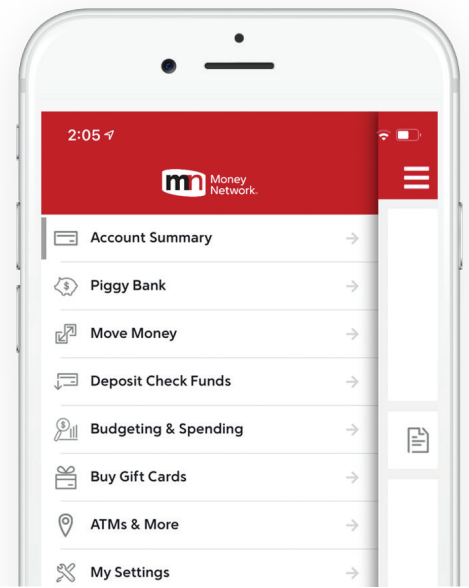
### More Security

- ✓ FDIC insured<sup>4</sup>
- ✓ Visa Zero Liability<sup>™</sup> or Mastercard Zero Liability<sup>™</sup>
- ✓ Security safeguards

## More Freedom

*Manage your money anytime, anywhere with the Money Network Mobile App*

- ✓ **Piggy Bank** → Set aside funds in up to three Piggy Banks for specific purposes.
- ✓ **Send Money to Friends** → Send money quickly to friends or family.
- ✓ **Deposit Check Funds** → Deposit check funds to your account by snapping a photo.
- ✓ **Budgeting Tools** → Customize and manage a monthly budget by category.
- ✓ **Move Money** → Transfer to a bank account in the U.S., Mexico, and Europe.
- ✓ **Locator** → Find nearby in-network Allpoint<sup>®</sup> ATMs, surcharge-free check cashing and participating retail reload locations.
- ✓ **Gift Cards** → Buy, send, and store digital gift cards with Gyft<sup>®</sup>.
- ✓ **Digital Wallet** → Add card to Apple Pay<sup>®</sup>, Samsung Pay<sup>®</sup>, or Google Pay<sup>™</sup> for contactless payments.
- ✓ **Card Lock & Unlock** → Lock card to easily disable spend.
- ✓ **Account Alerts** → Notifications for balance, deposits, withdrawals, and more.
- ✓ **Spending Alerts** → Notifications when your spending reaches the category budget you set.
- ✓ **Fraud Alerts** → Text alert when suspicious activity occurs on your card.



# Money Network Card Schedule A Fees

## List of all fees (Long Form) for the Money Network® Service Program

All Fees	Payor Program	Details
<b>Monthly Usage</b>		
Account Opening, Check, and Card Receipt	\$0.00	No fee for Account Opening, Checks, and initial Card.
Inactivity Fee	\$5.00	Fee is waived if you live in NY. Monthly fee charged when no activity occurs within Account for 12 consecutive monthly statement cycles.
<b>Add Money</b>		
Payor Deposit	\$0.00	Funds from a payor.
ACH Deposit of Other Funds	Not Available	Loads of other types of funds or payments, e.g. a tax refund.
<b>Spend Money</b>		
Signature Debit Transactions	\$0.00	Select "Credit" or sign at point-of-sale (POS).
PIN Debit Transactions	\$0.00	Select "Debit" and enter PIN at POS; cash back option at participating merchants.
Money Network® checks	\$0.00	Participating check cashing locations do not charge fees to cash Money Network Checks. To find these locations, use the locator on our Mobile App (data rates may apply) or at moneynetwork.com or call Customer Service. Non-participating check cashing locations may charge fees that are not monitored by us. Check cashing locations may also limit the dollar amount of checks they will cash.
<b>Get Cash or Send Cash</b>		
ATM Withdrawal Fee or ATM Decline Fee   In-Network	\$0.00	Withdrawal or Decline from ATM that is a part of our network. To find in-network ATMs, use the locator on our Mobile App (data rates may apply) or at moneynetwork.com, or call Customer Service.
ATM Withdrawal Fee   Out-of-Network	\$3.25	This is our fee. We waive our Out-of-network ATM Decline Fee if you live in NY. If you live in CT or IL, we will waive our fee for the first two ATM Declines (In-Network, Out-of-Network, or Non-US) in a calendar month. You may also be charged a fee by the ATM operator, even if you do not complete a transaction.
ATM Decline Fee   Out-of-Network		
Bank Teller Over the Counter Cash Withdrawal	\$0.00	At banks displaying the card association logo (except STAR) on the front of your Card. You may be charged a fee by the bank.

