RESOURCE CENTER
for independent living

DIRECT SUPPORT WORKER PACKET

This Direct Support Worker Packet must be read and completed in its entirety by the Consumer (person receiving services) and the Direct Support Worker (DSW - person providing the services). All pages must be completed, signed and returned (by mail, email or in person) to the following address before payroll services between the Resource Center for Independent Living (RCIL) and the DSW can begin:

Resource Center for Independent Living, Inc. (RCIL)
P.O. Box 257
1137 Laing
Osage City, Kansas 66523

To meet the requirements of the Department of Homeland Security, *all* Direct Support Worker are required to complete the Form I-9 and provide a copy of proof of identity and employment eligibility. Instructions for Form I-9 are provided online at **rcilinc.org**. The attached "List of Acceptable Documents" lists the types of identification that meet this requirement. Please note that only one document from List A is required **OR** one document from List B **AND** one document from List C will also meet the requirement. Payroll checks will not be issued without this documentation.

The Kansas Department for Aging and Disability Services requires all Direct Support Workers undergo and pass certain background check in order to be eligible to provide any Medicaid funded services, including, but not limited to Personal Care Services and Enhanced Care Services. DSWs cannot work until all background check has been returned and the State of Kansas has determined that the DSW applicant is eligible to provide Home and Community Based Services. Please be aware that it has been taking some of the background checks up to three weeks or more to be completed.

Direct Support Worker must be **at least 18 years of age**.

Incomplete packets will be returned for completion which may result in your payroll being delayed. If you have any questions about filling out this packet, please call the Payroll Help Desk at 785-528-3105 toll free 800-580-7245 or email the office at payrollhelpdesk@rcilinc.org for assistance.

Consumer Name_____ Labor Code_____ Waiver_____

Home and Community Based Services (HCBS)

Do you have a Durable Power of Attorney for health decisions? **YES___ NO___**
Active DPOA_____ Inactive_____
Do you have a Durable Power of Attorney for business decisions? **YES___ NO___**
Active DPOA_____ Inactive_____
Do you have a Guardian? **YES___ NO___**
Do you have a Designated Representative? **YES___ NO___**

Carefully read the following if you mark YES to any of the above.

You are NOT required to have a DPOA, Guardian, or Designated Representative.

1. You are required to provide a copy of paperwork to RCIL if a Guardian, DPOA, or Designated Representative has been appointed for you or by you.
2. A Guardian or Active DPOA must sign all paperwork in place of the Consumer. A Guardian or Active DPOA is **NOT** Permitted to be a paid worker unless a Designated Representative has been appointed to direct than individual's services.

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*A **"Guardian"** is appointed by a judge and is responsible for your personal affairs.

*An ***"Active Durable Power of Attorney"*** **(DPOA)** is appointed by you to make financial and/or medical decisions and is effective immediately, upon signing, or by measures outlined in the appointment.

*An ***"Inactive DPOA"*** is appointed by you to make financial and/or medical decisions when you are unable to make those decisions independently.

*A **"Designated Representative"** is appointed by a Guardian or Active DPOA to manage services for an individual. An individual is not required to appoint a designated representative but may voluntarily decide to appoint one to preform employer functions.

SIGNATURE REQUIRED *The above information is complete and true to the best of my knowledge.*

_____

Signature **(Consumer/Guardian/Active DPOA/ Designated Representative)** **Date**

11/08/2018

EMPLOYMENT AGREEMENT

THIS EMPLOYMENT AGREEMENT (the **"Agreement"**) is effective on this _____ day of_____, 20___, between _____ (the **"Employer"**), an individual, and _____, (the **"Caregiver"**), an individual.

W I T N E S S E T H:

WHEREAS, the Employer is a participant in a Home and Community Based Services waiver program under Medicaid (the **"Program"**) administered by the Kansas Department of Aging and Disability Services (**"KDADS"**) through KanCare and has elected to self-direct his/her services under the Program by employing one or more Caregivers (Direct Support Workers);

WHEREAS, the purpose of a direct support worker (or caregiver) under the Program is to provide assistance and support to a Program participant in accordance with the participant's integrated service plan (the **"ISP"**) under the Program;

WHEREAS, the Employer desires to hire the Caregiver to be his/her direct support worker under the Program;

WHEREAS, the Caregiver desires to be employed by the Employer as a direct support worker under the Program; and

WHEREAS, the Employer uses Resource Center for Independent Living, Inc. (RCIL) dba RCIL as Fiscal Agent (the **"FMS Provider"**) to provide financial management services (**"FMS"**) under the Program to the Employer, including but not limited to (i) processing of time worked by the Caregiver, (ii) billing KanCare on the Employer's behalf, (iii) distributing pay checks or electronic deposits for services rendered by the Caregivers under the ISP, (iv) withholding, filing and paying appropriate taxes for Caregiver services under the ISP, and (v) information and assistance services to assist the Employer in understanding his/her role and requirements as the employer of the Caregiver and his/her responsibilities under participant-direction.

NOW, THEREFORE, in consideration of the premises and of the mutual covenants and agreements hereinafter contained, the parties hereto agree as follows:

Section 1. **Employment.** The Employer hereby employs the Caregiver, and the Caregiver hereby accepts employment with the Employer, upon the terms and conditions hereinafter set forth.

Section 2. **"At-Will" Employment.** The Caregiver is an "at-will" employee of the Employer, which means that the Caregiver's employment may be terminated by the Employer, with or without notice, and with or without cause, at any time, for any reason not prohibited by law. **If employment is ended for any reason, it is the Caregiver's responsibility to notify RCIL by calling 1-800-580-7245 by the end of the next business day.** Caregivers are required to request that their name be added to the DSW Workers List for the purpose of determining eligibility and availability of additional work as well as other administrative purposes. Failure to do so may lead to the denial and/or interruption of unemployment benefits.

Section 3. **Duties under this Agreement.** The duties of the Caregiver under this Agreement shall be as set forth in the Employer's ISP (the **"Covered Duties"**). The Caregiver agrees to use his/her best efforts in performing his/her Covered Duties for the Employer and to comply with all Employer

directives, both written and oral. The Caregiver understands and agrees that his/her assignment, duties, and responsibilities may be changed at any time by the Employer, subject to the limitations in the ISP.

Section 4. Compensation for Covered Duties.

(a) The Employer shall pay the Caregiver for performing Covered Duties, in such amount as is agreed upon between the Employer and the Caregiver from time to time. Compensation for Covered Duties shall be made using Medicaid funds exclusively, in accordance with Kansas regulation 30-5-308.

(b) The Caregiver understands and agrees that although payment for Covered Duties will be made by the FMS Provider, on behalf of and as payroll agent for the Employer, the FMS Provider shall not be liable to the Caregiver for payment of any compensation. The FMS Provider is a third party beneficiary of this Section 4(b).

(c) If the Caregiver has concerns or questions about his/her compensation, the Caregiver is encouraged to contact the Employer immediately in order to resolve those concerns or questions. The FMS Provider is available to assist with unresolved compensation issues through information and assistance.

