HIRING INSTRUCTIONS

FOR

CHOICE VOUCHER

Prior to hiring a new worker

1. Must have potential employee full out recipient rights form and criminal background check authorization form. Criminal background check must have employer's name at the top, employee's name and information in the middle with signatures and your (employer's) information at the bottom. You MUST include a copy of the employer's driver's license and social security card – background checks cannot be processed without it.
2. *Send to Stuart Wilson or Ben Tenney at BABH -*
   - Stuart's fax – (989) 832-5404
     Stuart's email – training@stuartwilsonfi.com
   - Ben's fax – (989) 497-1569
     Ben's email – btenney@babha.org
   - You can also drop it off at Ben's office – 201 Mulholland, 3rd Floor Behavioral Health Center, Bay City.
3. Once Stuart's office gets the results they will call you. Our office can mail you a new hire packet or leave at the front desk for you to pick up. Call either Susan Curtis at 989-895-2277 or Ben Tenney 989-316-6120 to request a packet. Please let us know your preference.

Instructions for New Hire Packet

*Please print in dark ink (except signature line)

1. **CBC (Criminal Background Check) –** Needs to be completed and have the results back from check before employee can start working.
2. **Central Registry Clearance Request –** fill out section one, sign and date.
3. **ORR (Recipient Rights Check) -** Needs to be completed and have the results back from check before employee can start working.
4. **Employee Wage Information** – fill out all information. Vacation pay is typically not applicable.
5. **Employee Eligibility Checklist** – employee must read and sign/date the bottom. If they check any of the boxes they cannot work for you.
6. **Medicaid Provider paperwork for Self Determination participants** – both employee and employer must sign.
7. **Payroll Procedures** – have employee read and sign at the bottom.
8. **Direct Deposit Form** – If employee is interested have them fill everything our and sign. A copy of a voided check is not required.
9. **W-4 Federal Form** – employee must fill out steps 1 & 5. You can fill out steps 2-4 if they apply, but it is not necessary.
10. **W-4 State Form** – Employee must fill our I-8, sign #9. Employer name and address on #10.
11. **Employment Eligibility Verification (I-9)** – employee fills out page 1, the highlighted boxes, signs and dates. Employer information on page 2, highlighted box and signature.
12. **Medicaid Provider Agreement** – fill in date and employee's name on front page. Employee signs page 2. Leave self-determination coordinator line blank.
13. **Employment Agreement** – fill in date, employer and employee name in first section. Fill in contact person (of employer, not employee) on #3.
    Page 2 – fill in rate of pay on #13 (call Chelli or Stuart Wilson's office if unsure).

Page 3 – Employer's name on first line indicated.
Rate of pay on 2nd line.
Both employee and employer must sign the bottom.

14. **Choice Voucher Provider Agreement** – employee signs first line and leave second line for Chelli to sign.
15. **Job Description** – check the items/tasks that are relevant to your employee. Fill in any special rules/requests on page 2. Both employee and employer sign.
16. **Basic First Aid/Bloodborne Pathogens Quiz** – Have employee read all training literature and take the first aid quiz.
17. **Recipient Rights Quiz** – Have employee read literature and take the quiz.
18. **Environmental Emergencies Quiz** – Have employee read literature and take the quiz.
19. **Plan of Service Training Form (POS)** – Your supports coordinator/case manager will provide you with this form after the PCP. This is an extra copy if needed.

STUART T. WILSON CPA, PC
Fiscal Intermediary

Criminal Background Check Authorization Form

Do not provide any services prior to authorization.
You will not be paid for any time worked prior to a clear criminal background check and the completion of required trainings.

Employer (Participant): _____ Organization/Agency: BABH

Employee Full Name: _____

Previous Names Used (Include maiden name): _____

_____

Date of Birth: _____ Sex: _____ Race: _____

Driver's License #: _____

Social Security #: _____ Phone #: _____

You MUST include a copy of your Driver's License or State ID with this form.

I authorize the release of my criminal background information and driving record to my employer, to be run ongoing, and to the "Host Agency" which acts as project administrator; and to the "Fiscal Intermediary" which serves as my employer's financial administrator.

Furthermore, I acknowledge that I am required to notify Stuart T. Wilson CPA, PC as soon as possible, but no later than the next business day, if I have been convicted of any crime.

_____

Signature Date

Results are released to the participant/guardian or case manager.

For results contact:

Participant/Guardian Name: _____

Phone #: _____ Email: _____

or

Case Manager: _____

Phone #: _____ Email: _____

☐ I would also like a Driver's License Check conducted _____

Employer Initials

DHS-1929, CENTRAL REGISTRY CLEARANCE REQUEST

Michigan Department of Health and Human Services
(Revised 5-23)

COPY PHOTO ID HERE

OR

ATTACH A SEPARATE PAGE

SECTION 1 – INFORMATION ON PERSON BEING CLEARED

Name, (First, Middle, Last)

Maiden Name, Aliases, also known as (A.K.A)	Social Security Number	Date of Birth

Address	City	State	Zip Code

Phone Number	Email

☐ I would like to pick up my results in County (For Michigan Residents Only).

Signature Required for Individual Being Cleared Date

SECTION 2 – REQUESTER INFORMATION

Check Appropriate Box

☒ Employer
☐ Volunteer Agency
☐ Out-of-State Child Caring Institution
☐ Out-of-State Adoption/Foster Care Home Screening
☐ Michigan Court/Law Enforcement/Department of Corrections/Prosecuting Attorney
☐ Individual Self-Request

Name of Agency or Organization	Name of Requester
Stuart Wilson, CPA	

Address	City	State	Zip Code
6300 Schade Drive	Midland	MI	48642

Email	Fax	Phone Number
	989-832-5404	989-832-5400

Effective November 1, 2022, only confirmed cases of methamphetamine production, confirmed serious abuse or neglect, confirmed sexual abuse, or confirmed sexual exploitation will be classified as a central registry case in Michigan. Individuals may have child welfare history that previously resulted in central registry placement, but that would no longer meet the criteria. In addition, select criminal convictions involving children will result in placement on central registry.

