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

Employee's Withholding Allowance Certificate

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2018

1 Your first name and middle initial	Last name	2 Your social security number
Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code	4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ▶ ☐	

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	5	
6	Additional amount, if any, you want withheld from each paycheck	6	$
7	I claim exemption from withholding for 2018, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ▶	7	

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

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

8 Employer's name and address (Employer: Complete boxes 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

For Privacy Act and Paperwork Reduction Act Notice, see page 2. Cat. No. 10220Q Form **W-4** (2018)

Revenue Form K-4
42A804 (11-13)

KENTUCKY DEPARTMENT OF REVENUE
EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE

Payroll No. _____

Print Full Name _____ Social Security No. _____

Print Home Address _____

EMPLOYEE:

Failure to file this form with your employer will result in withholding tax deductions from your wages at the maximum rate.

EMPLOYER:

Keep this certificate with your records.

HOW TO CLAIM YOUR WITHHOLDING EXEMPTIONS

1. If SINGLE, and you claim an exemption, enter "1," if you do not, enter "0" ..... _____
2. If MARRIED, one exemption each for you and spouse if not claimed on another certificate.
   (a) If you claim both of these exemptions, enter "2"
   (b) If you claim one of these exemptions, enter "1" } ..... _____
   (c) If you claim neither of these exemptions, enter "0"
3. Exemptions for age and blindness (applicable only to you and your spouse but not to dependents):
   (a) If you or your spouse will be 65 years of age or older at the end of the year, and you claim this exemption, enter "4"; if both will be 65 or older, and you claim both of these exemptions, enter "8" ..... _____
   (b) If you or your spouse are blind, and you claim this exemption, enter "4"; if both are blind, and you claim both of these exemptions, enter "8" ..... _____
4. If you claim exemptions for one or more dependents, enter the number of such exemptions ..... _____
5. National Guard exemption (see instruction 1) ..... _____
6. Exemptions for Excess Itemized Deductions (Form K-4A) ..... _____
7. Add the number of exemptions which you have claimed above and enter the total ..... ☐
8. Additional withholding per pay period under agreement with employer. See instruction 1 ..... $ _____

I certify that the number of withholding exemptions claimed on this certificate does not exceed the number to which I am entitled.

Date _____ Signed _____

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Aging and Independent Living &
Department for Behavioral Health, Developmental and Intellectual Disabilities

PARTICIPANT DIRECTED SERVICES
EMPLOYMENT APPLICATION

Participant/Employer Name: _____

Applicant Instructions

1. *Please print answers to all questions;*
2. *A resume will not be accepted in lieu of this application;*
3. *Proof of eligibility to work in the United States must be submitted prior to employment;*
4. *Registry and/or background checks must be completed prior to employment; and*
5. *Any false statements and/or omissions may result in a rejection of this application and/or removal from employment after hire.*

Personal Information

_____
Last Name First Name Middle Name

_____
Date of Birth SSN # Telephone #

_____
Street Address (Including Apt. # or P.O. Box #) City State Zip Code

If you have not lived in Kentucky within the past year, please provide a previous address:

_____
Street Address (Including Apt. # or P.O. Box #) City State Zip Code

_____
Street Address (Including Apt. # or P.O. Box #) City State Zip Code

If required to transport, can you provide proof of valid Liability Vehicle insurance? ☐Yes ☐No
Can you lift more than 50lbs while standing? ☐Yes ☐No
Are you legally eligible for employment in the United States? ☐Yes ☐No
Have you ever been arrested or convicted of a criminal offense? ☐Yes ☐No

_____
If yes, please describe. *Please note that an affirmative answer will not automatically disqualify you from being considered as a candidate for employment.*

What is your relationship to the participant/employer? _____

Certification/Education

Are you currently certified in CPR/ First Aid? ☐Yes ☐No
If yes, please provide case management agency with documentation.

Please list any other certifications relevant to the position: _____

Please list highest level of education completed: _____

Work Experience

Do you have experience as a caregiver? ☐Yes ☐No

If yes, please describe.

Are you currently employed? ☐Yes ☐No

Company Name | Supervisor Name | Telephone #

Street Address (Including Apt. # or P.O. Box #) | City | State | Zip Code

Start Date | Schedule (Days & Hours Working)

Please list any job history relative to the position, beginning with the most recent.

