

ANOTHER DAY, INC.

Home and Community Based Waiver (HCBS) Program.

MR/DD Waiver Packet for Direct Support Worker

Hello,

Thank you for your interest in Another Day Inc. In order for us to determine your eligibility for this position, you must first complete the enclosed Application Packet. Once completed, please return the following items to our office so that we can process your application:

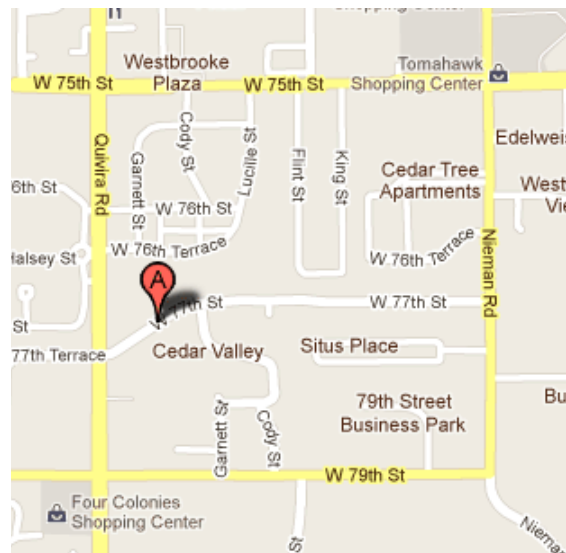
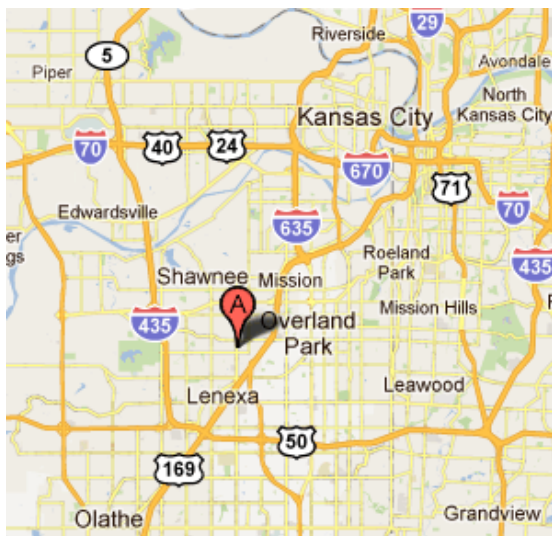
- Completed Application Packet (**see the Forms Checklist on the next page**)
- Photo Copy of Driver's License or picture ID.
- Photo Copy of Social Security Card.

If you have any questions or concerns, please do not hesitate to contact us at 913-599-2221, or toll free at 1-866-599-2221. You may also email us at office@anotherday.info.

Thank you again for your interest in Another Day Inc. We look forward to working with you.

Sincerely,

The Another Day Inc. Team



Address: 11802 W 77th St. Lenexa, KS 66214

Phone: 913-599-2221 Fax: 913-599-5660 Toll Free: 1-866-599-2221

Website: www.anotherday.info E-mail: office@anotherday.info

DD

KC Area Employment Application Packet Checklist

Please complete the following items in blue or black ink and bring them to the Another Day Inc. office.

IMPORTANT: FORMS MUST BE COMPLETED AND RETURNED TO ANOTHER DAY, INC. BEFORE THE DIRECT SUPPORT WORKER CAN BEGIN WORKING!

Use this checklist to double check that all forms are completed:

- _____ Caregiver Information Form.
- _____ Another Day, Inc. Background Check Authorization: Kansas.
- _____ Kansas Department of SRS Adult Abuse and Neglect Form.
- _____ Kansas Department of SRS Child Abuse and Neglect Form.
- _____ Kansas Health Occupation Credentialing Criminal Records Check.
- _____ Missouri Family Care Safety Registry Worker Registration Form.
- _____ Direct Support Worker Agreement Form.
- _____ FMS Provider and Direct Support Worker Agreement Form.
- _____ I-9 Form (Section A).
- _____ W-4 Form.
- _____ Verification of Training Form.
- _____ Direct Deposit Form.

In addition, please make sure you also submit clear copies of the following documents:
(please do not fax because the copies will not come through clearly)

- _____ Driver's License or State issued ID card.
- _____ Social Security card.

Another Day Inc. Caregiver Information Form

Personal Information

Name _____ Social Security Number _____

Address (street, city, state, zip) _____

Home Telephone _____ Work Telephone _____

Cellular Telephone _____ Email address _____

Emergency Contact Name _____ Emergency Contact Phone _____

Desired Employment

Available to Start _____

Seeking Full time _____ or Part time _____ max hours per week _____

Maximum distance you are willing to travel to job site _____

Availability:

Monday: _____ AM _____ PM Tuesday: _____ AM _____ PM

Wednesday: _____ AM _____ PM Thursday: _____ AM _____ PM

Friday: _____ AM _____ PM Saturday: _____ AM _____ PM

Sunday: _____ AM _____ PM

How did you hear about Another Day, Inc.? _____

Other Information

Other than English, do you speak any languages fluently? Y N

If so, please indicate which language(s)? _____

Do you have any additional skills or training relevant to the position you are applying for that you would like us to know about? _____

Do you have any (except minor traffic violations):

Criminal Convictions Y N

Findings of guilt Y N

Pleas of guilty Y N

Pleas of *Nolo Contendo* Y N

If you answered yes to any of the above, please explain: _____

If you consent, please initial the statements below:

I give my consent to conduct a pre-employment criminal background check _____

I give my consent to conduct a closed record check pursuant to Section 610.120, RSMo. _____

Your application will be kept on file at the Another Day Inc. office for six months.