This clearance does not identify individuals with child abuse/neglect history who did not meet the new central registry requirements as noted above or history in other states, territories, or tribal trust land.

With your signature, you are authorizing agencies to receive notice of all placements on central registry as allowable by Child Protection Law (MCL 722.627-722.627j).

The confidentiality of central registry information is protected by Sections 7 through 7j of the Michigan Child Protection Law (MCL 722.627-722.627j). Anyone who violates this protection is guilty of a misdemeanor and is civilly liable for damages.

AUTHORIZATION TO DISCLOSE
EMPLOYEE INFORMATION
AND RELEASE OF LIABILITY
(ORR CHECK)

I, _____ authorize Bay Arenac Behavioral Health (BABH) and the
(print full name)
BABH Office of Recipient Rights to disclose to the Provider/Consumer listed below any and all information in your possession regarding any violation of recipients' rights committed by me. I recognize that any disclosure cannot include confidential client information protected by any Federal, State, or common law.

I, _____ release BABH and BABH Office of Recipient Rights, its
(print full name)
officers, its agents and its employees for disclosing the information requested by me and I shall indemnify and hold harmless should any claims, suits or actions be filed against them.

PREVIOUS PLACES OF EMPLOYMENT:

1. _____ Dates employed: _____ to _____
2. _____ Dates employed: _____ to _____
3. _____ Dates employed: _____ to _____
4. _____ Dates employed: _____ to _____

_____ _____ _____
Applicant's Signature **Date** **Previous Names Used (print)**

_____ _____ _____
Witness Signature **Date** **Applicant's Birth Date**

INFORMATION TO BE SENT TO:

Stuart Wilson
Provider/Consumer

Street Address

989-832-5404
City **State** **Zip Code** **Fax**

RIGHTS OFFICE USE ONLY

The above applicant ☐ Does ☐ Does not have a substantiated recipient rights violation(s) according to BABH records.

By: _____ Date: _____
BABH Office of Recipient Rights

STUART T. WILSON CPA, PC
Fiscal Intermediary

Employee Wage Information

Employee Name: _____

Employee Phone #: (_____) _____

Employee Email: _____

Is your address the same as your employer? ☐ yes ☐ no

Are you the parent or legal guardian of your employer? ☐ yes ☐ no

This portion to be completed by the employer/representative.
Employers, please review your budget to ensure accuracy.

Hourly Rate: _____

Benefits: (If applicable)

Holiday Pay ☐
Employees receive time and a half for the 7 standard holidays, if worked. Seven standard holidays are New Year's Day, Easter, Memorial Day, July 4, Labor Day, Thanksgiving Day and Christmas Day.

Vacation/PTO ☐ _____hours per calendar year
Vacation time is calculated January-December. If left unused, it does not roll over. If employment is terminated or participant leaves the program, any unused vacation is forfeited.

Benefits are subject to budget allocation.

STUART T. WILSON CPA, PC
Fiscal Intermediary

Bay CMH Employee Eligibility Checklist

Please fill out and sign below to validate that Stuart Wilson FI has informed you on prohibited conflicts of interest based on Medicaid requirements.

Please check if any apply to you. If you **do** check any of the items below, you are **NOT** qualified to work for that "employer" (person receiving the service). If you have any questions please call your Supports Coordinator/Case Manager.

1. Community Living Supports (CLS) may not be provided by the following individuals.
Are you:

___ A spouse of the employer?
___ Parent of an employer who is a minor child?
___ The guardian of the employer, or co-guardian or alternate/standby guardian of employer?
___ Spouse of the employer's guardian or spouse of employer's co-guardian or alternate/standby guardian?
___ Individual designated by the employer as attorney-in-fact, or an alternate attorney-in-fact under a durable power of attorney?
___Spouse of individuals designated by the employer as attorney-in-fact or alternate attorney-in-fact under a durable power of attorney?
___ "Live-together" partner in which one partner is the guardian or attorney-in-fact for the employer?

2. Respite Care may not be provided by any of the persons listed above or the following.
Are you:

___Any of the persons listed above in section 1?
___Living in the home?
___ Unpaid primary caregiver of the person receiving services?

3. Stricter rules apply if your employer is enrolled in Children's Waiver (CW). CLS or Respite Care may not be provided by the following if your employer is enrolled in CW.
Are you:

___ Any of the persons listed above in sections 1 or 2?
___ Living in the same home as the employer?

If none of the above pertains to you, please check here____

_____ _____

Employee Signature **Date**

If at any time the above mentioned conditions should change, it is the responsibility of the employee to notify the supports coordinator/case manager.

STUART T. WILSON CPA, PC
Fiscal Intermediary

Bay-Arenac Behavioral Health

In order to be considered a Medicaid provider and be paid with Medicaid funds, this packet must be completed in its entirety. Do not provide any services prior to the notification of a clear background check.
The employment relationship is with the Participant and not with Stuart T. Wilson CPA, PC or Community Mental Health.
IMPORTANT: Please ensure this checklist is completed prior to submission. There are portions of this packet that must be completed by the employer. If an incomplete packet is submitted payment may be delayed.

- ☐ Criminal Background Check Authorization
- ☐ Recipient Rights Check Authorization
- ☐ W-4
- ☐ I-9 (Two forms of identification are required. Please refer to page three for all options.)
  - ○ Employer Signature on Page 2
  - ○ Copy of Driver's License
  - ○ Copy of Social Security Card
- ☐ Employment Agreement
  - ○ Employer Signature
  - ○ Employee Signature
- ☐ Medicaid Provider Agreement
  - ○ Provider Signature (Employee is the provider)
- ☐ Choice Voucher Provider Agreement
- ☐ Employee Eligibility Checklist
- ☐ Employee Wage Information
- ☐ Payroll Procedures (Please read carefully)
  - ○ Employee Signature
- ☐ Direct Deposit Application (Attachment required)
- ☐ IPOS Training
- ☐ Required Training (Training must be submitted with/by your first timesheet)

_____ _____

Employee Email Employee Phone #

If you have any questions, please feel free to contact the Personnel Department at 989-832-5400.
Return packet via Fax: 989-832-5404 Email: training@stuartwilsonfi.com
Mail: Stuart T. Wilson CPA, PC Attn: Personnel 6300 Schade Dr. Midland, MI 48640.

