



Fiscal Management Services

504 Miller Drive PO Box 408 Wamego, KS 66547

FMS: 785-456-8573 Main: 785-456-9915

Fax: 785-456-9923 Text: 844-617-9689

Email: fms@threeriversinc.org

Direct Service Worker Application Packet

3Rivers Financial Management Services (FMS) connects compassionate, dependable individuals with Consumers enrolled in 3Rivers' services. 3Rivers **does not** employ or place Direct Service Workers; we serve as payroll agent on behalf of our Consumers, who are tasked with employing and directing their workers.

Please review and complete all sections of the attached application.

Position Requirements:

- Must be 18 years of age or older
- Access to reliable transportation
- Clearance of Background Checks – **There is a \$20.00 charge for background checks which must be included with your application.**

Required Documents:

- Copy of Valid Driver's license or State ID (front and back)
- Copy of Social Security card (front and back)

ATTENTION! ALL FORMS OF ID **MUST** REFLECT YOUR LEGAL NAME/IDENTITY.

Failure to provide these documents will prevent the completion of your application until received.

Additional Information:

- Experience preferred
- High School Diploma or GED preferred
- Use secure mobile app on your phone for time tracking

Items to return include:

- Completed Application
- Copy of current Driver's License, or State ID (front and back)
- Copy of Social Security card (front and back)
- \$20.00 Background Check fee – **pay by cash, check, or credit/debit card.**

Email, Fax, Mail, or Drop Off application when completed.

Make Checks Payable to

Three Rivers Inc.
504 Miller Dr
PO Box 408
Wamego, KS 66547

or Contact 3Rivers FMS team to pay by card.

NOTE: You are not eligible to work until background checks are completed. You will be notified when you are eligible to work in a Medicaid funded program, typically two weeks from submittal date. KS Statute 39-2009 specifies adverse findings and offenses that would prevent someone from qualifying; you may request additional information by contacting the FMS team at 3Rivers.



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Complete All Information Below. Information Must Match Your Social Security Card

Note: 3Rivers neither employs nor places in home workers. 3Rivers serves as a payroll agent for individuals seeking in-home workers. 3Rivers processes applications, manages payroll duties and maintains a registry of qualified workers.

NAME _____ DATE OF BIRTH ____/____/____
Last First Middle

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ COUNTY: _____

SOCIAL SECURITY NUMBER: _____ CELL PHONE: (____) _____

Do you agree to opt in for text messaging? YES _____ NO _____ (You can opt out anytime by replying STOP)

EMAIL ADDRESS: _____ HOME PHONE: (____) _____

EMERGENCY CONTACT PERSON: _____ PHONE: (____) _____

- ☐ Yes ☐ No Have you graduated from high school or received a GED Certificate?
- ☐ Yes ☐ No Are you legally permitted to work in the United States?
- ☐ Yes ☐ No Do you have a valid driver's license? By completing this application you are authorizing Three Rivers to run a check with the state of issue for violations on your driving record.*
- ☐ Yes ☐ No *If yes, do you maintain the necessary auto liability insurance as required by the state of Kansas?
- ☐ Yes ☐ No *If yes, are you willing and able to provide transportation for your consumer/employer?
- ☐ Yes ☐ No Have you ever been convicted of a felony? If yes, what state(s) _____
(certain convictions will prohibit you from being hired)
- ☐ Yes ☐ No Do you have a current CNA or CMA license? If yes, please attach certificate to application.
- ☐ Yes ☐ No Duties of a Direct Service Worker often require ability to lift a minimum of 25 lbs. Do you have any limitations that a Consumer should be aware of? If yes, please explain: _____
- ☐ Yes ☐ No Have you been enrolled with 3Rivers Financial Management Services under a different name?
If yes, previous name: _____
- ☐ Yes ☐ No Direct Service Worker Registry – Three Rivers, Inc. maintains a list of workers that is handed out to our Consumers seeking new Direct Service Workers. Would you like to be included on this list?