AUTHORIZATION:

Another Day Inc. will provide equal employment opportunity without regard to race, color, sex, age, disability, religion, national origin, marital status, sexual orientation, or ancestry. The policy applies to all areas of employment, including recruitment, hiring, development, termination, layoff, compensation benefits, social and recreational programs, and all other conditions and privileges of employment in accordance with applicable federal, state, and local law.

“I certify that the facts contained in this application are true to the best of my knowledge. I understand that, if employed, falsified statements on this application are grounds for dismissal. I authorize investigation of all statements contained herein. I authorize the references and former employers listed above to give you all the information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release the company from all liability for damage that may result from utilizing such information. I also understand and agree that no representative of the company has the authority to enter into any agreement of employment for any specific time, or to make any agreement contrary to the foregoing, unless it is in writing and signed by the authorizing company representative.”

Signature

Date

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Background Check Section

Contents:

1. Kansas Background Authorization Form
2. Kansas Adult Abuse and Neglect Registry Form
3. Kansas Child Central Registry Form
4. Kansas Health Occupations Credentials Form
5. Missouri Family Care Registry Form

IMPORTANT:

- Use blue or black ink only
- Maiden name field **MUST** be used
 - Female applicants must enter their last name at birth
 - Male applicants must enter N/A
- If it doesn't apply to you, you must enter N/A
- The fee is paid by Another Day, Inc., you **do not need to send money**

DO NOT LEAVE ANY SPACES BLANK WHEN COMPLETING

THESE FORMS

Another Day Inc. Background Check Authorization: Kansas

I authorize Another Day, Inc., to procure on Consumer Employer’s behalf a background check report on me that is prepared by a consumer reporting agency, private investigating agency, police agency, or other suitable provider of information. I understand that, if I am hired, Another Day, Inc. may rely on this authorization without procuring additional background check reports during and throughout my employment by Consumer Employer without asking for my authorization again.

I understand that as part of the background investigation, the consumer reporting agency, private investigating agency, police agency, or other suitable provider of information chosen by Another Day, Inc. may check, among other records, my criminal history and the information sought may concern character, general reputation, personal characteristics, and mode of living.

I understand and hereby consent to Another Day, Inc., providing information to the Consumer Employer about the results of my background check. I further understand that the Consumer Employer may deny or discontinue my employment based upon the results of the background check at their sole discretion.

I understand that the refusal to sign this form and submit to the investigation will result in my not being considered for employment.

If you begin working before the results of the background check are completed, your continued employment will be dependent upon, and subject to, the results of this check.

Please complete this form in blue or black ink.

APPLICANT NAME _____ TELEPHONE _____

APPLICANT SIGNATURE _____ DATE _____

If hired, I will be working with _____
(print consumer name)

Relationship to consumer _____

Expected start date _____

APPLICANTS UNDER THE AGE OF 18

A parent or guardian signature is also required.

PARENT OR GUARDIAN SIGNATURE _____ DATE _____

Relationship to applicant _____

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**KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
ADULT ABUSE, NEGLECT, EXPLOITATION CENTRAL REGISTRY
RELEASE OF INFORMATION**

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

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

Contact Person(s)* Karen House Phone 913-599-2221
Agency name Another Day, Inc.
Agency mailing address 11802 W. 77th St. Lenexa, KS 66214

***If you are requesting information about yourself please complete the address information below**

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

Address: _____
Street City State Zip Code

DOB: ____ / ____ / ____ **SS#:** ____ - ____ - ____ **Sex:** M or F
(mm/dd/yyyy) (circle 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 the information provided is true and correct to the best of my knowledge.

Signature: _____ **Date:** ____ / ____ / ____
(mm/dd/yy)

RETURN TO:
Adult Abuse Registry
915 SW Harrison Rm. 551 South
Topeka, Kansas 66612

FOR CENTRAL OFFICE USE ONLY:

Record found?
Yes ___ No ___ If yes, finding: ___ AB ___ NG ___ EX ___ FA (Check all that apply)
"Yes" indicates the individual is listed on the adult abuse, neglect, exploitation registry.

Perpetrator's Name: _____

Region _____ Date Substantiated: _____

Initial: _____ Date: _____

Kansas Department of Social and Rehabilitation Services Child Abuse and Neglect Central Registry 915 SW Harrison 5 th Fl. South Topeka, Kansas 66612	Child Abuse and Neglect Central Registry Release of Information
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I, _____, give permission for the release of any information concerning
(please print complete first, middle and last name)
myself in the Child Abuse and Neglect Central Registry to:

Contact Person: Karen House
Agency Name: Another Day, Inc.
Mailing address: 11802 W. 77th St.
Lenexa, KS 66214
Phone Number (913) 599-2221

I understand that all information released will be for the exclusive and confidential use of the above named organization/person/agency.