STUART T. WILSON CPA, PC
Fiscal Intermediary

PAYROLL PROCEDURES

In order to be paid correctly, avoid any delay, or forfeit the ability to be paid with Medicaid funds, the following payroll procedures must be followed:

Turning in Timesheets for Payment:

- **Please refer to the payroll calendar for scheduled pay days.**
  - All time worked must be reported within 14 days of the end of the pay period.
- **Timesheets received late and/or separate may not be paid on time.**
  - All timesheets for a Participant are to be faxed/e-mailed together by noon on Monday each week.
- **Only correct timesheets will be processed.**
  - If a timesheet contains omissions or errors, it will be returned to the employer and payment may be delayed.
  - Overlapping time with another provider will not be processed
  - Only authorized hours will be paid
  - Insufficient documentation or progress notes will result in unpaid shifts
  - If a shift is paid that the funding agency deems ineligible due to insufficient documentation, funds will be recouped.
- **Mileage logs must be turned in weekly with the corresponding timesheet.**
- **No Photocopied signatures will be accepted.**
  - A new timesheet must be used each week. Duplicated timesheets are not accepted.

Payment Methods:

- Mail-out checks
  - Paychecks will be received within 2-4 days of the pay date.
  - Missing checks may be reissued 10 business days from the date of the check. We do not reissue checks prior to that time.
- Direct deposit
  - Check stubs are sent via email.
- **Changes in payment method must be submitted in writing and may take 2-3 weeks to become effective.**
  - Do not close your bank account without providing our office with enough notification; otherwise your payment will be delayed.
  - Address changes must be submitted in writing.

Employee Signature _____ Date _____

I have read and understand Stuart T. Wilson CPA, PC payroll procedures. Additionally, I understand that I am responsible for any information and/or notifications that are included with my paycheck/paystub.

STUART T. WILSON CPA, PC
Fiscal Intermediary

Payment Options

Name: _____ Employer's Name: _____

Email Address **(required)**: _____

(Must choose one)

☐ **Direct Deposit** A voided check, a letter from the bank or a copy of a membership card that includes both the account and routing number **must** be attached. *See information below Account Type: ☐ Checking ☐ Savings	☐ **Netspend Skylight ONE Payroll Card** *See attached information

When you apply for direct deposit you authorize Stuart T. Wilson CPA, PC to deposit your payroll automatically into your checking or savings account.

- All cancellations must be submitted in writing.
- Any changes may take up to 2 pay periods.
- **Do not close your bank account without providing our office with sufficient notification; otherwise, your payment will be delayed.**
- On payday you will receive your check stub **via email**. This also serves as your notice of deposit. The email comes from no_reply@stuartwilsonfi.com. Please check your spam folder if you do not receive your notice.
- Stuart T. Wilson CPA, PC is not held accountable for any overdraft fees that you may incur for using funds prior to their **actual confirmed deposit.**
- Stuart T. Wilson CPA, PC is authorized to correct errors that may occur. This authority remains in effect until we are notified in writing that you no longer want direct deposit.

I have read and understood the terms of my chosen payment option with Stuart T. Wilson CPA, PC.

I understand that if I do not submit my banking information

I will automatically be signed up for the Netspend Skylight ONE Payroll Card.

_____ _____

Signature Date Phone #

Return via Fax: 989-832-5404 Email: payroll@stuartwilsonfi.com

Mail: Stuart T. Wilson CPA, PC Attn: Personnel 6300 Schade Dr. Midland, MI 48640

NETSPEND

Skylight ONE® Card

Your Skylight Account Info Is With You Wherever You Are

With the Skylight ONE® Mobile App, you can get updates on your Skylight Account from the palm of your hand.[1]

Card account usage is subject to card activation and identity verification.*

Check your balance at a glance

Log in to your Skylight Account, and see how much money is there, right from your smartphone.

Find the nearest ATM

Need some cash? Locate the surcharge-free ATM[2] that is closest to where you are, wherever you are.

See your most recent transactions

See if a payment has posted, or if your paycheck has arrived in just a few taps.

Manage your alerts

Enroll to get a text message[1] or email whenever you get paid, for every transaction, or just periodic balance updates with Anytime Alerts™.

Download the Skylight ONE Mobile App Today!

Download on the App Store

GET IT ON Google Play

IMPORTANT INFORMATION FOR OPENING A CARD ACCOUNT: To help the federal government fight the funding of terrorism and money laundering activities, the USA PATRIOT Act requires us to obtain, verify, and record information that identifies each person who opens a Card Account. **WHAT THIS MEANS FOR YOU:** When you open a Card Account, we will ask for your **name, address, date of birth, and your government ID number.** We may also ask to see your driver's license or other identifying information. Card activation and identity verification required before you can use the Card Account. If your identity is partially verified, full use of the Card Account will be restricted, but you may be able to use the Card for in-store purchase transactions. Restrictions include: no ATM withdrawals, international transactions, account-to-account transfers and additional loads. Use of Card Account also subject to fraud prevention restrictions at any time, with or without notice.

[1] No charge for this service, but your wireless carrier may charge for messages or data.

[2] Surcharge free ATM options will vary by card program. Please see your Cardholder Agreement for surcharge free options. An ATM Cash Withdrawal Fee applies at ATMs outside the surcharge free network specified in your Cardholder Agreement. A separate ATM owner fee may also apply.