If you are completing this application to work for a particular Consumer, please provide us their name:

Application and required documents should be returned to:
Three Rivers, Inc. Fiscal Agent
Attn: FMS
P.O. Box 408
Wamego, Kansas 66547-0408

Providing Fiscal Management Services (FMS) for individuals self-directing their in-home services since 1990
Serving 13 counties in Kansas.

www.threeriversinc.org



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Memorandum of Understanding Between 3Rivers Fiscal Agent and the Direct Service Worker

What are SELF-DIRECTED SERVICES?

Under Kansas Medicaid rules, qualifying individuals (known as Consumers) can self-direct their services to assist them in living independently in their homes. The Consumer you are enrolling to work for has chosen this option and will direct you in all aspects of your work. The Consumer – your employer – is responsible for hiring, training, scheduling, monitoring, and terminating their employees. Individuals in Self-Directed programs have plans of care that outline services allowed, with weekly and monthly caps on allowable hours.

How is Three Rivers, Inc., Fiscal Agent involved?

3Rivers Fiscal Agent (FA) has been selected by your employer to provide payroll and financial management services (FMS) on their behalf. 3Rivers processes required financial and human resources paperwork necessary for your employment. On behalf of your employer, 3Rivers FA will assist you with paperwork, training for timekeeping systems, and will process payroll for authorized hours of work.

3Rivers FA neither hires nor places workers.

Please initial beside each below. Three Rivers, Inc., Fiscal Agent Expectations as your Payroll agent:

_____ I understand that the Consumer for whom I am working is my employer/supervisor and is responsible for training, scheduling, terminating employment, and monitoring my time worked.

_____ I am responsible for discussing employment disputes, including wage disputes, with my employer. My employer may ask me to contact 3Rivers FA staff for specific information and to provide me additional training.

_____ I am responsible for notifying 3Rivers FA of any relationship to/for the person I work for, including guardian, conservator, personal representative, payee, or durable power of attorney. Failure to disclose this information may lead to recoupment of wages and/or termination.

_____ I will NOT share medical/personal information about my employer without a signed release by my employer allowing me to share specific information. This includes talking to family and friends of my employer.

_____ I understand I am an “employee-at-will” and may be terminated with or without cause.

_____ I understand falsifying documents or AuthentiCare time tracking will be reported to authorities as attempted Medicaid Fraud prosecutable through the Kansas Attorney General’s Office.

_____ I understand 3Rivers FA is not authorized to pay me for hours worked outside the scope of my employer’s Plan of Care developed with their insurance provider. I understand my employer must be present while I’m working. **Employers are responsible for DSW wages for hours worked beyond or outside their plan of care.**

Direct Service Worker Signature

Date



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Termination Notification Policy

____ As a Direct Service Worker, I understand I am employed by the participant enrolled in 3Rivers financial management services program *and* that 3Rivers' FMS team manages unemployment claims with, and on behalf, of the participant, THEREFORE,

____ I understand if for any reason my employment ends with this participant; I WILL contact 3Rivers' FMS at 785-456-8573 *within 3 days*.

Failure to contact 3Rivers will indicate that I am no longer interested in providing personal services for participants enrolled with this payroll agency, *and* that I do not wish to remain on the worker registry list provided to Three Rivers' consumers seeking workers.

Direct Service Worker Signature

Date

My Signature Indicates I have read and understand the above employment notification policy.



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Direct Service Worker

Mandatory Use of AuthentiCare

For Medicaid Funded In Home Services (HCBS)

What is AuthentiCare?

AuthentiCare is an Electronic Verification System that Direct Service Workers (DSW) use to clock in and out when providing services for your Consumer/employer as outlined in their care plan.

Use of AuthentiCare:

DSWs and employers are **REQUIRED** by the state of Kansas to use this service to document time worked for HCBS Consumers. Failure to do so may result in the termination of the employer's right to self-direct their Medicaid funded services or a termination of all services.