Section 5. Non-Covered Duties are Outside this Agreement. This Agreement does not prohibit the Employer from employing the Caregiver to perform duties that are not Covered Duties (**"Non-Covered Duties"**). To the extent that the Caregiver performs Non-Covered Duties, the parties agree that the Employer is obligated to pay the Caregiver directly for those Non-Covered Duties, with no involvement by the FMS Provider, in such amount as is agreed upon between the Employer and the Caregiver from time to time, and that the Employer is responsible for paying any overtime wages that are not properly payable under the Program. The parties understand that the Program does not provide funds to pay for any Non-Covered Duties.

Section 6. Work Schedule and Overtime.

(a) The Caregiver's work schedule shall be set by the Employer (not the FMS Provider). The Caregiver understands that he/she is expected to adhere to the work schedule and to provide the Employer with advance notice of any absence or requests for schedule changes.

(b) The Caregiver understands and agrees not to work more than forty hours in any workweek for the Employer without advance approval from the Employer. The Employer develops the Caregiver's schedule which is submitted to the FMS Provider. Changes to the schedule must be submitted in-advance to the FMS Provider. The Caregiver's workweek shall be the 7-day period starting at 12:01 A.M. on Sunday and ending at midnight on the following Saturday.

Section 7. Time Records. The Caregiver shall report all time worked on Covered Duties using the AuthentiCare® KS IVR system and shall *not* report any time worked on Non-Covered Duties using the AuthentiCare® KS IVR system. The Caregiver shall not begin working until they have completed the hiring process with RCIL including authorization to begin using the AuthentiCare® KS IVR system. Time worked on Non-Covered Duties (if any) shall be reported to the Employer, in the manner directed by the Employer (not by the FMS Provider).

Section 8. Supervision, Cooperation, and Compliance with ISP, the Program, Instructions, Policies, Rules, Regulations, and Laws.

(a) The Caregiver shall be directly supervised and managed by the Employer or the Employer's "Authorized Representative" (if any)..

(b) The Caregiver agrees to adhere to all rules, policies, and regulations of the Employer.

(c) The Caregiver and the Employer agree to strictly comply with the ISP, the Customer Service Worksheet (if any), and any and all other Program requirements.

(d) The Caregiver and the Employer agree to strictly comply with any instructions, rules, or policies maintained by the FMS Provider with regard to the billing and payment for Covered Duties services rendered by the Caregiver.

(e) The Caregiver and Employer agree to strictly comply with any and all Kansas statutes, regulations, or policies (including, but not limited to, the KDADS's Field Services Manual, as amended) relating or pertaining to Covered Duties services to the Employer and for payment for such services.

(f) The Caregiver agrees to cooperate fully with the FMS Provider and with KDADS, the Employer's case manager, case management agency (if any) from whom the Employer receives case management services under the Program, and the Case Management Entity (the **"CME")** (if any) from whom the Employer receives case management services under the Program, regarding any questions and/or inquiries about the Employer's case and services provided by the Caregiver under the Program.

Section 9. **FMS Provider is Not the Common Law Employer for Purposes of Patient Protection and Affordable Care Act.** The parties hereby understand and agree that the **FMS Provider is not the "common law employer" of the Caregiver for purposes of the Patient Protection and Affordable Care Act ("PPACA") or under any other law and that the FMS Provider has no legal obligation to offer health care coverage to any Caregiver.** The parties further agree and understand that, under the legal standards established by the Internal Revenue Service, the "common law employer" for purposes of PPACA compliance is the Employer. The parties agree never to argue or raise as a defense in any legal proceeding that the FMS Provider is the "common law employer" of the Caregiver for purposes of PPACA or for any other purpose. The FMS Provider is a third-party beneficiary of Section 9 of this Agreement.

Section 10. **FMS Provider is Not the "Employer" for Purposes of the Fair Labor Standards Act.** The parties hereby understand and agree that **the FMS Provider is not the "employer" of the Caregiver for purposes of the Fair Labor Standards Act or under any other law that uses the "economic reality test" to determine employer/employee status.** The parties agree never to argue or raise as a defense in any legal proceeding that the FMS Provider is the "employer" of the Caregiver for purposes of the Fair Labor Standards Act or for any other purpose. The FMS Provider is a third-party beneficiary of Section 10 of this Agreement.

Section 11. **Changes in Information.** The Caregiver agrees to notify the Employer of any change in the Caregiver's name, address, telephone number, e-mail address, emergency contact information, and/or Form W-4 and Form K-4 elections.

Section 12. **Safety.** The Caregiver is expected to follow generally accepted safety procedures while performing Covered Duties and must promptly report all safety concerns to the Employer.

(a) If an accident results in injury to the Employer and the Employer has an Authorized Representative the Caregiver must report the accident to the Authorized Representative, as soon as possible.

(b) If a work-related accident results in injury to the Caregiver, the Caregiver must report such accident to the Employer as soon as possible, but no later than 24 hours after such injury. As making arrangements for Workers' Compensation coverage on the behalf of the Employer is a prescribed function of FMS Providers, the Caregiver must immediately notify the RCIL's Work Comp department and their Employer regardless of how insignificant the injury may appear, involving physical injury or property damage. Speak with the RCIL's Work Comp department prior to seeking medical attention for a workers compensation injury.

In case of emergency and life-threatening accidents, Caregiver's should seek medical attention at the nearest hospital. Caregiver's with non-life threatening injuries should seek medical attention at nearby medical clinics, not hospitals. Upon arrival, Caregiver's should inform the medical provider that the injury is work-related and may be covered by workers' compensation insurance.

Injuries must be communicated to the RCIL's Work Comp department within 24 hours to ensure appropriate medical attention is provided. Injuries must be reported within the earliest of the following to be covered by workers compensation: 20 days from the date of the incident or injury, 20 days from the date medical treatment is sought, or 10 days from the employee's last date of employment.

Fraudulent or Abusive Acts: Administrative and Criminal
Defined in K.S.A. 44-5,120(d) and 44-5,125. Examples of fraudulent or abusive acts include but are not limited to:

- making false or misleading statements to obtain benefits
- presenting a false certificate of insurance
- submitting a charge for health care not furnished

The penalty for committing such acts:

- $2,000 fine for each act of fraud or abuse
- misdemeanor or felony criminal charges

Report all work-related incidents resulting in an injury to self or Employer/Consumer to RCIL's Workers Compensation representative at 1-800-580-7245.

Section 13. **Driving.** The Caregiver is prohibited from providing transportation services to the Employer unless the duties specified in the Employer's ISP include providing transportation services. If the Caregiver's duties under the ISP include providing transportation services, the Caregiver (a) must have a current, valid driver's license and must have automobile insurance in the minimum amount required by the State of Kansas or in such greater amount as the Employer otherwise requires and (b) must notify the Employer immediately if the status of the Caregiver's driver's license or automobile insurance changes.

Section 14. **Medicaid Fraud.** The parties agree and understand that if either of them submits false or inaccurate information to the FMS Provider or through the AuthentiCare® KS IVR system

regarding the work times or duties performed by the Caregiver under the Program, it will be considered Medicaid fraud and exploitation of benefits, which the FMS Provider is required to report to the State of Kansas. RCIL reserves the right to recover funds from the Caregiver and/or Employer paid as a result of fraudulent claims or activities.