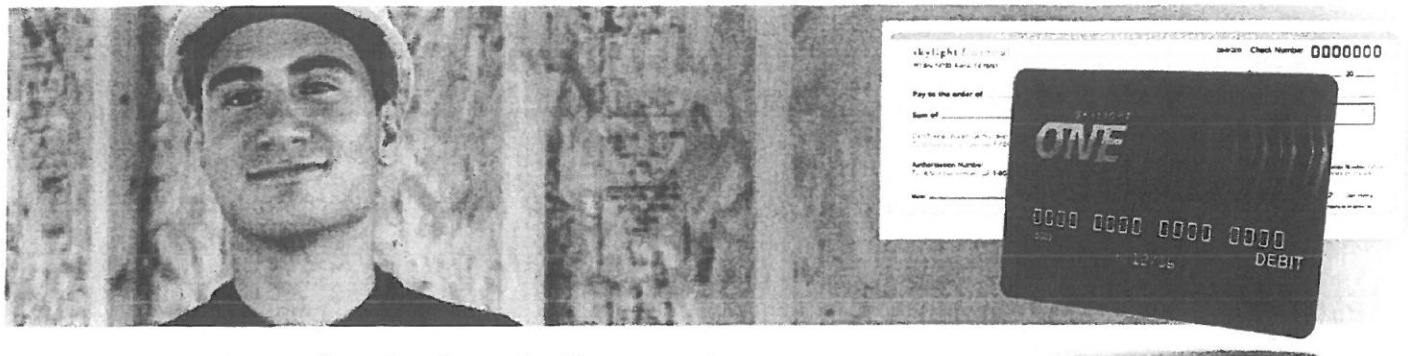
Apple and the Apple logo are trademarks of Apple Inc., registered in the U.S. and other countries. App Store is a service mark of Apple Inc., registered in the U.S. and other countries.

Google Play and the Google Play logo are trademarks of Google Inc.

The Skylight ONE® Visa Prepaid Card is issued by Bofl Federal Bank, Republic Bank & Trust Company or SunTrust Bank pursuant to a license from Visa U.S.A. Inc. and may be used everywhere Visa debit cards are accepted. The Skylight ONE® Prepaid Mastercard is issued by Bofl Federal Bank, Republic Bank & Trust Company, or SunTrust Bank pursuant to a license by Mastercard International Incorporated. Please see back of card for Issuing Bank. Bofl Federal Bank, Republic Bank & Trust Company and SunTrust Bank; Members FDIC. Netspend, a TSYS® Company, is a registered agent of Bofl Federal Bank, Republic Bank & Trust Company, and SunTrust Bank. Certain products and services may be licensed under U.S. Patent Nos. 6,000,608 and 6,189,787. Use of the Card Account is subject to activation, ID verification and funds availability. Transaction fees, terms, and conditions apply to the use and reloading of the Card Account. See the Cardholder Agreement for details.

Mastercard is a registered trademark, and the circles design is a trademark of Mastercard International Incorporated.

Card may be used everywhere Debit Mastercard is accepted.



Frequently Asked Questions

The Skylight® PayOptions™ Program

VISA MasterCard

What is the Skylight PayOptions Program?

The Skylight PayOptions Program provides you with a safe and convenient alternative to cash and traditional paper paychecks. Your money is direct deposited into an account at BofI Federal Bank, Member FDIC, and can be accessed either through your Skylight ONE® Visa® Prepaid Card or Skylight ONE® Prepaid MasterCard®, or by using a Skylight Check to withdraw all of the cash from your Skylight Account.

Where can I use my Skylight ONE Card?

Your Skylight ONE® Card can be used at millions of ATMs to withdraw cash, and anywhere Visa debit cards or Debit MasterCard (based on the logo on the front of your card) are accepted for purchases, such as supermarkets and other retail locations.

What are Skylight Checks and how can I use them?

If you prefer, you can use Skylight Checks to write your own paycheck! Each payday, whether you're at work, at home, or on vacation, you can use a Skylight Check to withdraw all of the cash from your Skylight Account. Skylight Checks can be cashed free of charge at all U.S. Bank branch locations, at participating Walmart locations, and at participating ACE Cash Express locations.[1] You will receive 2 checks in your new account packet. Order additional checks at no cost by calling Customer Service at the number on the back of your card.

What does the Skylight PayOptions Program cost?

There is no cost to sign up and there are many ways to access your wages for free. Some fees may apply based on how you use your Skylight Account. You will receive a fee schedule with your new account packet.

Will I get a new card each payday?

No. Once you are enrolled in the program, you'll automatically receive a personalized Skylight ONE Card. Your pay will be added to the card by 8 a.m. CT each payday. If you accidentally lose the card, just give Skylight a call to request a replacement. Your first replacement card per year is available at no additional cost.[2]

My Skylight ONE Card doesn't have my name on it. Can I still use it to make purchases?

Yes. The first card you receive is a temporary card but it can be used to make signature-based purchases in restaurants, stores, online, and by phone anywhere Visa debit cards or Debit MasterCard are accepted.[3] Once you are enrolled in the program, a card with your name on it will automatically be sent to your mailing address.

Can I request more than one card?

You can add an additional cardholder to your account simply by calling the number on the back of your card.[2,3]

What happens if I lose my card?

When you lose cash, your money is gone. If you lose your card, contact Skylight immediately so your lost card can be cancelled and your money stays safe.[4] When you call, you can ask that a replacement card be sent to you. Your first replacement card per year is available at no additional cost.[2]

How can I check my balance and track my spending?

Skylight makes it convenient for you to manage your money. A toll-free automated telephone service provides 24/7 account information. Plus, when you register for online access at skylightpaycard.com, you can visit the Online Account Center anytime to check your balance, review your transactions, and view or print your statements. You can also enroll in Anytime Alerts™ to schedule balance, deposit, or payment updates to be sent directly to your cell phone or email inbox.[5] Or, text us and we'll text your balance back to you!

What if I want to talk to someone about my account?