Kansas Medicaid funded services, requires the HCBS Consumer/employer to have a landline phone for the DSW to call into the AuthentiCare system, **OR**, the DSW can download the AuthentiCare mobile app on their (the DSW's) smartphone. Again, the use of AuthentiCare is mandatory for HCBS participants.

The AuthentiCare system rounds time worked to the nearest 15-minute interval. For example, if you clock out at 7:06pm, AuthentiCare will round back to a 7:00pm clock out time. If you clock out at 7:08pm, AuthentiCare will round up to a 7:15pm clock out time. This occurs during both clock in and clock out. The system will provide a report of time used so Consumers and DSW's can monitor this. 3Rivers provides training on this system.

What if a clock in and/or out is missed?

If a clock in and/or out is missed, your employer should immediately contact 3Rivers to report your time worked and duties performed. *Call 785-456-9915 option #3 to report this information.*

3Rivers FMS department may request a signed timesheet to verify this information.

Hours of Work and Pay Schedule:

- *Your employer's care plan guides approved duties and does not cover overtime wages!*
- Your employer's care plan has weekly limits and monthly limits. You should carefully track your time
- 3Rivers is not authorized to pay DSWs for hours worked over these weekly/monthly units, if you work hours beyond the care plan allowance, your Consumer/Employer is responsible for payment.
- You are responsible for discussing your work schedule with your employer and any planned absences should be approved by your employer.
- A pay week starts on Sunday and ends on Saturday. Workers are paid every other Friday.

Direct Service Worker Signature

Date



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By accepting Medicaid Funds, you 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:

- Claiming time worked when the consumer is out of the home due to hospitalization, nursing facility, rehabilitation facility or incarceration (jail or prison)
- DSWs (Direct Support Workers) submitting time when not actually working
- Employers/consumers submitting time for a worker who is not working
- Using someone else's worker ID to submit time
- 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 worker

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 3Rivers 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



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General Policy

Abuse, Neglect and Exploitation

All participant, direct service workers, and Three Rivers, Inc., Fiscal Agent employees' reserve the right and responsibility to report to the state of Kansas any suspected abuse, neglect, or exploitation. If you suspect a participant is being abused, neglected, or exploited, you will contact the *Kansas Protection Report Center* at 1-800-922-5330. Your identity will be kept confidential. The Kansas Protection Report Center is staffed 24 hours a day. In the event of an emergency, call 911. If Medicaid fraud or abuse is suspected, you will report it immediately to 1-866-551-6328.

Injury in the Workplace Must Be Reported Immediately

If you are injured while working for a participant and require immediate medical attention, go to the nearest emergency room. You are required to submit to drug-testing at the time of your treatment. Failure to submit to drug-testing may be grounds for termination. You, or the participant on your behalf, must contact the Three Rivers, Inc. FMS at 785-456-8573 regarding the injury within 24 hours, regardless of if the timeframe falling on a weekend or holiday. If the FMS Coordinator is unavailable, you must leave a detailed message. You will be contacted by the FMS Coordinator within one business day.

Additionally, you are responsible to:

- Ensure the hospital/clinic/doctor's office is informed the injury occurred on the job and related medical bills should be sent to Three Rivers, Inc., Fiscal Agent.
- Complete an *Employee's Report of Accident* form and an *Authorization Form for Release of Protected Health Information* (supplied by Three Rivers, Inc.) and return them to Three Rivers, Inc. as soon as possible, but no later than one week from the date of accident.
- Request any witness/witness' complete an Accident Witness Statement and send it to Three Rivers, Inc.

Three Rivers, Inc., Fiscal Agent reserves the right to determine your treating physician. Your privilege preventing the furnishing of medical information is waived when seeking worker's compensation benefits. Unreasonable refusal to cooperate may result in compensation being denied or terminated. All alleged violations, including fraud or abusive acts, with regards to the *Worker's Compensation Act* will be reported immediately to the Kansas Division of Worker's Compensation Ombudsman/Claims Advisory Unit for answers to questions, assistance with claim information and problems by calling toll free 1-800-332-0353.