## List of all fees (Long Form) for the Money Network® Service Program

### Information

Monthly Paper Statement	\$0.00	You may also obtain account activity without a fee via Mobile App (data rates may apply), moneynetwork.com, or Customer Service
Customer Service	\$0.00	24/7 toll free Account access, including Account balance inquiries.
ATM Balance Inquiry Fee   In-Network	\$0.00	To find in-network ATMs, use the locator on our Mobile App (data rates may apply) or at moneynetwork.com, or call Customer Service.
ATM Balance Inquiry Fee   Out-of-Network	\$3.25	This is our fee. You may also be charged a fee by the ATM operator, even if you do not complete a transaction.

### Other

Reissuance of Lost/Stolen Card	\$6.00	Reissued Card shipped via U.S. mail 7-10 business days after order placed. One replacement Card provided at no charge each calendar year.
Priority Shipping Fee	\$24.00	Additional fee to ship replacement Card 4-7 business days after order placed. Reissuance of Card Fee also applies.
Money Network Check Stock Order	\$0.00	Shipped 7.10 business days after order placed. Up to 30 checks per order.

## Additional Disclosures

Your funds are eligible for deposit insurance up to the applicable limits by the Federal Deposit Insurance Corporation ("FDIC"). Your funds will be held at MetaBank®, N.A. or placed by MetaBank as custodian at one or more participating FDIC-insured banks (each a "Program Bank"). In the event the FDIC were to be appointed as a receiver for MetaBank or a Program Bank, your funds, aggregated with any other funds you have on deposit at such institution, would be eligible to be insured up to \$250,000 for each legal category of account ownership, subject to compliance with FDIC deposit insurance requirements. You are responsible for monitoring the total amount of all direct or indirect deposits held by you or for you with MetaBank and the Program Banks for purposes of monitoring the amount of your funds eligible for coverage by FDIC insurance. To assist with calculating your FDIC deposit insurance coverage, the FDIC has an Electronic Deposit Insurance Estimator available at <https://edie.fdic.gov>. For more information, see also <https://www.fdic.gov/deposit/deposits/prepaid.html>. No overdraft/credit feature. Contact Customer Service by calling 888-913-0900, by mail at 2900 Westside Pkwy, Alpharetta, GA 30004, or visit [moneynetwork.com](https://moneynetwork.com). For general information about prepaid accounts, visit [cfpb.gov/prepaid](https://cfpb.gov/prepaid). If you have a complaint about a prepaid account, call the Consumer Financial Protection Bureau at 1-855-411-2372 or visit [cfpb.gov/complaint](https://cfpb.gov/complaint).

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## 2-Week Participant/Self-Direction Timesheet for Payment

**FAX 1-866-302-6787**

Have you faxed this timesheet before (is it a duplicate)?  Yes  No If Yes, when?

Employee Name:				Employee ID# (last 4 digits of employee's social security #)	
Member/Participant:				Is this a correction to a PRIOR Timesheet? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Member/Participant's Date of Birth:				Begin Date	End Date
Date	Time In Circle AM or PM	Time Out Circle AM or PM	Hours	Service Code	Services Provided (Please enter)
<b>Week 1</b>	AM	PM	AM	PM	
	-----	-----	-----	-----	
	AM	PM	AM	PM	
	-----	-----	-----	-----	
	AM	PM	AM	PM	
	-----	-----	-----	-----	
	AM	PM	AM	PM	
	-----	-----	-----	-----	
	AM	PM	AM	PM	
	-----	-----	-----	-----	
	AM	PM	AM	PM	
	-----	-----	-----	-----	
	AM	PM	AM	PM	
	-----	-----	-----	-----	
	AM	PM	AM	PM	
	-----	-----	-----	-----	
Total Hours for Week 1 →				<b>Must not be over 40</b>	
<b>Week 2</b>	AM	PM	AM	PM	
	-----	-----	-----	-----	
	AM	PM	AM	PM	
	-----	-----	-----	-----	
	AM	PM	AM	PM	
	-----	-----	-----	-----	
	AM	PM	AM	PM	
	-----	-----	-----	-----	
	AM	PM	AM	PM	
	-----	-----	-----	-----	
	AM	PM	AM	PM	
	-----	-----	-----	-----	
	AM	PM	AM	PM	
	-----	-----	-----	-----	
	AM	PM	AM	PM	
	-----	-----	-----	-----	
Total Hours for Week 2 →				<b>Must not be over 40</b>	
<b>Total Hours for Timesheet (2 weeks)</b> →				<b>Must not be over 80</b>	