Skylight's friendly, specially trained Customer Service representatives are available to assist you between 6 a.m. and midnight CT Monday through Friday and on weekends between 8 a.m. and 8 p.m. CT, with bilingual service available. You can reach someone by calling the number on the back of your card.[6]

[1] Skylight Checks can be cashed free of charge at all U.S. Bank branch locations, at participating Walmart locations, and at participating ACE Cash Express locations. Other check cashers set their own policies regarding check acceptance and may charge you a fee to cash Skylight Checks. See the Skylight Checks for step-by-step instructions.
[2] There may be a cost for additional replacement cards. Consult your Cardholder Agreement and fee schedule for details.
[3] There is no application or credit approval process for the Skylight PayOptions Program. **IMPORTANT INFORMATION ABOUT PROCEDURES FOR OPENING A NEW CARD ACCOUNT:** To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens a Card Account. **What this means for you:** When you open a Card Account, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents. In accordance with federal regulations, until it is activated and registered, a prepaid card is subject to initial load limitations, may not be used for ATM use, international transactions or account-to-account transfers, or be reloaded.
[4] To minimize losses, Cardholder must notify Skylight promptly of any loss of the card or compromise of the Skylight Account. Other terms apply. See the Cardholder Agreement for details.
[5] Skylight does not charge for this service, but your wireless carrier may charge you for messages or data.
[6] A fee may apply for this call. Consult your Fee Schedule for details.

skylight

MI-W4

(Rev. 12-20)

EMPLOYEE'S MICHIGAN WITHHOLDING EXEMPTION CERTIFICATE
STATE OF MICHIGAN - DEPARTMENT OF TREASURY

This certificate is for Michigan income tax withholding purposes only. ***Read instructions on page 2 before completing this form.***

Issued under P.A. 281 of 1967.

▶ 1. Full Social Security Number	▶ 2. Date of Birth

▶ 3. Name (First, Middle Initial, Last)	4. Driver's License Number or State ID

Home Address (No., Street, P.O. Box or Rural Route)	▶ 5. Are you a new employee? ☐ Yes If Yes, enter date of hire..... (mm/dd/yyyy) ☐ No

City or Town	State	ZIP Code

6. Enter the number of personal and dependent exemptions (see instructions) ▶ 6.	
7. Additional amount you want deducted from each pay (if employer agrees) 7.	$ .00

8. I claim exemption from withholding because (see instructions):

a. ☐ A Michigan income tax liability is not expected this year.

b. ☐ Wages are exempt from withholding. Explain: _____

c. ☐ Permanent home (domicile) is located in the following Renaissance Zone: _____

EMPLOYEE: If you fail or refuse to file this form, your employer must withhold Michigan income tax from your wages without allowance for any exemptions. Keep a copy of this form for your records. See additional instructions on page 2.

Under penalty of perjury, I certify that the number of withholding exemptions claimed on this certificate does not exceed the number I am allowed to claim. If claiming exemption from withholding, I certify that I do not anticipate a Michigan income tax liability this year.

9. Employee's Signature	▶ Date

EMPLOYER: Complete the below section.

10. Employer's Name	▶ 11. Federal Employer Identification Number		
Address (No., Street, P.O. Box or Rural Route)	City or Town	State	ZIP Code
Name of Contact Person	Contact Phone Number		

INSTRUCTIONS TO EMPLOYER: Keep a copy of this certificate with your records. All new hires must be reported to the State of Michigan. See **www.mi-newhire.com** for information.

In addition, a copy of this form must be sent to the Michigan Department of Treasury if the employee claims 10 or more exemptions or claims they are exempt from withholding. Send a copy to:

Michigan Department of Treasury
Tax Technical Section
P.O. Box 30477
Lansing, MI 48909

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)

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

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

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

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

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

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

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

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

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

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

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

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

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

a **Qualified tips.** If your total income is less than $150,000 ($300,000 if married filing jointly), enter an estimate of your qualified tips up to $25,000 . . . . . 1a $

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

c **Qualified passenger vehicle loan interest.** If your total income is less than $100,000 ($200,000 if married filing jointly), enter an estimate of your qualified passenger vehicle loan interest up to $10,000 1c $

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

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

a Enter $6,000 if you are age 65 or older before the end of the year . . . . . 3a $

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

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

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

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

a **Medical and dental expenses.** Enter expenses in excess of 7.5% (0.075) of your total income . 6a $

b **State and local taxes.** If your total income is less than $505,000 ($252,500 if married filing separately), enter state and local taxes paid up to $40,400 ($20,200 if married filing separately) . 6b $

c **Home mortgage interest.** If your home acquisition debt is less than $750,000 ($375,000 if married filing separately), enter your home mortgage interest expense (including mortgage insurance premiums) . . . . . 6c $

d **Gifts to charities.** Enter contributions in excess of 0.5% (0.005) of your total income . . . . 6d $

e **Other itemized deductions.** Enter the amount for other itemized deductions . . . . . 6e $

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

8 **Limitation on itemized deductions.**

a Enter your total income . . . . . 8a $

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

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

. . . . . 9 $

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

11 **Standard deduction.**

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

. . . . . 11 $

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

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

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

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

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

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

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

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

Employment Eligibility Verification

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

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

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

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

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

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

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

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

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

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

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

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

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

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

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

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

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
	6300 Schade Dr., Midland, MI 48640

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

LIST A **Documents that Establish Both Identity and Employment Authorization**	OR	LIST B **Documents that Establish Identity**	AND	LIST C **Documents that Establish Employment Authorization**
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
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		**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		

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.

MEDICAID PROVIDER AGREEMENT

This agreement is made on _____ between Bay Arenac Behavioral Health and _____ (known as Medicaid Provider). The purpose of this agreement is to define the roles and responsibilities of the above named parties. This agreement shall remain in effect until such time it must be terminated or modified. Any party can initiate a termination or modification by providing written notice to the other of the desire to terminate or modify this agreement.
Upon receipt of this agreement, CMHSP will certify the Medicaid Provider as available to provide services to individuals who receiving services and/or supports in accordance with their individual plans of services and supports developed in a person-centered planning process, authorized by CMHSP or one of its subcontractors, and financed through Michigan's Medicaid Specialty Pre-paid Mental Health Plan.

The Medicaid Provider stipulates that it agrees to the following
1. To keep any records necessary to disclose the extent of services and Medicaid Provider furnishes to recipients of services.

2. to furnish any information maintained under paragraph (1) of this section and any information regarding payments claimed by the Medicaid Provider for furnishing services under the individual plan of services and supports upon request to CMHSP, the State Medicaid Agency, the Secretary of the Department of Health and Human Services or the State Medicaid fraud control unit.