1)

Company Name | Supervisor Name | Telephone #

Street Address (Including Apt. # or P.O. Box #) | City | State | Zip Code

Start Date (Month/Year) | End Date (Month/Year) | Reason(s) for Leaving

2)

Company Name | Supervisor Name | Telephone #

Street Address (Including Apt. # or P.O. Box #) | City | State | Zip Code

Start Date (Month/Year) | End Date (Month/Year) | Reason(s) for Leaving

3)

Company Name | Supervisor Name | Telephone #

Street Address (Including Apt. # or P.O. Box #) | City | State | Zip Code

Start Date (Month/Year) | End Date (Month/Year) | Reason(s) for Leaving

References

1) _____
Full Name Occupation Telephone #

_____
Street Address (Including Apt. # or P.O. Box #) City State Zip Code

2) _____
Full Name Occupation Telephone #

_____
Street Address (Including Apt. # or P.O. Box #) City State Zip Code

3) _____
Full Name Occupation Telephone #

_____
Street Address (Including Apt. # or P.O. Box #) City State Zip Code

Emergency Contacts

1) _____
Full Name Relationship Telephone #

_____
Street Address (Including Apt. # or P.O. Box #) City State Zip Code

2) _____
Full Name Relationship Telephone #

_____
Street Address (Including Apt. # or P.O. Box #) City State Zip Code

I certify that the information provided within this employment application is true and correct to the best of my knowledge.

_____ _____
Signature **Date**

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Aging and Independent Living

Kentucky Participant Directed Services
Employee/Provider Contract

I (*employee name*) _____, have agreed to work under the employment of

(*employer name)* _____.

Services under this contract will consist of the following:

SERVICE PROVIDED	**RATE PER HOUR**

Services Available Through Participant Directed Services:

(**SCL**) Community Access
(**SCL**) Community Guide
(**SCL**) Personal Assistance
(**ABI**) Companion Care
(**MPW**) Attendant Care
(**MPW**) Homemaking
(**ABI, ABI-LT, MPW,** and **SCL**) Respite
(**ABI, ABI-LT, MPW,** and **SCL**) Supported Employment
(**ABI, ABI-LT, MPW,** and **SCL**) Day Training
(**ABI-LT** and **MPW)** Community Living Supports (CLS)
(**ABI** and **MPW**) Personal Care

As an employee:

I agree to provide the above listed services as required by my employer at the rate stated above per hour.

I understand civil or criminal penalties could be pursued and potential termination from employment in PDS can occur if allegations of fraud against the Department for Medicaid Services are substantiated.

I understand that I shall not be approved as a Participant Directed Services (PDS) provider if results from my background check reveal that I have pled guilty to or been convicted of committing an offense as outlined in (SCL) 907 KAR 12:010, Section 3 (3), or (ABI) 907 KAR 3:090, Section 10, or (ABI-LT) 907 KAR 3:210, Section 10, or (MP) 907 KAR 1:835, Section 7.

I understand that I shall not be approved as a PDS provider if I am registered on the Kentucky Nurse Aide Abuse registry, or if I have been substantiated for abuse through the Central Registry Check.

I understand that I shall not be approved as a PDS provider for a participant under the ABI, ABI-LT, or MP waiver if I am registered on the Caregiver Misconduct Registry.

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Aging and Independent Living

I understand that under KRS 205.5607 (Kentucky Independence Plus Through Consumer Directed Services Program) Workers Compensation (KRS Chapter 342) shall not apply to my employment as a Participant Directed Services provider. This means that neither the state, nor any state agency, nor political subdivision, nor any fiscal intermediary, nor representative, nor service advisor can be held liable for any injuries or losses I may incur while providing services.

I understand that I shall not be approved as a PDS provider for a participant under the SCL waiver if results from my drug screening reveal a positive drug test as outlined in 907 KAR 12:010.

I understand that if I do not complete all training that is required with the specified timelines, I will no longer be eligible as a PDS provider for the participant.

I understand that I must maintain employee/employer confidentiality.

I understand this is an at-will contract and either party may terminate this agreement at any time.

I understand that I must notify my employer of the contraction of any infectious disease(s) and I shall abstain from work until the infectious disease can no longer be transmitted as documented by a medical professional.

I agree to follow all relevant state and federal statutes and regulations.

I have received and fully understand the list of employment guidelines and will follow them to the best of my ability. I further understand that any or all items of this contract may be subject to renewal or change upon agreement by my employer and myself.

As an employer:

I understand that I may be responsible for costs associated for employment requirements, including employee training.