Initial timesheets must be submitted for payment within ninety (90) days from date of service to meet timely-filing requirements. Initial timesheets submitted past ninety (90) days from date of service will deny for failure to meet Medicaid timely-filing requirements.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Employer Signature

\_\_\_\_\_  
Date Employee Printed Name

\_\_\_\_\_  
Date Employer Printed Name

# How to Complete a Timesheet

Example:

	Date	Time In Circle AM or PM	Time Out Circle AM or PM	Hours	Service Code	Services Provided (Please enter)
Week 1	04-23-11	AM 8:00 PM	AM 11:30 PM	3.5	99509	Prepared meals, went grocery shopping, ADLs, cleaned house.
		AM 3:00 PM	AM 5:00 PM	2.0	99509	
	04-24-11	AM 9:00 PM	AM 12:00 PM	3.0	99509	Prepared meals, laundry, shopping, went to pharmacy.
		AM PM	AM PM			
Total Hours for Week 1 →				8.5	Must not be over 40	

1. You must complete “Time In”, “Time Out”, “Hours”, “Service Code”, and “Services Provided”, and circle am/pm.
2. Please write clearly. All columns must be completed.
3. Employee must sign and print their name in the space provided and submit the form to the Employer.
4. Employer must sign and print their name in the space provided and submit via FAX to the number at the top of the Timesheet form.
5. Incomplete timesheets will not be processed and will be returned to the Employer.
6. Do not submit timesheets for over 40 hours of work per week.
7. In the “Services Provided” space, briefly describe the activities carried out that day to support the member/participant’s SSP outcomes.

For more information on completing timesheets, refer to the “Toolkit for Completing Timesheets”.

## PARTICIPANT/SELF-DIRECTION WAIVER SERVICE CODES (for Employees)

PARTICIPANT/SELF-DIRECTION WAIVER SERVICE	CODE <sup>1</sup>
Community Direct Support/Navigation <sup>2</sup>	H2021
Employment Supports (includes Job Coach)	T2019
Homemaker/Direct Support	99509
Respite - Standard	T1005SD
Transportation Time <sup>3</sup>	T2007

1 All codes available for Mi Via

2 Not available for Self-Direction

3 Not available for Supports Waiver

Please see the program policy for specific provider requirements at [http://www.hsd.state.nm.us/mad/pdf\\_files/provmanl/prov83146.pdf](http://www.hsd.state.nm.us/mad/pdf_files/provmanl/prov83146.pdf) or call the Participant/Self-Direction Helpdesk: 1-800-283-4465

**Self-Direction 2-Week Employee Work & MILEAGE Sheet**

**FAX 1-866-302-6787**

Driver Name (Employee):					Employee ID# (last 4 digits of Employee's social security #)	
Member/Participant:					Is this a correction to a PRIOR Mileage Sheet? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Member's Date of Birth:			Service Code:		Pay Period Begin Date	Pay Period End Date
Vehicle Year		Vehicle Model		Driver's License #		License Plate #
Date	Time In	Time Out	Location (From) Odometer Start	Location (To) Odometer End	Total Miles	Purpose of Trip
W						
Total Hours and Miles for Week 1 →						
W						
Total Hours and Miles for Week 2 →						
Total Hours and Miles for Pay Period (2 weeks) →						

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Employer (EOR) Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee Printed Name

\_\_\_\_\_  
Employer (EOR) Printed Name