3. To comply with the disclosure requirements specified in 42 CFR 455, subpart B, as applicable.

4. To comply with the advance directives requirements specified in 42 CFR 489, Subpart I and 42 CFR 417.436 (d), as applicable.

Both parties expressly acknowledge that the sole purpose of this agreement is to assure compliance with 42 USC 1902 (a) 27. Further both parties recognize and reaffirm that CMHSP is not the employer of the Medicaid Provider of Services, and that the Participant is the sole employer of the Medicaid Provider of Services.

This agreement sets forth the entire understanding between the parties with respect to the subject matters, and supersedes any and all other agreements, either oral or in writing between the parties pertaining to these matters. Not change or modification of the terms of this agreement is valid unless it is in writing and signed by the parties.

The parties agree to terms and conditions of this agreement.

Self-Determination Coordinator Date

Medicaid Provider Agency/Individual Employee Date

BAY ARENAC
BEHAVIORAL HEALTH

EMPLOYMENT AGREEMENT

This contract made this date _____, by and between _____ (herein referred to as "Employer") and _____ (herein referred to as "Employee").

The employee recognizes that employment is condition on my employer's participation in the Self-Determination Initiative. If my employer is no longer a participant in the initiative, I may no longer be employed. In order to acknowledge the terms of my employment, I agree to the following:

1. During the terms of this Agreement, I shall assist my employer by performing the duties outlined in this agreement and any attachments to this agreement.

2. I agree to assist my employer in maintaining the necessary documentation and records as required by my employer or their host agency. I agree to complete all the necessary paperwork to secure necessary payroll deductions from my pay. All records I may have or assist in maintaining will be kept confidential and released only upon the consent of my employer. I acknowledge that all records I may have access to be the property of and must be returned to the employer at the time my employment relationship terminates. In addition, illness and incident reports will be filled out at appropriate times, as required or requested by the Host Agency or my employer.

3. I shall immediately notify (enter the name of the desired contact person, for example, it may be a family member or their designee _____ __ of any medical emergency or illness. I will also notify designee (if applicable) before taking my employer to the physician, except in case of an emergency.

4. I agree to participate in any meetings if requested by my employer.

5. I agree to abide by all of my employer's rules and regulations pertaining to providing support to my employer through the Self-Determination Initiative.

6. I hereby acknowledge receipt of the following rules and regulations:

   a. Recipient Rights Booklet (I understand that I shall assist my employer in filing right complaints upon request. I also understand that I have a responsibility to report rights violations, which I am aware of or any potential abusive or neglectful situations I observe. I understand that I may be requested to cooperate with a recipient rights investigation, and/or assist my employer with exercising their rights.

b. Attachment A to this agreement, which outlines the services I shall provide to my employer.
c. (Individual can add whatever additional rules thy may have...regarding phone usage, non-smoking, etc., in their home.)
d. If the Host Agency has any policies and/or procedures for the Self-Determination Initiative, or other policies the employee needs to be aware of, they should be given to the employee.
e. If there any required time cards or other documentation the employee must fill out and return to the fiscal intermediary to verify their hours that should be given to the employee, or those requirements can be put into this agreement.

(Use only one option in number 7)

7. I understand that this is an employment at will relationship, which can be terminated by either party, at any time. However, I agree to give 5 days written notice to my employer if I need to terminate this Employment Agreement. *Or*

I understand that this is a contractual position, not an at will relationship, and that either party can terminate the relationship by providing written notice to other of the desire to terminate the relation in writing 5 days prior to the termination of the agreement. It is understood that I will be compensated for any work completed while the contract is in effect. If I fail to provide requested services for the entire term of the contract, it shall be considered a breach of contract.

8. I understand that, although my pay check will be drafted by a fiscal intermediary, they are only acting as a financial administrator of my employer's budget/funds for the Self-Determination Initiative.

9. I agree to hold the fiscal intermediary harmless for their role as the financial administrator of my employer's budget/fund for the Self-Determination Initiative, and acknowledge that I have only one employer.

10. I understand and acknowledge that the Host Agency's role in this project is that of project administrator, and that the Host Agency is not my employer.

11. Further, I agree to hold the Host Agency harmless for their role as a project administrator of the Self-Determination Initiative.

12. I agree to the following compensation for the services I shall perform:
13. $ per hour Not to include any other benefits.

I agree to execute a 42 CFR 431.107 agreement with the Host Agency and acknowledge that this agreement does not alter the fact that the Host Agency is only the project administrator of the Self-Determination Initiative and that my employer is I understand that my employment is contingent on completing this agreement.

I, agree to the following: (Employer)

Provide my fiscal intermediary with the necessary documentation to assure timely compensation of my employee. Compensate my employee in the following manner: $ per hour. Not to include any other benefits.

1. Assure appropriate training to my employee. Further, I will assure that my providers meet the five minimum requirements of Chapter Three of the State Medicaid Manual: 1) at least 18 years of age; 2) able to prevent transmission of any communicable disease from self to others in the environment in which they are providing supports; 3) able to communicate expressively and receptively with me in order to follow individual plan requirements and participant-specific emergency procedures, and report on activities performed; 4) in good standing with the law (i.e. not a fugitive from justice, a convicted felon, or an illegal alien); 5) able to perform basic first aid procedures. Further the Host Agency shall assure all other providers of services (i.e. clinical services, supports coordination, personal agents); meet the required standards of Chapter Three of the State Medicaid Manual.

2. Evaluate the performance of my employees or contractors, and provide appropriate feedback to assure I am purchasing quality of services.

3. Provide training to my employees on my health needs, my medications and medication procedures, safety and emergency procedures specific to my needs and my home, and my IPOS.

4. **Assure that my employee executes a Medicaid Provider Agreement with the specified Community Mental Health Services Program_____.**

_____

Employee Signature Date

_____

Employer Signature Date

Choice Voucher Provider Agreement

The Choice Voucher Provider is a provider directly employed by or contracted by a person using arrangements that support self-determination. The sole purpose of this agreement is to assure compliance with federal Medicaid requirements. This agreement shall remain in effect until such time it must be terminated or modified. Any party can initiate a termination or modification by providing written notice to the other of the desire to terminate or modify this agreement.