Section 15. **Consent to Release of Confidential Information.** The Caregiver consents and authorizes the FMS Provider and the Employer to release and exchange information related to the services provided by the Caregiver to the following agencies and individuals: the Employer's case manager; the Employer's case management agency or CME (as applicable), including, but not limited to, a Managed Care Organization (**"MCO"**) that is a CME; the Employer's Community Developmental Disability Organization (**"CDDO"**); KDADS; the Division of Health Care Finance of the Kansas Department of Health and Environment; HP Enterprises/KS Medicaid Fiscal Agent; the KDADS's Quality Assurance Department; AuthentiCare® KS; and any other governmental agency as required by law and Kansas FMS requirements.

Section 16. **Termination of the Agreement.** This Agreement shall remain in effect while the Caregiver is employed by the Employer. The Caregiver understands and agrees that his/her employment, and this Agreement, will terminate upon the earliest occurrence of one of the following events:

(a) Denial of the Employer's Medicaid and/or KanCare eligibility;

(b) Termination/closure of the Employer's applicable HCBS case;

(c) Termination of the Financial Management Service Agreement between the Employer and the FMS Provider.

(d) Termination of the Employer's right to self-direct his/her care; or

(e) A decision of either party to terminate the employment relationship.

Section 17. **Third Party Beneficiary.** Though KDADS and the CME (if any) are not parties to this Agreement, the parties specifically intend that KDADS and the CME (if any) each be a third-party beneficiary and, as a result thereof, further acknowledge and agree that KDADS and/or the CME (if any) may, at their option, enforce the terms of this Agreement.

Section 18. **Assignment.** The parties shall not assign, subcontract, or delegate any duties or obligations required by this Agreement to any other individual, agency, or organization. Subject to that limitation, this Agreement shall be binding upon and inure to the benefit of the parties and their heirs, personal representatives, successors, and assigns.

Section 19. **Amendment.** This Agreement may only be modified by a written agreement signed by the parties hereto. No failure by either party to insist upon the strict performance of this Agreement on one or more occasions shall constitute a waiver of any right or remedy hereunder.

Section 20. **Severability.** The invalidity or unenforceability of any provision of this Agreement shall not affect the other provisions hereof and this Agreement shall be construed in all respects as if such invalid or unenforceable provision were omitted.

Section 21. **Entire Agreement.** This Agreement has been entered into in good faith by the parties. This Agreement sets forth the entire agreement and understanding of the parties with respect to the subject matter hereof and supersedes any and all prior and contemporaneous negotiations,

understandings, and agreements with regard to the subject matter hereof, whether oral or written. In entering into this Agreement, none of the parties have made or relied upon any representation or provision not set forth herein.

Section 22. **State Law.** The terms and provisions of this Agreement shall be construed in accordance with and governed by the laws of the State of Kansas. The titles of the Sections, Subsections, Paragraphs, and Subparagraphs in this Agreement have been inserted for convenient reference only and shall not affect the construction of this Agreement.

Section 23. **Venue.** For any action to enforce this Agreement by KDADS or CME (if any), venue shall solely be in the District Court of Shawnee County, Kansas. For all other actions to enforce this Agreement, venue shall solely be in the District Court of Osage County, Kansas.

Section 24. **Compliance with Program.** It is the intent of the parties that this Agreement be interpreted to comply with the Program requirements.

Section 25. **Signatures.** This Agreement (and any amendments, modifications, or waivers in respect hereof) may be executed in any number of counterparts, each of which shall be deemed to be an original, but all of which shall constitute one and the same document. Facsimile signatures or signatures emailed in portable document format (PDF) shall be acceptable and deemed binding on the parties hereto as if they were originals.

By signing this document, both parties verify they have read and understand all the provisions and responsibilities, and

IN WITNESS WHEREOF, the parties have executed this Agreement as of the day and year first above written.

CAREGIVER

_____
Signature

_____
Print name

EMPLOYER

_____
Signature of
Employer/Authorized Representative

_____
Print name

_____
If Employer does not sign, the relationship of the person signing to the Employer /Authorized Representative (Guardian, Active DPOA, Designated Representative, or other authorized representative)

For Office Use Only:
Hire Date_____ EVV ID#_____ Date_____ MAS90#_____

Direct Support Worker (DSW) Information
Notice of New Hire

S.S. #_____-_____-_____

LAST _____FIRST_____MIDDLE_____

PHYSICAL ADDRESS _____

MAILING ADDRESS _____ E-MAIL _____

CITY _____ STATE _____ ZIP _____

PHONE NUMBER (_____) _____ DATE OF BIRTH _____

ALTERNATE CONTACT NAME: _____PHONE NUMBER (___) _____

Are you a current spouse of this consumer? **YES___** **NO___**
****You must notify RCIL immediately if you become the spouse of this consumer.****

Are you related to the consumer? **YES___** **NO___**
If Yes, Check one
___Parent ___Adoptive Parent ___Son/Daughter ___Grandparent ___Grandchild
___Spouse ___Aunt/Uncle ___Sibling ___ First Cousin

Are you Bilingual? **YES___** **NO___**
Do you use sign language? **YES___** **NO___**
Do you require any other language accommodations? **YES___** **NO___**
Do you have a Work Visa from the U.S. Citizenship & Immigration Services? **YES___** **NO___**
Do you live with the consumer? **YES___** **NO___**

****You must notify RCIL immediately if you move in or begin to live with this consumer. ****

If you have previously worked for RCIL under a different name please list that name below:

_____

I, _____, have read each page of the DSW packet with the
(DSW Name)
Consumer _____, have had the opportunity to ask questions,
(Consumer Name)
understand the policies and agreements. I understand that the Consumer is my employer and that the RCIL as Fiscal Agent is the Financial Management Service provider.

The information provided in all documents is complete and true to the best of my knowledge.

_____ _____
Consumer/Guardian/DPOA/Designated Representative Signature Date

_____ _____
DSW Signature Date

Consumer Name_____ Labor Code_____ Waiver_____

Payroll Payment Request

Wage Payment Schedule: RCIL issues weekly wage payments on Fridays.
See wage payment schedule attached to the Kansas Authenticare Instructions.

Please Note: The first two wage payments may be mailed as a check, the remaining wage payments will be direct deposit or Wisely Pay Card per your choice.

Direct Support Worker Information

DSW Name:_____

Street Address :_____ Street Address 2 (P.O. Box): _____

City:_____ State:_____ Zip:_____

☐ **Existing Worker** - Already enrolled with a payment method

****IF DIRECT DEPOSIT INFORMATION HAS CHANGED, YOU MUST COMPLETE DIRECT DEPOSIT SECTION BELOW AND PROVIDE VOIDED CHECK****

☐ **Wisely Pay Card** (REQUIRED: fill out enrollment form contained in packet)

☐ **Direct Deposit** **Bank Account Information**

Account Type: ☐ Checking ☐ Savings

- **You MUST provide account verification of your bank acount routing # and and account #. Incomplete or inaccurate information will cause delay in hiring or errors in your pay.**
- Typically pay should be automatically deposited into your account(s) within 2 pay periods.
- It is your responsibility to notify Payroll of any changes to/closure of your bank account. Failure to notify Payroll may delay payment.