I give permission for the release of any information concerning myself in the Child Abuse and Neglect Central Registry each year while I am employed or associated with the above agency. Yes No

**** Please complete the information below by printing in ink. Please print legibly. Do not leave any space blank. All requested information is required to process this request. Incomplete information will result in the release not being processed and will be returned as insufficient.****

First, Middle and Last Name: _____

Maiden Name: (Female applicant only) _____

Married Names, Nicknames or Other Names Used:
(Use N/A if no other names used) _____

Date of Birth: _____ **Race:** _____

Social Security # _____ **Gender:** Male Female

Signature: _____ **Date:** _____

Current Address: _____

Each request must be submitted with payment prior to the request being processed. Please attach appropriate fee of \$10.00 per release of information. All releases and fees should be sent via postal mail to the attention of SRS, Child Abuse and Neglect Central Registry, P.O. Box 2637, Topeka, KS 66601. The following state agencies are exempt from the \$10.00 fee: JJA (Central Office or Facilities), KNI, Dept. Of Education- Central Office, KDHE, State Hospitals, State Correctional Institutions, Attorney General's Office, Kansas School for the Blind, Kansas School for the Deaf, Child Welfare agencies in other states. Mentor record checks, i.e. Big Brothers Big Sisters, are exempt from the \$10.00 fee. For a complete list of Mentor Programs, go to: <http://kansasmentors.kansas.gov/Pages/FindaProgram.aspx>. If this is a mentor record check, please make sure the box below is checked.

Mentor Program: **If yes, please check**

For Central Registry Use Only

_____ **FEE ATTACHED**

HEALTH OCCUPATIONS CREDENTIALING
1000 SW JACKSON, SUITE 200, TOPEKA, KS 66612- 1365
CRIMINAL RECORD CHECK REQUEST FORM

FACILITY NAME:

FACILITY I D #

ADDRESS:

CITY:

STATE :

ZIP CODE:

Applicant information: **ALL REQUESTED INFORMATION MUST BE PROVIDED** or the form will not be processed.

Last Name:	First Name:	Middle Name	Suffix (Jr, Sr, etc)

Other Names Ever Used:

Last Name:

Last Name: **

** List additional names on back. Check here if more on back.

One of the following **must** be selected

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Social Security Number	Date of Birth	Sex	Race	A - Asian or Pacific Islander B - Black I - Native American/Alaskan Native W - White

Address

Post Office Box # (if applicable)

City

State

County

Zip Code

Home Phone

Work Phone

Certificate # (if applicable)

Job Classification: Determine the correct job classification for the applicant and Insert the three letter abbreviation in the box.

WEL

Activities Staff	ACS	Food Service Worker	FSW	Medical Records Staff	MRS
Administrator	ADM	Home Health Aide	HHA	Operator	OPR
Business and Administrative	BAS	Home Health Aide Trainee	HHT	Paid Driver	DRV
Certified Medication Aide	CMA	Housekeeping	HSK	Paid Nutrition Assistant	PNA
Certified Nurse Aide	CNA	Human Resources Staff	HRS	Personnel Staff	PER
Nurse Aide Trainee	NAT	Laundry Workers	LDW	Restorative Aide	RSA
Chaplain	CHN	Maintenance Worker	MTW	Social Service Designee	SSD
Clerical Staff	CLS	Marketing Staff	MKT	Volunteer Coordinator	VLC
				Wellness Staff	WEL

Another Day Inc. Background Check Instructions: Missouri

Thank you for your interest in becoming a Personal Care Attendant (caregiver) with Another Day Inc. The state of Missouri requires all care givers to be registered with the **Missouri Family Care Safety Registry**. Please note that *although you may not be working in Missouri, because of where you live you are required to undergo a background check from the state of Missouri*.

We will submit this form for you and pay the application fee on your behalf. However, if we submit this form, it may take up to six weeks to process in our office. If you would like to speed up this process you may submit the form yourself online at www.dhss.mo.gov/fcsr. The cost is \$11.00. If you provide us with a receipt and you are hired we will be happy to refund you this cost at the time of your first paycheck. If you have questions, please call our office at 913-599-2221.

If you would like us to submit the Missouri Family Care Safety Registry form, please follow these instructions carefully and fill out all of the information on the following pages. Incorrectly completing the form may result in a processing delay.

- Check the box in Section A labeled “Personal Care Worker”.
- Use blue or black ink and print clearly.
- Please provide us with a copy of your **Driver’s License and Social Security card**. *If you do not provide this documentation we cannot process your paperwork and you may not be able to start work.*
- You are not required to pay the fee. We will take care of that.
- Under “Prior Names Used”, please include any previous names you have had, including your maiden name. If you do not have any prior names, put N/A.
- Please remember to sign the form after reading the authorization to release background screening information.

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MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
 FAMILY CARE SAFETY REGISTRY
WORKER REGISTRATION

FCSR USE ONLY

RESET

PLEASE TYPE OR PRINT CLEARLY

SECTION A: WORKER TYPE (CHECK ONE BOX ONLY)

- CHILD CARE WORKER (\$9.00)
 PERSONAL CARE WORKER(\$9.00)
 VOLUNTARY REGISTRANT (\$9.00)
 ELDER CARE WORKER (\$9.00)
 RECIPIENT OF STATE OR FEDERAL FUNDS (\$9.00)
 FOSTER PARENT (NO FEE)

SECTION B: IDENTIFYING DATA FOR BACKGROUND SCREENING

LAST NAME	FIRST NAME	MIDDLE NAME	MAIDEN NAME
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PRIOR NAMES USED

SOCIAL SECURITY NUMBER (ATTACH COPY OF SOCIAL SECURITY CARD)	DATE OF BIRTH	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	TELEPHONE NO. (optional) ()
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MAILING ADDRESS