Upon receipt of this agreement, the PIHP/CMHSP will certify the Choice Voucher Provider as available to provide services to individuals who receiving services and/or supports in accordance with their individual plans of services (IPOS) developed in a person-centered planning process, authorized by the PIHP/CMHSP or one of its subcontractors, and financed through Michigan's Medicaid Specialty Pre-paid Mental Health Plan.

The Choice Voucher Provider stipulates that it will do the following

1. Accept payment, in form of check(s) or direct deposit, from (Name of Fiscal Intermediary), doing business in the State of Michigan.
2. No additional payments (beyond payment agreed to in the employment or purchase-of- service agreement and paid by the fiscal intermediary) will be accepted directly from individuals using arrangements that support self-determination.
3. Agree to keep records of the service(s) or purchase(s) provided as required by the individual(s) using arrangements that support self-determination or the PIHP/CMHSP.
4. Provide only the service(s) or item(s) described in the employment or purchase-of-service agreement with the employer (as authorized in the person's IPOS) and do not exceed the hours set forth in the employment or purchase-of-service agreement except in emergency situations or with authorization from the PIHP/CMHSP.
5. Accept the check(s) or direct deposit(s) as payment in full for service(s) or item(s) purchased.
6. Upon request, provide information regarding the service(s) or purchase(s) for which payment was made to and to provide such information and any related invoices or billings, upon request, to the individual using arrangements that support self-determination, PIHP/CMHSP, the State Medicaid Agency, the Secretary of the Department of Health and Human Services or the State Medicaid fraud control unit.

X _____ _____

Choice Voucher Provider Agency/Individual Date

_____ _____

Self-Determination Coordinator Date

Home Health Aide/Personal Care Assistant
Job Description/Task List

Employee Name: _____ **Date:** _____

Participant/Employer: _____ **Date:** _____

Qualifications/Training:

CPR Training: _____ **Universal Precautions:** _____

Blood Borne Pathogens: _____ **First Aid:** _____

Additional Training Requirements: _____

Services Performed:

CLS (personal care/homemaking): _____

In Home Respite: _____ **Chore Service:** _____

Community Living Services Functions (including but not limited to):

a. **Bathing/Assist:** _____
b. **Shampooing:** _____
c. **Skin care/Nail care:** _____
d. **Oral Hygiene:** _____
e. **Shaving:** _____
f. **Dressing/Assist:** _____
g. **Ambulation:** _____
h. **Toileting/Incontinence:** _____
i. **Linen Change** _____

Community Living Service Functions Continue:

a. **Meal Preparation:** _____

b. Feeding: _____

c. Laundry: _____

d. Cleaning: _____

e. Other: _____

Chore Services (including, but not limited to):

a. Yard Work: _____

b. Snow Removal: _____

Transportation Needs: (drivers license confirmation required)

a. _____

b. _____

Scheduling (Days/Hours)

***Contact employer if arriving more than 10 min. late or need to change schedule*. All changes to the schedule is made with the approval of the participant/employer.**

S M T W TH F S Days and time may vary not to exceed _____ per week.

It is important to me that my worker: (e.g. does not smoke in my home, maintains confidentiality, is punctual, honors my requests, treats me with respect, etc.) as well as the following:

a._____ b. _____

c._____ d. _____

Workers will not be paid for hours when the employer is in the hospital, if time sheets are not signed by the appropriate person or for duplicated hours with other workers.

I expect my worker to perform other related duties and responsibilities as deemed necessary.

_____ ____/____/____

Employer Signature **Date**

_____ ____/____/____

Employee Signature **Date**

Basic First Aid/Bloodborne Pathogens Quiz

*Must have a score of at least 80% (2 or less questions wrong) to pass

1. If someone has a nosebleed, you have the person lean back and look at the ceiling
   True False

2. First aid for a burn includes cooling the area with large amounts of cool water
   True False

3. Firm, direct pressure with clean or sterile bandages is one of the first steps in caring for a bleeding wound
   True False

4. Covering the burn area with clean or sterile dressings will reduce the chance of infection and reduce the pain
   True False

5. It is very important to know where the first aid supplies and emergency numbers are when you are a responsible adult caring for someone
   True False

6. If someone is having a seizure, you should put something in their mouth and try to stop the movement
   True False

7. If there is an insect stinger imbedded in someone's skin, scrape it out and wash the area with soap and water
   True False

8. If you are having trouble breathing, notice someone else having trouble breathing, or is experiencing an allergic reaction, call 9-1-1
   True False

9. Universal precautions means treating everyone's blood and other body fluids as infectious
   True False

10. Contaminated sharps needles, broken glass, etc. must be placed in a covered puncture-resistant leakproof container tat is red or has a biohazard label
    True False

11. If you come in contact with blood or other body fluids you should wash your skin immediately
    True False

12. You must clean equipment and work surfaces if they're visibly contaminated with blood or other body fluids
    True False

Signature of Employee: _____

Name of Employee (print neatly): _____ Date: _____

*I attest that this employee has passed the Basic First Aid/Bloodborne Pathogens Quiz: Passed □ Failed □

Trainer/Employer Signature: _____

Please return completed quiz with signature to:

Stuart T. Wilson CPA, PC
Attn: Personnel Dept.
6300 Schade Dr.
Midland, MI 48640
Fax: 989-832-5404

Recipient Rights Test

Name _____ DATE: _____

Work Site /Employer _____

1. Who are the Recipient Rights staff for Bay and Arenac Counties?

    a. Gale Bradish and Diane Swank
    b. George Bush and Bill Clinton
    c. Melissa Neering-Prusi, Janelle Steckley and Jeff Wells
    d. Judge Judy and Joe Brown

2. Who must report suspected incidents of Abuse, Neglect or rights violations?

    a. All employees of a Mental Health Board
    b. Contract employees of a Mental Health Board
    c. Volunteers with a Mental Health Board
    d. All of the Above