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Date



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Direct Deposit Authorization Form

PAYROLL INSTRUCTIONS – Indicate below your choice to receive your paycheck biweekly on Fridays by direct deposit. Please double check your information to avoid payroll errors. Regardless of pay method; you will receive an email with a link to open your paystub when your pay is processed. Please provide the email you would like to use here:

Email: _____ @ _____

_____ I would like my wages deposited to my **CHECKING** account.

Bank Name * _____

Routing Number * _____ Account Number * _____

_____ I would like my wages deposited to my **SAVINGS** account.

Bank Name * _____

Routing Number * _____ Account Number * _____

_____ I would like my wages deposited to a **PAYROLL CARD**.

_____ **WISELY PAY CARD** provided and mailed by Three Rivers.

_____ **PAY CARD** you provide:

Routing number * _____ Account number * _____

Please make sure to include the ENTIRE routing and account number. A debit card will be issued if banking account information is not provided.

This authority is to remain in full effect until Employer or Financial Institution has received written notification from me fourteen (14) days prior to its termination, or until Employer or Financial Institution has sent me written notice of the Employer's or Financial Institution's termination of this agreement. It is my understanding that my paycheck will be deposited on payday, unless said day is not a banking day. I further acknowledge that in the event of mechanical or technological failure, or other circumstances beyond the control of the Employer or Financial Institution in connection with this service, I will accept my earned compensation in an alternative fashion customary with Employer's policies and procedures. In the event a transaction is rejected by the Receiving Depository Financial Institution due to the closing of an account or incorrect information given by me, I authorize the company to deduct from my compensation, the amount of any administrative fee charged by Employer's Financial Institution for the notification of said rejection. It is my understanding this enrollment is automatically cancelled upon the termination of my employment.

Employee Signature: _____ Date: _____

Print Name: _____ Phone Number: _____

Attach voided check here.
(REQUIRED for a checking account.)

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)

K-4

(Rev. 7-24)

KANSAS**EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE**K-4
Attach
500524

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 re-figure your withholding each year.

Exemption from Kansas withholding: To qualify for exempt status you must verify with the Kansas Department of 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).**

Non-wage income: If you have a large amount of non-wage *Kansas* source income, such as interest or dividends, consider making *Kansas* 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

- A Allowance Rate:** If you are a single filer mark "Single" **A** ☐ Single
 If you are married and your spouse has income mark "Single" ☐ Joint
 If you are married and your spouse does not have income mark "Joint"
- B** Enter "0" or "1" if you are married or single (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** _____

K-4

(Rev. 7-24)

Kansas Employee's Withholding Allowance Certificate

Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the Kansas Department of Revenue. Your employer may be required to send a copy of this form to the 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. ☐ 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 the conditions above, 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 ID Number) _____	



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Direct Service Worker Release for Information for Background Checks

I have applied for employment as a Direct Service Worker (DSW) for a participant who uses Three Rivers, Inc., Fiscal Agent. I authorize Three Rivers Inc. Fiscal Agent to seek required background checks on me from the Kansas Bureau of Investigation and any other agency or organization.

I authorize Three Rivers Inc. Fiscal Agent to share the information found in the background check with any participant(s) I may work for, his/her personal representative, or his/her Independent Living Counselor/Case Manager.

I understand Three Rivers Inc. Fiscal Agent does not compile the information found in the background checks and is not responsible for any errors that may be contained in the report(s). If any derogatory information is found while conducting the background check, Three Rivers, Inc. Fiscal Agent will provide me with a copy of the derogatory report.

Direct Service Worker Signature

Date



Release of Information Child and/or Adult Abuse and Neglect Central Registry Form

OBI 1011
REV. Jan. 2026
Page 1 of 1

I give permission to check my personal information against the following registries:

☐ Child (\$10 per person) ☐ Adult (Free) ☒ Both (\$10 per person)

Confidentiality: Kansas Department for Children and Families' 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.