STREET ADDRESS OR POST OFFICE BOX	CITY	STATE	ZIP CODE	COUNTY
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HOME ADDRESS (if different than mailing address)

STREET ADDRESS	CITY	STATE	ZIP CODE	COUNTY
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SECTION C: CURRENT EMPLOYER INFORMATION (IF APPLICABLE)

EMPLOYER NAME	CONTACT PERSON	PHONE NUMBER ()
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ADDRESS	CITY	STATE	ZIP CODE
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SECTION D: AUTHORIZATION TO RELEASE BACKGROUND SCREENING INFORMATION

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

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

SIGNATURE OF APPLICANT (REQUIRED IN INK)	DATE
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IMPORTANT

- Individuals are required to register one time only.
- Contact 1-866-422-6872 (toll-free) if you have questions on how to complete this form
- Read back of form for instructions and information on registrant notification and appeal rights
- Send completed registration form, copy of Social Security card and required fee to:

Missouri Department of Health and Senior Services
 Attn: Fee Receipts
 P.O. Box 570
 Jefferson City, MO 65102

WHAT IS THE FAMILY CARE SAFETY REGISTRY?

The Family Care Safety Registry (FCSR), administered by the Missouri Department of Health and Senior Services (DHSS), provides families and other employers with a method to obtain background screening information. The Registry, through various state agencies, offers several resources to screen child care, elder care and personal care workers and child care and elder care providers:

1. State criminal history and sex offender registry records maintained by the Missouri State Highway Patrol
2. Child abuse/neglect records, maintained by the Department of Social Services
3. The Employee Disqualification List, maintained by the Department of Health and Senior Services
4. The Employee Disqualification Registry maintained by the Department of Mental Health
5. Child care facility licensing records, maintained by the Department of Health and Senior Services
6. Foster parent, residential care facility, and child placing agency licensing records, maintained by Department of Social Services
7. Residential living facility and nursing home licensing records, maintained by the Department of Health and Senior Services

WHO HAS TO REGISTER?

Any person hired on or after January 1, 2001, as a child care worker or elder care worker, or hired on or after January 1, 2002 as a personal care worker, as defined in §210.900, subsection 2, RSMo, is required to make application for registration in the Family Care Safety Registry within fifteen (15) days of the beginning of employment. **Such person who fails to submit a completed registration form to the DHSS without good cause, as determined by the department, is guilty of a class B misdemeanor.** Employees and volunteers from non-State and/or Federally regulated entities are NOT REQUIRED to register with the FCSR.

HOW DO I COMPLETE THE REGISTRATION FORM?

Section A: Type of Worker - Check one box that best describes your worker category. A "voluntary registrant" is a person who is not mandated to register with the Family Care Safety Registry pursuant to §210.900 to §210.936, RSMo.

Section B: Identifying Data for Background Screening - List your current name, maiden name, all prior names used, Social Security number, date of birth, gender, home address, and mailing address. You must provide your Social Security number pursuant to §210.906.2, RSMo Supp. 1999. This identifying information, including Social Security number, will be used for internal identification purposes and to conduct background screenings for the resource information listed in paragraph one above.

Section C: Current Employer Information (If Applicable) - If you are currently employed by or are seeking employment with a child care or elder care provider, please list the facility name, owner/operator, telephone number and facility address. If you are a foster parent, a voluntary registrant, or receive state or federal funds for child care or elder care services, leave this section blank.

Section D: Authorization to Release Background Check Information - Sign and date the registration form. Your signature will authorize the Family Care Safety Registry to conduct the background screening outlined in §210.903.2, RSMo and to provide the information to requestors for "employment purposes", as provided in §210.921.1, RSMo.

WHERE DO I SEND MY REGISTRATION FORM?

Send your completed registration form and photocopy of Social Security card and required fee to the Missouri Department of Health and Senior Services, Family Care Safety Registry, P.O. Box 570, Jefferson City, MO, 65102. If you have questions, please call the Registry using the toll-free telephone number, 1-866-422-6872.

WHEN WILL I KNOW THE RESULTS OF MY BACKGROUND CHECK?

After the background screening has been completed, you will be notified in writing of the results that will be recorded in the Family Care Safety Registry. You will also be notified in writing each time background screening information is provided. The notification will contain the name and address of the person who made the request and the background information disclosed. The person making the request will be informed that information will be released for employment purposes only as defined pursuant to §210.921.1, RSMo. **Any person using Registry information for any other purpose is guilty of a class B misdemeanor.** In addition, state agencies can request information for licensure or regulatory purposes. Prior to disclosing information, the Registry obtains the name and address of the person calling, and determines that the request is for employment or regulatory purposes. To ensure you receive these notifications, it will be important for you to notify the Family Care Safety Registry when you have a change in your mailing address. You can send address changes to Family Care Safety Registry, P.O. Box 570, Jefferson City, MO, 65102.

WHAT IF I DON'T AGREE WITH THE RESULTS OF MY BACKGROUND CHECK?