By providing the information requested above and signing below, I hereby elect and consent to receive my wages via direct deposit. In addition, I hereby authorize RCIL as Fiscal Agent on its own behalf and on behalf of its direct and indirect subsidiaries and affiliates to make (electronically or otherwise) all deposits and deposit adjustments involving my pay, including those involving off cycle pay and pay upon discharge, to the account(s) identified above, and I authorize the bank(s) listed above to accept such deposits and make such adjustments. I also authorize RCIL as Fiscal Agent, at its election, to pay any off cycle wage payments and wage payments due to me upon discharge by means of electronic transfer of funds to a paycard, and I acknowledge that a copy of the terms, conditions, and fees associated with using such paycard are available at my workplace and upon request made to my manager. These authorizations will remain in effect until RCIL as Fiscal Agent receives written notice from me terminating my authorization.

Check Stubs by Email (*Please print clearly*)

Email Address

Please do not use your email account password. Choose a password to Access your pay stub attachment only

Password

DSW Signature: _____ **Date:** _____

****This form is required if using the Wisely Pay Card option****

Wisely Pay Card Enrollment Form

***If you already have Wisely Pay Card with RCIL**
please provide your account number below and do not fill out this form.*

Account Number _____

If you do *not* have a Wisely Pay Card please fill out this form.

Wisely Pay Card – Account Owner Information (Please Print Legibly)			
First Name:	**Middle Initial:**	**Last Name:**	
Street Address:		**Apartment #:**	
City:		**State:**	**Zip Code:**
Home Telephone: ( )		**Date of Birth (MM/DD/YYYY):**	
Social Security Number: -- --		**Employee ID #:(office use only-do not complete)**	
_____ **Employee Signature**		_____ **Date**	

By providing the information requested above and signing above, I hereby elect and consent to receive my wages, including but not limited to off cycle wage payments and wage payments upon discharge, by electronic transfer of wages to a paycard. In addition, to the extent permitted by applicable law, I hereby authorize Resource Center for Independent Living, Inc. (dba as RCIL as Fiscal Agent) to make all of my deposits and deposit adjustments, including those involving off cycle wage payments and wage payments upon discharge, to my paycard, and I authorize the bank where such funds are deposited to accept such deposits and make such adjustments. I acknowledge I have received a copy of the terms, conditions, and fees associated with using such paycard. This authorization shall remain in effect until fourteen (14) days after RCIL as Fiscal Agent receives written notice from me terminating my authorization.

****This form is required if using the Wisely Pay Card option****

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

2026

Step 1: Enter Personal Information

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

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **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.)

Caution: To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.

TIP: Consider using the estimator at *www.irs.gov/W4App* to determine the most accurate withholding for the rest of the year if you: are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

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*.

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for the 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 Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(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.)

Step 3: Claim Dependent and Other Credits

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

(a) Multiply the number of qualifying children under age 17 by $2,200 . . . . . **3(a)** $

(b) Multiply the number of other dependents by $500 . . . **3(b)** $

Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here . . . . . **3** $

Step 4: Other Adjustments

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

(b) Deductions. Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) Enter the result here . . **4(b)** $

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

Exempt from withholding

I claim exemption from withholding for 2026, and I certify that I meet **both** of the conditions for exemption for 2026. See *Exemption from withholding* on page 2. I understand I will need to submit a new Form W-4 for 2027 . ☐

Step 5: Sign Here

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

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2026 if you meet both of the following conditions: you had no federal income tax liability in 2025 **and** you expect to have no federal income tax liability in 2026. You had no federal income tax liability in 2025 if (1) your total tax on line 24 on your 2025 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2026 tax return. To claim exemption from withholding, certify that you meet both of the conditions by checking the box in the *Exempt from withholding* section. Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2027.

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* if you:

1. Are submitting this form after the beginning of the year;

2. Expect to work only part of the year;

3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;

4. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

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

TIP: Have your most recent pay stub(s) from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

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

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

Specific Instructions

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

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work. Submit a separate Form W-4 for each job.

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 of tax withheld 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 (and/or your spouse if married filing jointly) must have the required social security number to claim certain credits. 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.

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 15, if you expect to claim deductions other than the basic standard deduction on your 2026 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for qualified tips, overtime compensation, and passenger vehicle loan interest; student loan interest; IRAs; and seniors. You (and/or your spouse if married filing jointly) must have the required social security number to claim certain deductions. For additional eligibility requirements, see Pub. 501.

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 when you file your tax return.

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

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 5. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . **1** $

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 5 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . **2a** $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 5 and enter this amount on line 2b . . . . . **2b** $

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

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3**

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (plus any other additional amount you want withheld) . . . . . **4** $

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

See the Instructions for Schedule 1-A (Form 1040) for more information about whether you qualify for the deductions on lines 1a, 1b, 1c, 3a, and 3b.

1 Deductions for qualified tips, overtime compensation, and passenger vehicle loan interest.

- **a** **Qualified tips.** If your total income is less than $150,000 ($300,000 if married filing jointly), enter an estimate of your qualified tips up to $25,000 . . . . . **1a** $
- **b** **Qualified overtime compensation.** If your total income is less than $150,000 ($300,000 if married filing jointly), enter an estimate of your qualified overtime compensation up to $12,500 ($25,000 if married filing jointly) of the "and-a-half" portion of time-and-a-half compensation . . . . . **1b** $
- **c** **Qualified passenger vehicle loan interest.** If your total income is less than $100,000 ($200,000 if married filing jointly), enter an estimate of your qualified passenger vehicle loan interest up to $10,000 **1c** $

2 Add lines 1a, 1b, and 1c. Enter the result here . . . . . **2** $

3 **Seniors age 65 or older.** If your total income is less than $75,000 ($150,000 if married filing jointly):

- **a** Enter $6,000 if you are age 65 or older before the end of the year . . . . . **3a** $
- **b** Enter $6,000 if your spouse is age 65 or older before the end of the year and has a social security number valid for employment . . . . . **3b** $

4 Add lines 3a and 3b. Enter the result here . . . . . **4** $

5 Enter an estimate of your student loan interest, deductible IRA contributions, educator expenses, alimony paid, and certain other adjustments from Schedule 1 (Form 1040), Part II. See Pub. 505 for more information . . . . . **5** $

6 **Itemized deductions.** Enter an estimate of your 2026 itemized deductions from Schedule A (Form 1040). Such deductions may include qualifying:

- **a** **Medical and dental expenses.** Enter expenses in excess of 7.5% (0.075) of your total income . **6a** $
- **b** **State and local taxes.** If your total income is less than $505,000 ($252,500 if married filing separately), enter state and local taxes paid up to $40,400 ($20,200 if married filing separately) . **6b** $
- **c** **Home mortgage interest.** If your home acquisition debt is less than $750,000 ($375,000 if married filing separately), enter your home mortgage interest expense (including mortgage insurance premiums) . . . . . **6c** $
- **d** **Gifts to charities.** Enter contributions in excess of 0.5% (0.005) of your total income . . . . **6d** $
- **e** **Other itemized deductions.** Enter the amount for other itemized deductions . . . . . **6e** $

7 Add lines 6a, 6b, 6c, 6d, and 6e. Enter the result here . . . . . **7** $

8 **Limitation on itemized deductions.**

- **a** Enter your total income . . . . . **8a** $
- **b** Subtract line 4 from line 8a. If line 4 is greater than line 8a, enter -0- here and on line 10. Skip line 9 **8b** $

9 Enter:
- $768,700 if you're married filing jointly or a qualifying surviving spouse
- $640,600 if you're single or head of household
- $384,350 if you're married filing separately

. . . . . **9** $

10 If line 9 is greater than line 8b, enter the amount from line 7. Otherwise, multiply line 7 by 94% (0.94) and enter the result here . . . . . **10** $

11 **Standard deduction.**

Enter:
- $32,200 if you're married filing jointly or a qualifying surviving spouse
- $24,150 if you're head of household
- $16,100 if you're single or married filing separately

. . . . . **11** $

12 **Cash gifts to charities.** If you take the standard deduction, enter cash contributions up to $1,000 ($2,000 if married filing jointly) . . . . . **12** $

13 Add lines 11 and 12. Enter the result here . . . . . **13** $

14 If line 10 is greater than line 13, subtract line 11 from line 10 and enter the result here. If line 13 is greater than line 10, enter the amount from line 12 . . . . . **14** $

15 Add lines 2, 4, 5, and 14. Enter the result here and in Step 4(b) of Form W-4 . . . . . **15** $

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$480	$850	$850	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020
$10,000 - 19,999	0	480	1,480	1,850	2,050	2,220	2,220	2,220	2,220	2,220	2,220	2,620
$20,000 - 29,999	480	1,480	2,480	3,050	3,250	3,420	3,420	3,420	3,420	3,420	3,820	4,820
$30,000 - 39,999	850	1,850	3,050	3,620	3,820	3,990	3,990	3,990	3,990	4,390	5,390	6,390
$40,000 - 49,999	850	2,050	3,250	3,820	4,020	4,190	4,190	4,190	4,590	5,590	6,590	7,590
$50,000 - 59,999	1,020	2,220	3,420	3,990	4,190	4,360	4,360	4,760	5,760	6,760	7,760	8,760
$60,000 - 69,999	1,020	2,220	3,420	3,990	4,190	4,360	4,760	5,760	6,760	7,760	8,760	9,760
$70,000 - 79,999	1,020	2,220	3,420	3,990	4,190	4,760	5,760	6,760	7,760	8,760	9,760	10,760
$80,000 - 99,999	1,020	2,220	3,420	4,240	5,440	6,610	7,610	8,610	9,610	10,610	11,610	12,610
$100,000 - 149,999	1,870	4,070	6,270	7,840	9,040	10,210	11,210	12,210	13,210	14,210	15,360	16,560
$150,000 - 239,999	1,870	4,100	6,500	8,270	9,670	11,040	12,240	13,440	14,640	15,840	17,040	18,240
$240,000 - 319,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,780	14,980	16,180	17,380	18,580
$320,000 - 364,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,860	15,860	17,860	19,860	21,860
$365,000 - 524,999	2,720	5,920	9,390	12,260	14,760	17,230	19,530	21,830	24,130	26,430	28,730	31,030
$525,000 and over	3,140	6,840	10,540	13,610	16,310	18,980	21,480	23,980	26,480	28,980	31,480	33,990

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$90	$850	$1,020	$1,020	$1,020	$1,070	$1,870	$1,870	$1,870	$1,870	$1,870	$1,970
$10,000 - 19,999	850	1,780	1,980	1,980	2,030	3,030	3,830	3,830	3,830	3,830	3,930	4,130
$20,000 - 29,999	1,020	1,980	2,180	2,230	3,230	4,230	5,030	5,030	5,030	5,130	5,330	5,530
$30,000 - 39,999	1,020	1,980	2,230	3,230	4,230	5,230	6,030	6,030	6,130	6,330	6,530	6,730
$40,000 - 59,999	1,020	2,880	4,080	5,080	6,080	7,080	7,950	8,150	8,350	8,550	8,750	8,950
$60,000 - 79,999	1,870	3,830	5,030	6,030	7,100	8,300	9,300	9,500	9,700	9,900	10,100	10,300
$80,000 - 99,999	1,870	3,830	5,100	6,300	7,500	8,700	9,700	9,900	10,100	10,300	10,500	10,700
$100,000 - 124,999	2,030	4,190	5,590	6,790	7,990	9,190	10,190	10,390	10,590	10,940	11,940	12,940
$125,000 - 149,999	2,040	4,200	5,600	6,800	8,000	9,200	10,200	10,950	11,950	12,950	13,950	14,950
$150,000 - 174,999	2,040	4,200	5,600	6,800	8,150	10,150	11,950	12,950	13,950	14,950	16,170	17,470
$175,000 - 199,999	2,040	4,200	6,150	8,150	10,150	12,150	13,950	15,020	16,320	17,620	18,920	20,220
$200,000 - 249,999	2,720	5,680	7,880	10,140	12,440	14,740	16,840	18,140	19,440	20,740	22,040	23,340
$250,000 - 449,999	2,970	6,230	8,730	11,030	13,330	15,630	17,730	19,030	20,330	21,630	22,930	24,240
$450,000 and over	3,140	6,600	9,300	11,800	14,300	16,800	19,100	20,600	22,100	23,600	25,100	26,610

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$280	$850	$950	$1,020	$1,020	$1,020	$1,020	$1,560	$1,870	$1,870	$1,870
$10,000 - 19,999	280	1,280	1,950	2,150	2,220	2,220	2,220	2,760	3,760	4,070	4,070	4,210
$20,000 - 29,999	850	1,950	2,720	2,920	2,980	2,980	3,520	4,520	5,520	5,830	5,980	6,180
$30,000 - 39,999	950	2,150	2,920	3,120	3,180	3,720	4,720	5,720	6,720	7,180	7,380	7,580
$40,000 - 59,999	1,020	2,220	2,980	3,570	4,640	5,640	6,640	7,750	8,950	9,460	9,660	9,860
$60,000 - 79,999	1,020	2,610	4,370	5,570	6,640	7,750	8,950	10,150	11,350	11,860	12,060	12,260
$80,000 - 99,999	1,870	4,070	5,830	7,150	8,410	9,610	10,810	12,010	13,210	13,720	13,920	14,120
$100,000 - 124,999	1,870	4,270	6,230	7,630	8,900	10,100	11,300	12,500	13,700	14,210	14,720	15,720
$125,000 - 149,999	2,040	4,440	6,400	7,800	9,070	10,270	11,470	12,670	14,580	15,890	16,890	17,890
$150,000 - 174,999	2,040	4,440	6,400	7,800	9,070	10,580	12,580	14,580	16,580	17,890	18,890	20,170
$175,000 - 199,999	2,040	4,440	6,400	8,510	10,580	12,580	14,580	16,580	18,710	20,320	21,620	22,920
$200,000 - 249,999	2,720	5,920	8,680	10,900	13,270	15,570	17,870	20,170	22,470	24,080	25,380	26,680
$250,000 - 449,999	2,970	6,470	9,540	12,040	14,410	16,710	19,010	21,310	23,610	25,220	26,520	27,820
$450,000 and over	3,140	6,840	10,110	12,810	15,380	17,880	20,380	22,880	25,380	27,190	28,690	30,190

K-4

(Rev. 8-15)

KANSAS

EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

Use the following instructions to accurately complete your K-4 form, then detach the lower portion and give it to your employer. For assistance, call the Kansas Department of Revenue at 785-368-8222.