I understand that I may be responsible for wages for my employee should my employee or I not provide employee qualifications by the respective deadlines.

I understand that I can only require my employee to assist with duties that are relevant to my needs and outcomes that are specified on the Person Centered Service Plan for Medicaid payment.

I understand that I may be responsible for payment for any hours I may require my employee to work beyond any prior authorization limits or waiver regulation guidelines.

_____ _____

Employee/Provider Date Employer/Participant Date

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

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

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

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

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

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

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

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

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

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

Additional Information

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

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

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

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

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

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

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

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

Examples of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Bluegrass.org

KyHealth Choices Consumer Directed Option Program

Employee – Employer Acknowledgment Form

I (employee name) _____, have agreed to work under the employment of (employer name) _____.

By reading and signing this form, both employee and employer expressly acknowledge their respective understanding of the following:

1) Upon the approval of the Kentucky Cabinet for Health and Family Services, the Bluegrass Regional Mental Health – Mental Retardation Board, Inc. ("Bluegrass") will provide services to employer under the KyHealth Choices Consumer Directed Option Program ("CDO") as a fiscal intermediary as defined in K.R.S §205.5606.

2) Bluegrass is not an employer under CDO.

3) Bluegrass is under no legal duty to provide worker's compensation coverage under CDO.

4) Bluegrass is under no legal duty to provide any benefits and/or insurance coverage, including, but not limited to, health, life, disability, home, auto, and liability under CDO.

5) Bluegrass will not be liable for any injuries or losses incurred by employee or employer under CDO.

6) I (employee) authorize Bluegrass to complete the following required criminal record checks: Central Registry Check, Caregiver Misconduct Registry, Administrative Office of the Courts, Kentucky Nurse Abuse Registry, the Cabinet for Families and Children and Adult Protective Services.

7) I (employee) **have/have not** lived out of state in the past year. I understand that if I have had residency out of state within the past year I am required to have Bluegrass complete the Nationwide Criminal Search.

8) I (employer) **agree/disagree** to have Bluegrass complete a Nationwide Criminal and Sex Offender background check (Intellicorp) on (employee). **(Please circle preference).**

9) I (employee) authorize that a copy of any of the record checks may be forwarded to the employer for their review. This review may be a determining factor regarding my employment.

10) I (employee) and (employer) understand that the employee cannot begin work until the employer receives notification that results of the Administrative Office of the Courts has been received by Bluegrass and meet the requirements established in state regulations.

_____ _____

Employee Date Employer Date

Support Broker: _____

Client: _____

Waiver:_____

Intellicorp: _____ Yes _____ No Out of State Residency: _____ Yes _____ No

ADMINISTRATIVE OFFICE OF THE COURTS
RECORDS UNIT
1001 VANDALAY DRIVE
FRANKFORT, KENTUCKY 40601
502-573-1682 or 800-928-6381
records@kycourts.net

The process to obtain the information contained in CourtNet is as follows:

Individuals

Requesting a record on yourself requires a $20.00 fee **(check or money order)**. If you do not receive a response in 30 days contact us at the number listed above.

Nonprofit/Commercial/Others

Requesting a record on individuals requires a $20.00 fee **(check or money order)** .

Criminal Justice Agencies

Criminal Justice Agenices do receive a waiver of fees for requests that are for criminal justice purposes.

Fees are paid to the order of the KENTUCKY STATE TREASURER by check or money order ONLY. FAILURE TO COMPLY WITH THESE PROCEDURES WILL RESULT IN THE REQUEST BEING RETURNED UNPROCESSED. If you suspect information contained on the record is incorrect, or have any questions, please contact the Records Unit at (502) 573-1682 or (800) 928-6381.

PLEASE **PRINT OR TYPE** THE INDIVIDUAL'S INFORMATION **CLEARLY**.

SOCIAL SECURITY NUMBER: _____ DLN: _____

NAME: _____

MAIDEN NAME(S) AND/OR ALIAS: _____

DATE OF BIRTH: _____

STREET ADDRESS / P.O. BOX: _____

CITY, STATE, ZIP CODE: _____

I understand the information supplied by me must be truthful and falsification with an intent to mislead may result in my prosecution under KRS 523.100. I have provided the basic information necessary to qualify for record processing and exemption of fees - if applicable.