Pursuant to §210.912, RSMo, you have the right to appeal the information transferred onto the Family Care Safety Registry. Your right to appeal is limited only to the accuracy in the transfer of information from the state agency that maintains the background information and does not include a right to appeal the accuracy of the substance of the information transferred. An appeal needs to be filed in writing to the Office of the Director, Missouri Department of Health and Senior Services, P.O. Box 570, Jefferson City, MO, 65102, within 30 days of receiving the results of the background screening determination. An administrative appeal shall be set within 30 days of the filing of the appeal and a decision shall be made within 60 days. This right to appeal is in addition to any other appeal rights granted by state law.

WHAT INFORMATION WILL BE DISCLOSED BY THE FAMILY CARE SAFETY REGISTRY?

Disclosure of background information on a person registered in the Family Care Safety Registry will be limited. A Registry worker will first confirm whether the person in question is registered. If the person is registered, the Registry worker will then disclose whether the person's name is listed in any of the background checks pursuant to §210.903, subsection 2, RSMo, and if so, which one. Specific information will only be disclosed by the Registry upon receipt of a written request from the caller.

Direct Support Workers Agreement

I, _____, the Direct Support Worker, hereafter referred to as (“DSW”), understand the following:

1. Another Day Inc. (“ADI”) is the agent who performs the Financial Management Service.
2. The Consumer is the beneficiary of the services and is the employer of the DSW.
3. The Parent or Guardian is the person who acts on behalf of the Consumer when necessary and has the authority to make decisions for the Consumer. The Parent or Guardian also has the authority to hire and fire the DSW, train the DSW, and set the schedule as to when the DSW works with the Consumer.
4. The DSW shall complete a time sheet that records time in and time out. This time sheet shall be turned in at the end of each reporting period on the 5th and the 20th of each month. The time sheet shall be signed by both the Consumer or Parent/Guardian and the DSW.
5. The DSW is responsible to follow all training and personal care instructions of the Consumer to whom they are providing services and comply with all reasonable requests of the Consumer.
6. The DSW is responsible for knowing the coverage limits of the Consumer’s Plan of Care and the maximum number of hours each Plan of Care allows for reimbursable services performed by the DSW. The DSW understands that hours worked in excess of the Plan of Care will **NOT** be reimbursed by Another Day, Inc.
7. Any change in the Consumer’s condition must be reported **immediately** to the Consumer’s Case Manager and Another Day, Inc.
8. The DSW and the Consumer understand that both must cooperate with the appropriate state agencies as a part of a periodic evaluation or audit and that the consumer will report any information about the DSW or any incidents involving the DSW as required by state law.
9. The DSW understands that they will be required to successfully undergo a background check as required by state law. The DSW authorizes the Consumer and/or its agent, Another Day, to report background results to appropriate government agencies. The DSW cannot, under any circumstances, be employed by the Consumer, under state law, if the DSW has been convicted of abuse, neglect or exploitation of a child or a vulnerable adult; the DSW will be notified of such findings.
10. The DSW is responsible for his/her own accident/disability and automobile insurance coverage at all times. The DSW is expected to follow generally accepted safety procedures while performing personal assistance tasks.
11. The DSW will receive payment on the 1st and 16th of each month for accepted time sheets.
12. If the job is terminated without fault of the DSW, the DSW may contact ADI Staffing for possible future employment.

DSW Name (Please Print)

DSW Signature

Date

**FINANCIAL MANAGEMENT SERVICES AND DIRECT SUPPORT WORKER
AGREEMENT**

This Financial Management Services and Direct Support Worker Agreement (the "Agreement") is made and entered into this ___ day of _____, 2011, by and between **Another Day, Inc.** and _____ ("DSW"), all of whom may collectively be referred to as the parties. For good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree as follows.

1. The Consumer ("Consumer") is a participant in an HCBS Waiver program administered by the Kansas Department of Social and Rehabilitation Services (SRS), and has selected DSW to be his/her self-directed DSW.
2. The Consumer has further selected Another Day, Inc. to provide Financial Management Services.
3. The DSW agrees to strictly comply with Consumer's Plan of Care and any and all other applicable HCBS waiver program requirements.
4. DSW further agrees to strictly comply with any instructions, rules or policies maintained by Another Day, Inc. with regard to DSW's billing and payment for services rendered.
5. DSW further agrees to strictly comply with any and all Kansas statutes, regulations or policies relating or pertaining to services provided to HCBS Waiver program Consumers and for payment for such services.
6. DSW further agrees to cooperate with the Consumer's Case Manager, case management agency, Another Day, Inc., and SRS regarding any questions and/or inquiries regarding the Consumer's applicable HCBS waiver case and the services provided by DSW.
7. This Agreement shall remain in effect pending the earlier occurrence of one of the following events: The denial of the Consumer's Medicaid eligibility; the termination/closure of the Consumer's applicable HCBS case; the termination of the DSW as the Consumer's self-directed worker; or the termination of the Consumer's right to self-direct his or her care.
8. Though SRS is not a party to this Agreement, the parties specifically intend that SRS be a third-party beneficiary and, as a result thereof, further acknowledge and agree that SRS may, at its option, enforce the terms of this Agreement.
9. In the event a new person is selected to provide self-directed services to the Consumer, the Consumer shall require the new DSW to execute a copy of this Agreement, with a copy of the same being provided to Another Day, Inc.
10. The parties shall not assign, subcontract, or delegate any duties or obligations required by this Agreement to any other individual, agency, or organization. This Agreement may only be modified by a written agreement signed by the parties hereto. 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. This Agreement supersedes all prior negotiations and agreements between the parties relative to the transaction and services contemplated by this Agreement, which contains the entire understanding of the parties. The terms and provisions of this Agreement shall be construed in accordance with and governed by the laws of the State of Kansas. In the event Judicial

Intervention is necessary, the parties agree that venue shall solely be in the District Court for Shawnee County, Kansas.