Purpose of the K-4 form: A completed withholding allowance certificate will let your employer know how much *Kansas* income tax should be withheld from your pay on income you earn from Kansas sources. Because your tax situation may change, you may want to refigure your withholding each year.

Exemption from Kansas withholding: To qualify for exempt status you must verify with the Kansas Department or Revenue that: **1)** last year you had the right to a refund of all STATE income tax withheld because you had no tax liability; and **2)** this year you will receive a full refund of all STATE income tax withheld because you will have no tax liability.

Basic Instructions: If you are not exempt, complete the **Personal Allowance Worksheet** that follows. The total on line F should not exceed the total exemptions you claim under "Exemptions and Dependents" on your Kansas income tax return.

NOTE: *Your status of "Single" or "Joint" may differ from your status claimed on your federal Form W-4).*

Using the information from your **Personal Allowance Worksheet**, complete the **K-4** form below, sign it and provide it to your employer. If your employer does not receive a K-4 form from you, they must withhold Kansas income tax from your wages without exemption at the "Single" allowance rate.

Head of household: Generally, you may claim head of household filing status on your tax return only if you are **unmarried and pay more than 50% of the cost of keeping up a home for yourself and for your dependent(s).**

Nonwage income: If you have a large amount of nonwage Kansas source income, such as interest or dividends, consider making estimated tax payments on Form K-40ES. Without these payments, you may owe additional Kansas tax when you file your state income tax return.

Personal Allowance Worksheet (Keep for your records)

A	Allowance Rate: If you are a single filer mark "Single" If you are married and your spouse has income mark "Single" If you are married and your spouse does not work mark "Joint"	**A**	☐ Single ☐ Joint
B	Enter "0" or "1" if you are married or single and no one else can claim you as a dependent (entering "0" may help you avoid having too little tax withheld)	**B**	_____
C	Enter "0" or "1" if you are married and only have one job, and your spouse does not work (entering "0" may help you avoid having too little tax withheld)	**C**	_____
D	Enter "2" if you will file head of household on your tax return (see conditions under *Head of household* above)	**D**	_____
E	Enter the number of dependents you will claim on your tax return. Do not claim yourself or your spouse or dependents that your spouse has already claimed on their form K-4.	**E**	_____
F	**Add lines B through E** and enter the total here	**F**	_____

▼ **Cut here and give the lower portion to your employer. Keep the top portion for your records.**

K-4

(Rev. 9-12)

Kansas Employee's Withholding Allowance Certificate

Whether you are entitled to claim a certain number of allowances or exemptions from withholding is subject to review by the Kansas Department of Revenue. Your employer may be required to send a copy of this form to the Kansas Department of Revenue.

1 Print your first name and middle initial	Last Name	**2** Social Security Number
Mailing Address	**3** Allowance Rate Mark the allowance rate selected in line A above.	
City or Town, State, and ZIP Code	☐ Single ☐ Joint	

4 Total number of allowances you are claiming (from line F above)	**4**	
5 Enter any additional amount you want withheld from each paycheck (this is optional)	**5**	$
6 I claim exemption from withholding. You must meet the conditions explained in the "Exemption from withholding" instructions above. If you meet those conditions, write "Exempt" on this line. **Note: The Kansas Department of Revenue will receive your federal W-2 forms for all years claimed *Exempt*.**	**6**	

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.

SIGN HERE ▶ **DATE**

7 Employer's name and address	**8** EIN (Employer Identification Number)

DRUG-FREE WORKPLACE ACT NOTICE

In accordance with the Drug-Free Workplace Act of 1988, the consumer as the sole employer declares that they are committed to maintaining a drug-free workplace in order to ensure the safety and productivity of the DSW's and quality of services provided. To this end, be informed that:

A. The manufacture, distribution, dispensing, possession, and/or use of illegal drugs* and/or alcohol is prohibited: **a)** at any time on the Consumer's property, and/or **b)** either on or off the Consumer's property during working hours, including rest and lunch breaks.

B. Use of illegal drugs, prescription, and/or non-prescription drugs, and/or alcohol which results in substandard work performance and/or which renders the DSW unsafe to himself/herself and/or others is also prohibited.

C. When Consumer has reasonable cause to believe that any DSW has violated this Drug-Free Workplace Act Notice, the DSW may be required to submit to a drug-screening test and that DSW shall allow the results to be furnished to the Consumer.

D. DSW's are required to notify the Consumer of any DUI conviction and/or diversion within the past five years, as well as any drug-statute conviction. This requirement includes any conviction whether Municipal, State, or Federal. Additionally, the DSW is required to notify the Consumer of any such conviction occurring during the term of this Agreement.

*** Illegal drugs are controlled substances included in schedule I or schedule II as defined by section 8-2 (6) of title 21 of the US code, possession of which is unlawful under chapter 13 of that title. The term an illegal drug does not mean the use of a controlled substance pursuant to a valid prescription or other uses authorized by law.**

I have read and understand the Drug-Free Workplace Act Notice (or I have had the Drug-Free Workplace Act Notice read and explained to me). I agree, as a condition of my employment with

_____
(Consumer)

to abide by the Drug-Free Workplace Act or face disciplinary action up to and including possible discharge.

DSW Printed	DSW Signature	Date

Consumer/Guardian/DPOA/Designated Representative Printed	Consumer/Guardian/DPOA/Designated Representative Signature	Date

CONFIDENTIALITY STATEMENT

I hereby certify that I understand and agree to keep confidential any and all personal information, including medical information, concerning any Consumer of the Resource Center for Independent Living. I further understand that I may discuss the consumer's personal and health related information only when explicitly asked to do so by the Consumer. I further understand that if I disclose any personal/ medical information regarding any Consumer, that my employment with the Consumer may be terminated immediately and such disclosure constitutes a breach of privacy of the Consumer.

DSW Printed	DSW Signature	Date

Mandatory Contact Notice

Workers' Compensation – The consumer, the sole employer of their Direct Support Workers, hereby designates RCIL as Fiscal Agent as the entity to which notice must be given for all work related injuries.