*** ALL INFORMATION BELOW IS REQUIRED.**

_____
Individual's Signature

_____
Date

_____
Company

_____
E-mail address

_____
Requestor/Contact Person

_____
Telephone Number

_____
Address

_____
City, State, Zip

Please denote which purpose applies to this request:

- ☐ Employment
- ☐ Criminal Investigation
- ☐ Screening Housing Applicants
- ☐ Volunteer/Care over Juvenile
- ☐ Licensing
- ☐ Other (please explain) _____

Print Reset Form

DPP-156
(R. 1/18)
922 KAR 1:470

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
Department for Community Based Services

CENTRAL REGISTRY CHECK

FOR THE FOLLOWING TYPES OF EMPLOYMENT OR VOLUNTEERISM, STATE LAW OR KENTUCKY ADMINISTRATIVE REGULATION AUTHORIZES A CHILD ABUSE/NEGLECT (CAN) CHECK AS A CONDITION OF EMPLOYMENT OR VOLUNTEERISM. PLEASE CHECK THE CATEGORY LISTED BELOW THAT APPLIES TO YOU FOR WHICH THE CHILD ABUSE OR NEGLECT CHECK IS BEING REQUESTED:

☐ Child-Placing Agency (Foster/Adoption/Independent Living) Employee or Volunteer (Required by 922 KAR 1:310)

☐ Residential Child-Caring Facility Employee or Volunteer (Required by 922 KAR 1:300)
(Institution/Group Home/Emergency/Wilderness)

☐ Public School Employee, Student Teacher, Contractor, or School-Based Decision-Making Council Member (Required by KRS 160.380)

☐ Private, Parochial, or Church School Employee or Student Teacher (Permitted by KRS 160.151)

☐ Youth Camp Employee, Contractor, or Volunteer (Required by KRS 194A.380-194A.383)

☐ Power of Attorney Regarding the Care and Custody of a Child (Required by KRS 403.352)

☐ Supports for Community Living (SCL) Employee (Required by 907 KAR 1:145)

Other (If none of the above categories is applicable, please explain the reason for requesting a child abuse or neglect check, including the statutory or regulatory authority for the request):

_____

PERSONAL INFORMATION REGARDING THE INDIVIDUAL SUBMITTING TO A CHILD ABUSE OR NEGLECT CHECK (Please print and submit identifying information such as a copy of your driver's license, social security card, or birth certificate):

NAME: _____
(first) (middle) (maiden/nickname) (last)

Sex: ___ Race: _____ Date of Birth: _____Social Security #:_____

Date of Initial Hire: _____

Present Address: _____
City State Zip Code

Previous Address: _____
City State Zip Code

Previous Address: _____
City State Zip Code

Previous Address: _____
City State Zip Code

Previous Address: _____
City State Zip Code

Please list your addresses for the last five years. Use another sheet of paper, if necessary.

CENTRAL REGISTRY CHECK

A check or money order made payable to the "Kentucky State Treasurer" in the amount of ten dollars ($10.00) must accompany your request to process a Child Abuse or Neglect Check. The Child Abuse or Neglect Check will NOT be processed without payment. Mail check or money order and this completed form to:

Cabinet for Health and Family Services
Department for Community Based Services
Records Management Section
275 East Main St., 3E-G
Frankfort, Kentucky 40621

I hereby authorize the Cabinet for Health and Family Services to complete a Child Abuse or Neglect check and to submit the results of the check to me and, on my behalf, to the employer or agency listed below. I also release the Cabinet for Health and Family Services, its officers, agents, and employees, from any liability or damages resulting from the release of this information.

All the information provided is complete and true to the best of my knowledge. I understand if I give false information or do not report all of the information needed, I may be subject to prosecution for fraud.

_____ _____
Signature of the Individual Submitting to the Child Abuse or Neglect Check Date

_____ _____
Witness Date

The individual authorizing a Child Abuse or Neglect check may submit a CHFS-305, Authorization to Disclose Protected Health Information form, authorizing the Cabinet for Health and Family Services to disclose additional information regarding a finding to the employer or agency listed below should the employer or agency request additional information pursuant to 922 KAR 1:510, Authorization for disclosure of protection and permanency records.