Date:

Direct Support Worker (DSW):

Date:



Greg G. Olson
Chief Executive Office, Another Day Inc.

I-9 Form

The I-9 Form is required by the Immigration and Naturalization Service to determine eligibility to work in the United States. The Direct Support Worker must complete **Section 1** of this form and provide an acceptable form of identification to Another Day, Inc. when returning the packet. Please Read the Instructions carefully and remember to provide proper identification. See “List of Acceptable Documents” to determine which documentation to provide. An example of acceptable documentation would be a driver’s license and a social security card.

Instructions

Please read all instructions carefully before completing this form.

Anti-Discrimination Notice. It is illegal to discriminate against any individual (other than an alien not authorized to work in the U.S.) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work eligible individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents presented have a future expiration date may also constitute illegal discrimination.

What Is the Purpose of This Form?

The purpose of this form is to document that each new employee (both citizen and non-citizen) hired after November 6, 1986 is authorized to work in the United States.

When Should the Form I-9 Be Used?

All employees, citizens and noncitizens, hired after November 6, 1986 and working in the United States must complete a Form I-9.

Filling Out the Form I-9

Section 1, Employee: This part of the form must be completed at the time of hire, which is the actual beginning of employment. Providing the Social Security number is voluntary, except for employees hired by employers participating in the USCIS Electronic Employment Eligibility Verification Program (E-Verify). **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

Preparer/Translator Certification. The Preparer/Translator Certification must be completed if **Section 1** is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete **Section 1** on his/her own. However, the employee must still sign **Section 1** personally.

Section 2, Employer: For the purpose of completing this form, the term "employer" means all employers including those recruiters and referrers for a fee who are agricultural associations, agricultural employers or farm labor contractors.

Employers must complete **Section 2** by examining evidence of identity and employment eligibility within three (3) business days of the date employment begins. If employees are authorized to work, but are unable to present the required

document(s) within three business days, they must present a receipt for the application of the document(s) within three business days and the actual document(s) within ninety (90) days. However, if employers hire individuals for a duration of less than three business days, **Section 2** must be completed at the time employment begins. **Employers must record:**

1. Document title;
2. Issuing authority;
3. Document number;
4. Expiration date, if any; and
5. The date employment begins.

Employers must sign and date the certification. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. These photocopies may only be used for the verification process and must be retained with the Form I-9. **However, employers are still responsible for completing and retaining the Form I-9.**

Section 3, Updating and Reverification: Employers must complete **Section 3** when updating and/or reverifying the Form I-9. Employers must reverify employment eligibility of their employees on or before the expiration date recorded in **Section 1**. Employers **CANNOT** specify which document(s) they will accept from an employee.

- A. If an employee's name has changed at the time this form is being updated/reverified, complete Block A.
- B. If an employee is rehired within three (3) years of the date this form was originally completed and the employee is still eligible to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.
- C. If an employee is rehired within three (3) years of the date this form was originally completed and the employee's work authorization has expired **or** if a current employee's work authorization is about to expire (reverification), complete Block B and:

1. Examine any document that reflects that the employee is authorized to work in the U.S. (see List A **or** C);
2. Record the document title, document number and expiration date (if any) in Block C, and
3. Complete the signature block.

What Is the Filing Fee?

There is no associated filing fee for completing the Form I-9. This form is not filed with USCIS or any government agency. The Form I-9 must be retained by the employer and made available for inspection by U.S. Government officials as specified in the Privacy Act Notice below.

USCIS Forms and Information

To order USCIS forms, call our toll-free number at **1-800-870-3676**. Individuals can also get USCIS forms and information on immigration laws, regulations and procedures by telephoning our National Customer Service Center at **1-800-375-5283** or visiting our internet website at **www.uscis.gov**.

Photocopying and Retaining the Form I-9

A blank Form I-9 may be reproduced, provided both sides are copied. The Instructions must be available to all employees completing this form. Employers must retain completed Forms I-9 for three (3) years after the date of hire or one (1) year after the date employment ends, whichever is later.

The Form I-9 may be signed and retained electronically, as authorized in Department of Homeland Security regulations at 8 CFR § 274a.2.

Privacy Act Notice

The authority for collecting this information is the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 USC 1324a).

This information is for employers to verify the eligibility of individuals for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The form will be kept by the employer and made available for inspection by officials of U.S. Immigration and Customs Enforcement, Department of Labor and Office of Special Counsel for Immigration Related Unfair Employment Practices.

Submission of the information required in this form is voluntary. However, an individual may not begin employment unless this form is completed, since employers are subject to civil or criminal penalties if they do not comply with the Immigration Reform and Control Act of 1986.

Paperwork Reduction Act

We try to create forms and instructions that are accurate, can be easily understood and which impose the least possible burden on you to provide us with information. Often this is difficult because some immigration laws are very complex. Accordingly, the reporting burden for this collection of information is computed as follows: **1)** learning about this form, and completing the form, 9 minutes; **2)** assembling and filing (recordkeeping) the form, 3 minutes, for an average of 12 minutes per response. If you have comments regarding the accuracy of this burden estimate, or suggestions for making this form simpler, you can write to: U.S. Citizenship and Immigration Services, Regulatory Management Division, 111 Massachusetts Avenue, N.W., 3rd Floor, Suite 3008, Washington, DC 20529. OMB No. 1615-0047.