DSW's must immediately notify the RCIL's Work Comp department regardless of how insignificant a work related injury may appear, involving physical injury or property damage. Injured DSWs are required to call and speak with the RCIL's Work Comp department prior to seeking medical attention for a workers' compensation injury. In case of emergency or life-threatening accidents, DSW's should seek medical attention at the nearest hospital. DSW's with non-life threatening injuries should seek medical attention at nearby medical clinics, not hospitals. Upon arrival, DSW's should inform the medical provider that the injury is work-related and may be covered by workers' compensation insurance.

Injuries must be communicated to the RCIL's Work Comp department at 1-800-580-7245 within 24 hours to ensure appropriate medical attention is provided. Injuries must be reported within the earliest of the following to be covered by workers' compensation: 20 days from the date of the incident or injury, 20 days from the date medical treatment is sought, or 10 days from the employee's last date of employment.

Making false or misleading statements to obtain benefits, presenting a false certificate of insurance, or submitting a charge for health care not furnished are some examples of fraudulent or abusive acts. The penalty for committing such acts are minimally a $2,000 fine for each act of fraud or abuse, misdemeanor or felony criminal charges.

See the Workers' Compensation Fraudulent or Abusive Act as defined in K.S.A. 44-5,120(d) and 44-5,125 for more details.

Changes in Employment Status - RCIL provides Financial Management Services (including unemployment insurance coverage) for individuals ("consumers") that are approved to receive Home and Community Based Services from KanCare (Medicaid). As the sole employer, it is the Consumer's responsibility to make all employment decisions regarding their Direct Support Workers. Upon the request of the Consumer, RCIL provides the Consumer with a list of prospective DSW's.

Upon conclusion or during any interruption of employment with the consumer, the DSW must immediately contact RCIL by telephone at 1-800-580-7245 between the hours of 8AM and 4PM, Monday-Friday to report that employment was concluded either by the consumer or the DSW. Such notification is for the purpose of determining eligibility and availability of additional work as well as other administrative purposes.

Failure to make said contact by phone within one business day of the change in employment status may lead to the denial and/or interruption of unemployment benefits. Also, failure to inquire about the possibility of another assignment by having the DSW's name added to the list of available DSWs before filing for unemployment benefits, may lead to an interruption and/or denial of unemployment benefits.

By signing this document I verify I have read and understand all the provisions and responsibilities of the Workers' Compensation and Changes in Employment Status reporting procedures and agree to follow all of its provisions.

_____ (DSW Printed Name)	_____ (Social Security Number)
_____ (DSW Signature)	_____ (Date)
_____ (Consumer Printed Name)	
_____ (Consumer Signature)	_____ (Date)

Medicaid Fraud

Medicaid Fraud is a crime.

By accepting services paid for with Medicaid Funds, you, _____ (print your name), as the **Direct Service Worker (DSW)** agree to use those funds only in the manner for which they were intended. You need to be alert to any signs of potential Medicaid Fraud. Medicaid Fraud is committed when a CONSUMER, WORKER or PROVIDER intentionally submits false information to the Medicaid program about services rendered to Medicaid recipients.

Medicaid Fraud includes:

- DSWs (Direct Support Workers) submitting time when not actually working
- Consumer/employer submitting time for a worker who is not working
- Using someone else's worker ID to submit time for the person actually working
- Submitting incorrect dates and times for services performed
- Submitting overlapping hours for two or more Medicaid beneficiaries for the same time period
- Submitting time to Medicaid and accepting private pay from another source for the same service
- Submitting time for performing tasks not on the authorized Plan of Care/Service Plan
- Submitting time for activities not provided
- Giving or accepting "kickbacks" (something of value in return for receiving services)
- Knowingly submitting false information
- Splitting paychecks with your Consumer/employer
- Claiming time worked when the Consumer/employer is out of the home due to hospitalization, nursing facility, rehabilitation facility or incarceration (jail or prison)
- Claiming time worked when the DSW is in jail, prison or unable to work

There are serious consequences for committing Medicaid Fraud:

- Arrest and prosecution, criminal penalties, fines and jail time
- Civil damages and monetary penalties
- Termination of Medicaid Provider Services
- Exclusion from working in any facility receiving federal health care funds
- Loss of certification (e.g. CNA, LPN, RN, etc.)

To report suspected Medicaid Fraud, immediately notify RCIL or contact the Attorney General's office at 1-866-551-6328 or 785-368-6220.

Retaliation against any individual who reports suspected Fraud or participates in an investigation of such reports (referred to as whistleblowing) is strictly prohibited by law.

I have read and understand this information regarding Medicaid Fraud. By accepting services paid with Medicaid funds or accepting pay for providing services paid with Medicaid funds, I agree that if I intentionally commit any of the above mentioned acts, the suspected Medicaid Fraudulent activity will be reported to the Kansas Attorney General's office for investigation and potential prosecution.

_____ _____

Direct Support Worker's Signature Date

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

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.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 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

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.

	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)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

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

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.

First Day of Employment (mm/dd/yyyy):

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
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: 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 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.		5. U.S. Military card or draft record		5. U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		7. Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		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				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	OR	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

Background Check Requirements for all Direct Support Workers

The Kansas Department for Aging and Disability Services (KDADS) requires that **all** Direct Support Workers must undergo and pass certain background checks in order to be eligible to provide any Medicaid funded services, including, but not limited to, Personal Care Services, Enhanced Care Services, etc. Also, KDADS requires new background checks be conducted every two years.

The following background checks are required:

- Kansas Bureau of Investigations
- Kansas Department for Aging and Disability Services - Survey, Certification, and Credentialing Commission for Findings of Abuse, Neglect or Exploitation
- Driver's License Records through the Kansas Department of Revenue
- Department for Children and Families – Adult Abuse, Neglect, and Exploitation (ANE) Central Registry
- Department for Children and Families – Child Abuse and Neglect Central Registry
- Kansas State Board of Nursing
- Office of Inspector General

DSWs cannot work **until all background checks have been returned** and the State of Kansas has determined that the DSW applicant is eligible to provide Home and Community Based Services. Please be aware that it has been taking some of the background checks up to **three weeks or more** to be completed. Please complete the following forms in their entirety. Incomplete forms will slow the hiring process.

Payment Options for Background Checks:

- **Money order or cashier's check payable to RCIL in the amount of $20.00**
- **To pay by credit card call RCIL at 1-800-580-7245.**
- **Personal checks or cash will not be accepted.**
- **Payment for the background checks must be received before the checks are conducted.**

PLEASE DO NOT SEND PAYMENT FOR FEES OR FORMS TO OTHER AGENCIES. THE $20 FEE TO RCIL COVERS ALL BACKGROUND CHECKS. RCIL WILL SUBMIT THE FORMS TO THE APPROPRIATE AGENCIES ON YOUR BEHALF.

Please note – This background check policy is in the Kansas' Medicaid Waiver program approved by the US Federal Agency "Centers for Medicare and Medicaid Services". This is not RCIL's policy. All FMS providers are required to conduct the same background checks. Also, RCIL will not determine an individual's eligibility. Eligibility is determined by the state agency providing the background check.