Return results by encrypted email to the following email addresses:

cynthiag@threeriversinc.org ; _____ ; _____ ;
_____ ; _____

Payment/Account Information (Child Registry Only)

☐	Online Payment	Credit Card
☒	Pre-Pay Account	FEIN (XX-XXXXXXX): 32-0453490
☐	Mentoring Account	Agency:
☐	Exempt	No fee for state government agencies (sub-contracting agencies not included).

I give permission for the release of any of my information in the Child and/or Adult Abuse/Neglect Central Registry to the contacts listed above. I understand the information released is for their exclusive and confidential use.

☒ Yes ☐ No

First Name: _____ Middle Name: _____ Last Name: _____

Other Names Used: _____ , _____ , _____

Date of Birth: _____ Race: _____ Social Security Number: _____

Gender: ☐ Male ☐ Female Address: _____

City: _____ State: _____ Zip Code: _____ Phone Number: _____

Email: _____

Signature: _____ Date: _____

*Signature must be ink or electronically verified by a reputable company.

Applicant is under the age of 16 and I am (relationship to applicant): _____

Results will be sent electronically.

*This form is to remain on file for the duration of the active relationship between the agency and the person being searched.
DCF reserves the right to audit at any time to make sure all forms are up to date and on file.



Employment Eligibility Verification

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

USCIS
Form I-9

OMB No. 1615-0047
Expires 05/31/2027

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. An alien authorized to work until (exp. date, if any) If you check Item Number 4., enter one of these: <table border="1"><tr><td>USCIS A-Number</td><td>OR</td><td>Form I-94 Admission Number</td><td>OR</td><td>Foreign Passport Number and Country of Issuance</td></tr></table>							USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance
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)		Additional Information								
Issuing Authority										
Document Number (if any)										
Expiration Date (if any)										
Document Title 3 (if any)		☐ Check here if you used an alternative procedure authorized by DHS to examine documents.								
Issuing Authority										
Document Number (if any)										
Expiration Date (if any)										
Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States. <table border="1"><tr><td>Last Name, First Name and Title of Employer or Authorized Representative</td><td>Signature of Employer or Authorized Representative</td><td>Today's Date (mm/dd/yyyy)</td></tr></table> <table border="1"><tr><td>Employer's Business or Organization Name</td><td>Employer's Business or Organization Address, City or Town, State, ZIP Code</td></tr></table>						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
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 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 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. 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		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, sex, height, eye color, and address 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, sex, height, eye color, and address 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 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		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. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 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. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 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.
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.



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

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

**USCIS
Form I-9
Supplement A**
OMB No. 1615-0047
Expires 05/31/2027

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

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

Signature of Preparer or Translator		Date (mm/dd/yyyy)	
Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	
Address (Street Number and Name)	City or Town	State	ZIP Code

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

Signature of Preparer or Translator		Date (mm/dd/yyyy)	
Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	
Address (Street Number and Name)	City or Town	State	ZIP Code

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

Signature of Preparer or Translator		Date (mm/dd/yyyy)	
Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	
Address (Street Number and Name)	City or Town	State	ZIP Code

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

Signature of Preparer or Translator		Date (mm/dd/yyyy)	
Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	
Address (Street Number and Name)	City or Town	State	ZIP Code



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

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

**USCIS
Form I-9
Supplement B**
OMB No. 1615-0047
Expires 05/31/2027

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

Date of Rehire (if applicable)		New Name (if applicable)	
Date (mm/dd/yyyy)	Last Name (Family Name)	First Name (Given Name)	Middle Initial
Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.			
Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)	
I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.			
Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)
Additional Information (Initial and date each notation.)			☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire (if applicable)		New Name (if applicable)	
Date (mm/dd/yyyy)	Last Name (Family Name)	First Name (Given Name)	Middle Initial
Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.			
Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)	
I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.			
Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)
Additional Information (Initial and date each notation.)			☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire (if applicable)		New Name (if applicable)	
Date (mm/dd/yyyy)	Last Name (Family Name)	First Name (Given Name)	Middle Initial
Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.			
Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)	
I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.			
Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)
Additional Information (Initial and date each notation.)			☐ Check here if you used an alternative procedure authorized by DHS to examine documents.