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

Form I-9, Employment Eligibility Verification

Please read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification. To be completed and signed by employee at the time employment begins.

Print Name: Last	First	Middle Initial	Maiden Name
Address (Street Name and Number)		Apt. #	Date of Birth (month/day/year)
City	State	Zip Code	Social Security #

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):

- A citizen or national of the United States
- A lawful permanent resident (Alien #) A _____
- An alien authorized to work until _____
(Alien # or Admission #) _____

Employee's Signature	Date (month/day/year)
----------------------	-----------------------

Preparer and/or Translator Certification. (To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Preparer's/Translator's Signature	Print Name
Address (Street Name and Number, City, State, Zip Code)	Date (month/day/year)

Section 2. Employer Review and Verification. To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number and expiration date, if any, of the document(s).

List A	OR	List B	AND	List C
Document title: _____		_____	_____	_____
Issuing authority: _____		_____	_____	_____
Document #: _____		_____	_____	_____
Expiration Date (if any): _____		_____	_____	_____
Document #: _____		_____	_____	_____
Expiration Date (if any): _____	_____	_____	_____	_____

CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) _____ and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment.)

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name and Address (Street Name and Number, City, State, Zip Code)		Date (month/day/year)

Section 3. Updating and Reverification. To be completed and signed by employer.

A. New Name (if applicable)	B. Date of Rehire (month/day/year) (if applicable)
-----------------------------	--

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.

Document Title: _____ Document #: _____ Expiration Date (if any): _____

I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible 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	Date (month/day/year)
--	-----------------------

LISTS OF ACCEPTABLE DOCUMENTS

LIST A Documents that Establish Both Identity and Employment Eligibility	LIST B Documents that Establish Identity	LIST C Documents that Establish Employment Eligibility
OR	AND	
1. U.S. Passport (unexpired or expired)	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. U.S. Social Security card issued by the Social Security Administration (<i>other than a card stating it is not valid for employment</i>)
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 (<i>Form FS-545 or Form DS-1350</i>)
3. An unexpired foreign passport with a temporary I-551 stamp	3. School ID card with a photograph	3. Original or certified copy of a birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official seal
4. An unexpired Employment Authorization Document that contains a photograph (Form I-766, I-688, I-688A, I-688B)	4. Voter's registration card	4. Native American tribal document
	5. U.S. Military card or draft record	5. U.S. Citizen ID Card (<i>Form I-197</i>)
5. An unexpired foreign passport with an unexpired Arrival-Departure Record, Form I-94, bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, if that status authorizes the alien to work for the employer	6. Military dependent's ID card	6. ID Card for use of Resident Citizen in the United States (<i>Form I-179</i>)
	7. U.S. Coast Guard Merchant Mariner Card	
	8. Native American tribal document	7. Unexpired employment authorization document issued by DHS (<i>other than those listed under List A</i>)
	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	

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

Form W-4 (2011)

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

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2011 expires February 16, 2012. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds \$950 and includes more than \$300 of unearned income (for example, interest and dividends).

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

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 costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using

Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 919 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2011. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself if no one else can claim you as a dependent	A	<u> </u>
B	Enter "1" if: { <ul style="list-style-type: none"> • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. }	B	<u> </u>
C	Enter "1" for your spouse . But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C	<u> </u>
D	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return	D	<u> </u>
E	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above)	E	<u> </u>
F	Enter "1" if you have at least \$1,900 of child or dependent care expenses for which you plan to claim a credit (Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F	<u> </u>
G	Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. <ul style="list-style-type: none"> • If your total income will be less than \$61,000 (\$90,000 if married), enter "2" for each eligible child; then less "1" if you have three or more eligible children. • If your total income will be between \$61,000 and \$84,000 (\$90,000 and \$119,000 if married), enter "1" for each eligible child plus "1" additional if you have six or more eligible children 	G	<u> </u>
H	Add lines A through G and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.) ▶	H	<u> </u>
	For accuracy, complete all worksheets that apply. { <ul style="list-style-type: none"> • If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2. • If you have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$40,000 (\$10,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld. • If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below. }		

----- Cut here and give Form W-4 to your employer. Keep the top part for your records. -----