For a complete list of prohibited offenses, including statute numbers go to: http://rcilinc.org/wp-content/uploads/2019/02/2019-offenses.pdf or call *1-800-580-7245.*

08/01/2023

BACKGROUND RELEASE FORM

I, _____, give RCIL permission to utilize and/or release information concerning myself necessary for the completion of a Kansas Bureau of Investigation (KBI), Kansas Department for Aging and Disability Services (KDADS), Social Security Verification, Driver's License Record, Kansas Department of Health and Environment (KDHE), Kansas Department of Children and Families (DCF) adult and Medical Services Abuse and Neglect Central Registry, Kansas DCF Child Abuse and Neglect Central registry, as well as Excluded Individuals/Entities and U.S. Department of Health and Human services Office of Inspector General for Medicaid Fraud background checks, and other background checks as required by the program while I am employed or associated with the agency.

*****PLEASE COMPLETE INFORMATION BELOW BY PRINTING IN INK*****
*****DO NOT LEAVE ANY SPACES BLANK*****

First Name: _____

Middle Name: _____

Last Name: _____

Social Security #: _____ Date of Birth: _____

Race: _____ Gender: _____

Phone #: _____

I understand that information regarding the results of my background checks may be released to the consumer requesting the information. **After hire, DSWs shall immediately report any and all arrests AND outcomes of criminal or civil charges to the FMS Provider, RCIL as Fiscal Agent.** In the event of a conviction or adjudication, RCIL may conduct additional background checks.

_____ _____
Signature of Direct Support Worker (DSW) Date

STATE OF KANSAS
Department for Children & Families
Office of Background Investigations

ADULT ABUSE, NEGLECT, EXPLOITATION CENTRAL REGISTRY RELEASE OF INFORMATION

OBI 10400
REV 4/22

I, _____, give permission for the release of information concerning
(PRINT Full Name)

myself in the Adult Abuse, Neglect, Exploitation Central Registry to:

Contact Person(s)* Debbie Parsons **Phone** 785-528-3105

Agency name Resource Center for Independent Living

Agency mailing address PO Box 257, Osage City, KS 66523

Email address: **Will return via Encrypted email unless marked otherwise** Debbie.Parsons@rcilinc.org

Maiden Name and/or Other Names Known By: _____
(PRINT ONLY)

Address: _____
Street **City** **State** **Zip Code**

DOB: _____ **SS#:** _____ ☐ Male ☐ Female
(mm/dd/yyyy) **(mark one)**

I understand that all information released will be for the exclusive and confidential use of the above named organization/person. I have read and understand this form and information provided is true and correct to the best of my knowledge.

I give permission for the release of any information concerning myself in the Adult Abuse, Neglect, Exploitation Central Registry each year while I am employed or associated with the above agency. ☑ **Yes** ☐ **No**

Signature: _____ **Date:** _____
(An Ink Signature or a Verified E-Signature is Required for Processing) **(mm/dd/yyyy)**

RETURN TO:

Email: DCF.APSRegistry@ks.gov

Mail: Office of Background Investigations
Adult Abuse Registry
P.O. Box 751043
Topeka, Kansas 66675
(Please allow 3-5 days for processing email requests and an additional 5-7 days if returning by US Postal Service)

For Official Use Only: Mark in this area if PROHIBITED	**For Official Use Only: Mark in this area if CLEARED**

Kansas Department for Children and Families
Strong Families Make a Strong Kansas

KANSAS DEPARTMENT FOR CHILDREN AND FAMILIES
Release of Information
Child Abuse and Neglect Central Registry
P.O. Box 2637 • Topeka, KS 66601 • FAX 785-296-1729 •
DCF.CentralRegistry@ks.gov

This entire form must be completed before it will be processed. **All releases and fees are to be sent to the mailing address or email listed above with appropriate payment (see Payment/Account Information).**

CONFIDENTIALITY: ***Kansas Department for Children and Family records are confidential. No individual, association, partnership, corporation, or other entity shall willfully or knowingly disclose, permit, or encourage disclosure of the contents of records or reports in violation of the confidentiality requirements of K.S.A. 38-2209. Violation of this statute is a class A nonperson misdemeanor and the court may impose a civil penalty of up to $1,000.***

Contact Person: Debbie Parsons Agency/Org.: Resource Center for Independent Living

Phone #: (785) 528-3105 Address: P.O. Box 357, 1137 Laing St

Email: Debbie.Persons@rcilinc.org City/State/Zip: Osage City, Kansas 66523

Return Results by: ☐ Encrypted email (list if different than above): _____ ☐ Postal Mail

Payment/Account Information (check box which applies)

☐ *Fee included*	$10 per request. Check, Money Order (payable to DCF) or cash. ***Mail to address listed above.***	
☐ *Online Payment*	$10 per request. www.dcf.ks.gov >Online DCF Payments>Payment Portal. **Submit receipt with form(s)**	
☒ *Pre-Pay Account*	Agency/Org. has Pre-Pay Account.	**FEIN:** 48-0999139
☐ *Mentoring Account*	No fee for agencies listed in the Kansas Mentors' Partner Directory http://mentorkansas.org/Find-a-Program	
☐ *Exempt*	No fee for State government agencies (Sub-contracting agencies not included).	

1. I give permission for the release of any of my information in the Child Abuse/Neglect Central Registry to the contact listed above. I understand the information released is for their exclusive and confidential use: ☒ *Yes* ☐ *No*

2. This organization/person/agency may check my information each year I am employed or associated with them: ☒ *Yes* ☐ *No*

APPLICANT: ***PRINT CLEARLY.*** *All requested information is required for processing. Incomplete or illegible information will result in processing delays for the Release of Information. Use 'N/A' rather than leaving a space blank.*

FIRST, MIDDLE, LAST NAME: _____

OTHER NAMES USED: (Any/all aliases, married, maiden, nicknames, etc. (Enter 'N/A' if none used):

_____

DATE OF BIRTH: _____ **RACE:** _____

SOCIAL SECURITY #: _____ **GENDER:** ☐ *Male* ☐ *Female*

CURRENT ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE: _____ **EMAIL:** _____

SIGNATURE: _____ **DATE:** _____

Applicants under the age of 16 requires a parent/guardian signature and title of signatory.

For DCF use ONLY:

- A stamp in the Match box indicates the applicant is listed on the Central Registry.
- A stamp in the No Match box indicates the applicant is NOT listed on the Central Registry.

MATCH	NO MATCH

Kansas 3rd Party Consent Form

This form is required to request the Driver's License Record.

I hereby certify that my name is _____
(First Name) (Middle Name) (Last Name)

Address _____
(Street Address) (City) (State) (Zip Code)

Birthdate _____ Telephone Number _____
(MMDDYYYY)

Driver's License Number _____

☐ I certify that I currently do not have a valid driver's license and will not provide transportation for my employer

You will still need to document Driver's License number above

☐ I certify that I have NEVER possessed a Driver's License and will not provide transportation for my employer

I hereby certify that all information is true to the best of my knowledge and authorize Resource Center for Independent Living, Inc. (RCIL) to obtain my driver's license record information including my personal information on those records.

**********Signature Required**********

_____ _____
DSW Signature Date