In addition to receiving the results myself, I authorize the Cabinet for Health and Family Services to share the results with the following employer or agency:

NAME OF EMPLOYER/AGENCY: Bluegrass.org

ADDRESS: 1351 Newtown Pike **CITY**: Lexington

STATE: Kentucky **ZIP:** 40511 **PHONE:** 859.272.7483

RESULTS OF CHILD ABUSE OR NEGLECT CHECK [FOR OFFICIAL USE ONLY]

☐ No reportable incident found in accordance with 922 KAR 1:470
☐ Substantiated child abuse found on the registry Date of substantiated finding: _____
☐ Substantiated child neglect found on the registry Date of substantiated finding: _____
The substantiated abuse or neglect finding relates to sexual abuse, sexual exploitation, a child fatality, near fatality, or involuntary termination of parental rights ☐ Yes ☐ No
☐ A matter subject to administrative review found in accordance with 922 KAR 1:470

CHECK CONDUCTED ON _____ **BY** _____

DPP-156
(R. 1/18)
922 KAR 1:470

Person Centered Planning

Supports for individuals with disabilities will:

- Ensure dignity and respect for each person as a valued individual.
- Be entitled to the rights, privileges, opportunities, and responsibilities of community membership.
- Be supported and encouraged to develop personal relationships, learning opportunities, work and income options, and worship opportunities as full participants in community life.
- Be based on individually determined goals, choices, and priorities.
- Be easily accessed and provided regardless of the intensity of individual need.
- Be afforded the opportunity to direct the planning, selection, implementation and evaluation of their services
- Require that funding be flexible and cost effective and make use of natural, generic and specialized resources.
- Be the primary decision makers in their own lives.
- Be evaluated based on outcomes for individuals.

The work we do and the way we work will:

- Ensure that all persons have dignity and value, and are worthy of respect.
- Provide safeguards to ensure personal security, safety, and protection of legal and human rights.
- Be coordinated on person-centered and family-centered principles, focusing on individual needs, strengths, and choices.
- Support that all people have strengths and abilities and are the primary decision-makers in their lives.
- Provide information and supports that promote informed decision-making.
- Be accessible and culturally responsible.
- Access informal and generic community resources whenever possible in the most integrated community setting appropriate to the person.
- Be based on best practice and utilize state-of-the-art skills and information.
- Be directed toward the achievement of interdependence, contribution, and meaningful participation in the community.
- Distribute resources in an equitable manner according to the individual need and comply with requirements governing public funds administered by the system.

_____ _____

Signature Date

_____

Print Name

CHFS-305
(R. 5//04)

Authorization for Disclosure of PHI

PLEASE PRINT LEGIBLY

CABINET FOR HEALTH AND FAMILY SERVICES
COMMONWEALTH OF KENTUCKY
PROTECTION AND PERMANENCY
FAX (502) 564-9554

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)
This form must be completed to authorize the disclosure of protected health information.

I HEREBY AUTHORIZE PROTECTION AND PERMANENCY IN THE DEPARTMENT FOR COMMUNITY BASED SERVICES IN THE CABINET FOR HEALTH AND FAMILY SERVICES TO DISCLOSE AND USE THE SPECIFIED INFORMATION BELOW.

Individual Requesting Records: TYPE ONLY – NO PRINT Name	Address
City, State, Zip Code	
Telephone Number (Work)	
Please Send Records To: Name **Bluegrass.org Attn: Vickie Devary**	Address **1351 Newtown Pike**
City, State, Zip Code **Lexington, KY 40511**	
Telephone Number **859-272-7483 Ext. 250** (Home) (Work)	
The name of the individual whose information you authorize the disclosure of:	
Social Security Number - -	Date of Birth / /
Case Record # (if known) **N/A**	County where case record is maintained **N/A**

The purpose for disclosure is:
(Note: Must complete, Do Not Leave Blank) Pre-employment screening

The specific Protected Health Information (PHI) you authorized the disclosure of:

☐ Medical History ☐ Immunizations ☐ Treatment Information ☐ Developmental Information ☐ Benefits Eligibility Records ☐ Payment Records ☐ Medicaid Claim Information ☐ Child Protective Services Information (Provide Court Custody Order or Court Order) ☐ Guardianship Information (Provide Court Custody Order or Court Order) ☑ **Adult Protective Services Information** (Provide Court Custody Order, Court Order, or Birth Certificate) ☐ Other_____

NOTE: Disclosure of psychotherapy notes must be authorized using form CHFS-305A, Authorization for Disclosure of Psychotherapy Notes