Form W-4 Department of the Treasury Internal Revenue Service	<h2 style="margin: 0;">Employee's Withholding Allowance Certificate</h2> <p style="margin: 0;">▶ 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.</p>	OMB No. 1545-0074 2011
1 Type or print your first name and middle initial. Last name		2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> 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. ▶ <input type="checkbox"/>
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)	5 <u> </u>	
6 Additional amount, if any, you want withheld from each paycheck	6 \$ <u> </u>	
7 I claim exemption from withholding for 2011, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> • 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 <u> </u>
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 lines 8 and 10 only if sending to the IRS.)		9 Office code (optional)
		10 Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2011 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions	1	\$ _____
2	Enter: $\left\{ \begin{array}{l} \$11,600 \text{ if married filing jointly or qualifying widow(er)} \\ \$8,500 \text{ if head of household} \\ \$5,800 \text{ if single or married filing separately} \end{array} \right\}$	2	\$ _____
3	Subtract line 2 from line 1. If zero or less, enter “-0-”	3	\$ _____
4	Enter an estimate of your 2011 adjustments to income and any additional standard deduction (see Pub. 919)	4	\$ _____
5	Add lines 3 and 4 and enter the total. (Include any amount for credits from the <i>Converting Credits to Withholding Allowances for 2011 Form W-4 Worksheet</i> in Pub. 919.)	5	\$ _____
6	Enter an estimate of your 2011 nonwage income (such as dividends or interest)	6	\$ _____
7	Subtract line 6 from line 5. If zero or less, enter “-0-”	7	\$ _____
8	Divide the amount on line 7 by \$3,700 and enter the result here. Drop any fraction	8	_____
9	Enter the number from the Personal Allowances Worksheet , line H, page 1	9	_____
10	Add lines 8 and 9 and enter the total here. If you plan to use the Two-Earners/Multiple Jobs Worksheet , also enter this total on line 1 below. Otherwise, stop here and enter this total on Form W-4, line 5, page 1	10	_____

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the Deductions and Adjustments Worksheet)	1	_____
2	Find the number in Table 1 below that applies to the LOWEST paying job and enter it here. However , if you are married filing jointly and wages from the highest paying job are \$65,000 or less, do not enter more than “3”	2	_____
3	If line 1 is more than or equal to line 2, subtract line 2 from line 1. Enter the result here (if zero, enter “-0-”) and on Form W-4, line 5, page 1. Do not use the rest of this worksheet	3	_____
Note. If line 1 is less than line 2, enter “-0-” on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.			
4	Enter the number from line 2 of this worksheet	4	_____
5	Enter the number from line 1 of this worksheet	5	_____
6	Subtract line 5 from line 4	6	_____
7	Find the amount in Table 2 below that applies to the HIGHEST paying job and enter it here	7	\$ _____
8	Multiply line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	\$ _____
9	Divide line 8 by the number of pay periods remaining in 2011. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2010. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	\$ _____

Table 1

Table 2

Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above	If wages from HIGHEST paying job are—	Enter on line 7 above	If wages from HIGHEST paying job are—	Enter on line 7 above
\$0 - \$5,000 -	0	\$0 - \$8,000 -	0	\$0 - \$65,000	\$560	\$0 - \$35,000	\$560
5,001 - 12,000 -	1	8,001 - 15,000 -	1	65,001 - 125,000	930	35,001 - 90,000	930
12,001 - 22,000 -	2	15,001 - 25,000 -	2	125,001 - 185,000	1,040	90,001 - 165,000	1,040
22,001 - 25,000 -	3	25,001 - 30,000 -	3	185,001 - 335,000	1,220	165,001 - 370,000	1,220
25,001 - 30,000 -	4	30,001 - 40,000 -	4	335,001 and over	1,300	370,001 and over	1,300
30,001 - 40,000 -	5	40,001 - 50,000 -	5				
40,001 - 48,000 -	6	50,001 - 65,000 -	6				
48,001 - 55,000 -	7	65,001 - 80,000 -	7				
55,001 - 65,000 -	8	80,001 - 95,000 -	8				
65,001 - 72,000 -	9	95,001 -120,000 -	9				
72,001 - 85,000 -	10	120,001 and over	10				
85,001 - 97,000 -	11						
97,001 -110,000 -	12						
110,001 -120,000 -	13						
120,001 -135,000 -	14						
135,001 and over	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 who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

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

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

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

Direct Deposit

Direct Deposit is highly encouraged. There are several benefits to direct deposit, including that it is the fastest way to receive your pay. Other benefits include:

- Direct Deposit is FREE!!!
- Direct Deposit will always be deposited into your account as soon as the payroll is processed; occasionally paper checks can get stuck in the mail an extra day.
- Paper checks are NOT as safe and can be lost or stolen in the mail or from your mailbox.
- With paper checks you have to go to the bank and wait to deposit the money, direct deposit takes care of this for you.
- Banks prefer direct deposit because it is automated and reduces the chance of errors when processing your checks.

Form:

Please attach a voided check or bank card information with bank routing number and account number. Your information will be kept in a secure area. If you change banks or close your account PLEASE let us know immediately so we can update your direct deposit information. This will ensure your payments are sent to the correct account. Thank you!

Print Name: _____

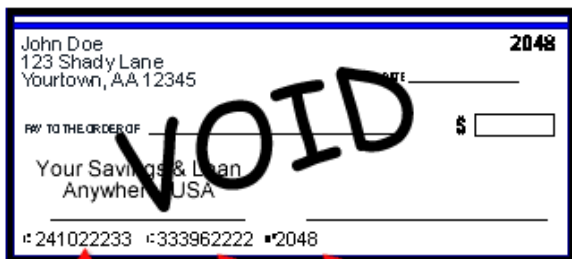
Bank Name: _____

Account Type: Checking _____ Savings _____

Signature: _____

We will need **your routing and account number**, so **please attach a VOIDED CHECK:**

Example Check



Routing Number	Account Number	Check Number
241022233	333962222	2048
<small>(9 digits: begins w/ 01-12 or 21-32)</small>		

Address: 11802 W 77th St. Lenexa, KS 66214

Phone: 913-599-2221 Fax: 913-599-5660 Toll Free: 1-866-599-2221

Website: www.anotherday.info E-mail: office@anotherday.info

DD