Please read carefully

- Complete this form within ten (10) days and mail to the **Cabinet for Health and Family Services, Department of Community Based Services, Records Management Section, 275 East Main St., Section 3E-G, Frankfort, Kentucky, 40621**
- I understand this authorization will expire in ninety (90) days.
- I understand I have the right to revoke this authorization at any time, however I must do so **in writing**. I further understand that actions already taken based on this authorization prior to revocation will **not** be affected.
- I understand I have the right to a copy of this authorization.
- I understand that authorizing the use/disclosure of PHI is voluntary. I need not sign this authorization in order to assure service. I may request to inspect or receive a copy of information to be used or disclosed, as provided in 45 CFR 164.524. I further understand that any disclosure of PHI carries with it the potential for an unauthorized disclosure and the information may not be covered by federal confidentiality rules. If I have questions about disclosure of PHI I can contact the Ombudsman's Office at (502) 564-5497 or the address listed above.
- I understand that information may be subject to re-disclosure and no longer protected.
- The following statement applies to any alcohol and/or drug abuse treatment information that we disclose. This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations, 42 CFR Part 2, prohibit you from making further disclosure of it without the specific written authorization of the person to whom it pertains, or as otherwise specified by such regulations. A general authorization for disclosure is **not** sufficient for this purpose.

My signature below acknowledges that I have read, understand and authorize the release of my PHI

Signature _____ Date_____

THIS FORM MUST BE COMPLETE

PARTICIPANT DIRECTED SERVICES
EMPLOYEE TRAINING VERIFICATION

As a chosen employee, I certify that prior to direct services being initiated, I received training from my employer or in the presence of my employer on:

- Principles of Self-Determination;
- Employee Contracts;
- Employee Background Checks;
- Timesheets;
- Person-Centered Planning;
- Fraud, Abuse, Neglect, and Exploitation; and
- Any additional topics required by my support brokerage agency, DAIL, DMS or employer.

_____ _____

Employee Signature **Date**

_____ _____

Participant/Representative/Employer Signature **Date**

_____ _____

Support Broker Signature (if applicable) **Date**

Direct Deposit Guidelines

- If you chose to participate in direct deposit, 100% of your net pay will be direct deposited into one valid checking or savings account. Paid amounts cannot be split between multiple accounts.

- To participate in direct deposit, please complete the Paycor Direct Deposit Worksheet.

- Leave the Employer Name field blank. Your Support Broker will add this information.

- Be sure to attach a voided check or written correspondence from your financial institution. If you supply written correspondence from your financial institution, it must be signed by an employee of the institution and contain the contact information for the employee that prepared the correspondence. Monthly statements will not be accepted.

- The voided check or correspondence from the financial institution must include, at a minimum, the employee name, routing number and account number.

- Be sure to sign and date at the bottom of the form.

- Only completed forms will be accepted.

- Direct Deposit Worksheets will only be accepted and processed during non-payroll weeks. They will not be accepted the week of payroll.

- Access to pay statements and W-2s are available on line. The employee should print their e-mail address on the space provided on the direct deposit form if they wish to gain on-line access.

- A link will be sent from Paycor once your email address is entered into the system. The email will contain the link needed to set up a username and password. It is the employee's responsibility to keep track of password information. Neither Paycor nor Bluegrass.org have access to the employee passwords.

DIRECT DEPOSIT WORKSHEET

Employer Name: _____ **Paycor #:** _____

Employee Name: _____ **Employee #**_____

☐ New Employee ☐ Existing Employee

ACCOUNT INFORMATION

☐ Checking 100% of full net amount	Attach Voided Check Here
Bank Name	
Name on Account	
Routing & Transit Number (9 Digits)	
Account Number	

- 100% of the employee's net check is to be deposit into one checking account only.
- Need a voided check with the employee's name, account # and routing # printed on the check.
- If the employee's checking account returns the funds due to inaccurate information provided by the employee. There will be a $15.00 fee charged to the employee and a live check will be issued. A $30.00 fee will be assessed if an employee request another direct deposit for the same pay period.

To access check stubs and W-2's online; please enter e-mail address below:

_____

A link will be sent to the e-mail address above to set up user name and password. It is the employee's responsibility to maintain username and password information.

I authorize Paycor, Inc., acting on behalf of my employer, to initiate electronic credit entries and, if necessary, debit entries to reverse erroneous credit entries to my account(s). It is agreed that these deposits will be made in accordance with the rules of the National Automated Clearing House Association (NACHA). This authorization will remain in effect until Paycor, Inc., has received written notification from me of its termination in such time and in such a manner as to afford Paycor, Inc. and the bank a reasonable opportunity to act upon the termination request.

Employee Signature:	**Date:**

To be retained by Employer. Keep in your employee files. This form may be photocopied.