3. When must suspected incidents of Abuse, Neglect, or rights violations be reported?

    a. Within one week
    b. Verbal reports must be made immediately
    c. A written report must be made by the end of your work shift
    d. B and C

4. There must always be a "need to know" basis when releasing confidential information, even if the release is to a co-worker.

    a. True
    b. False

5. Staff cannot take photographs or make video and audio recordings of recipients without written permission/authorization.

    a. True
    b. False

6. A recipient in a group home continually uses foul language in speaking with other recipients and home staff. Despite your (and staff's) repeated efforts to correct her and change this habit she continues to do so. You:

    a. Do nothing further as it is impossible to change the person's language.
    b. Have the staff wash the recipient's mouth out with soap and water and tell her they will do so again if she continues to use foul language. Make sure they follow up with those threats as consistency is the key to successful behavior modification.
    c. Have staff continue to encourage the recipient to use acceptable language by trying different approaches (modeling those approaches for staff yourself), working with your supervisor, or asking for a consultation with her case manager or a psychologist.

For questions 7-10 please identify the examples below as abuse, neglect or neither:

7. A staff is upset with a recipient for hitting him, so the staff grabs the arms of the recipient and pushes him against the wall.

    a. Abuse b. Neglect c. Neither

8. A staff member discovers a recipient laying on the floor, moaning, saying his hip hurts and is refusing to get up off the floor. The staff fails to seek out any assistance for the recipient and leaves him on the floor all night. The next day the recipient is taken by ambulance to the hospital and it is discovered he has a broken hip.

    a. Abuse b. Neglect c. Neither

9. A staff member asks another to help hold a recipient down so her prescribed medication can be passed on time. Both staff hold the recipient down and force the medication into her mouth.

a. Abuse b. Neglect c. Neither

10. Staff fails to put seat belts on the recipients in the van. There is an accident and one recipient cuts his hand, requiring stitches.

a. Abuse b. Neglect c. Neither

For questions 11-15 please match the word to the appropriate definition:

11. Dignity & Respect ___
12. Informed Consent ___
13. Civil Rights ___
14. Unreasonable Force ___
15. Person Centered Plan ___

a. Physical management applied to a recipient when there is no immediate risk of harm to staff or recipients.

b. The right in which the recipient and their family is treated professionally.

c. The rights guaranteed to all US citizens which include the rights to due process, voting, and religious expression.

d. A process in which recipients identify their goals, needs, dreams, and together with a team create a plan for services.

e. The recipient and/or guardian are fully knowledgeable of the treatment or medication they are about to receive or authorize.

*I attest that this employee has passed the Recipient Rights quiz: ____passed ____failed

Trainer/Employer Signature: _____

Employee Signature _____

Environmental Emergencies Quiz

1. Which of the following are environmental hazards for which you must be prepared?
   a. Water shortage, heat failures, power outages
   b. Fire, thunderstorms, tornadoes
   c. Floods, winter storms, lightning
   d. All of the above

2. Your BEST source of information in most emergencies is:
   a. The next-door neighbor
   b. Battery-powered radio, TV, NOAA weather radio
   c. Your co-worker
   d. Police Department

3. When taking a person for treatment of poison, what should you take with you?
   a. Any vomit from the person
   b. The poisonous substance, if any is left
   c. The poison container
   d. All of the above

4. A tornado watch means that conditions are favorable for a tornado to occur.
   a. True
   b. False

5. Which of the following is a way to prepare for possible isolation in winter storms?
   a. Have first aid supplies available
   b. Stock emergency supply of food and water
   c. Stock battery-powered radio, flashlight, etc.
   d. Have extra medication on hand, if possible
   e. All of the above

6. Some winter storm supplies you should have in your car/van are:
   a. Sand, shovel, windshield scrapper
   b. Blankets
   c. Emergency first aid kit
   d. Extra gloves, mittens and hats, boots
   e. All of the above

7. The primary responsibility of staff during a fire is to get everyone out of the house alive.
   a. True
   b. False

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8. Using a cell phone or texting while driving doesn't affect your ability to drive.
   a. True
   b. False

9. Carbon monoxide is caused when fuels such as gasoline, wood, coal, natural gas, propane, oil and methane burn incompletely.
   a. True
   b. False

10. Caron monoxide is easy to detect so it is not necessary to install a CO detector.
    a. True
    b. False

11. What does the acronym PASS stand for?
    a. Pull-Aim-Squeeze-Sway
    b. Push-Aim-Squirt-Sweep
    c. Pull the pin-Aim low-Squeeze the handle-Sweep from side-to-side

Signature of Employee: _____

Name of Employee (print neatly): _____ **Date:** _____

*I attest that this employee has passed the Environmental Emergencies Quiz: Passed □ Failed □

Trainer/Employer Signature: _____

First Aid:

- If someone is there, sent to call for help
- If the person is unresponsive, isn't breathing or isn't moving, proceed with CPR
- If bleeding, stop the bleeding by applying pressure to the wound with a sterile bandage or a clean cloth
- Apply a bag of ice to the injured area for up to 20 minutes, with a towel (paper or cloth) between the skin and ice
- If raising the injured part does not cause more pain to the victim, attempt to raise it
- If the person feels faint or is breathing in short, rapid breaths lay the person down with the head slightly lower than the trunk and, if possible, elevate the legs

Our body relies on oxygen to work properly, without oxygen the survival time could vary from 1 to 3 minutes. So, someone who is having breathing problems is in need of immediate medical attention. Common cause for such problems is air passage block.

General reasons for developing mild or severe air passage block include:

- Asthma
- Swelling of the lining of the airway, can be related to allergic reactions (eggs, peanuts, stings by insects and bees)
- Food, or small object, like medication pill, going down in to the air passage instead of stomach
- Infections
- Injuries to vital organs (head, stomach, etc.)

If the victim is developing an asthma attack, he/she might experience mild or severe breathing problems. Usually, the person will have the necessary medication, which should relieve the symptoms quickly. Check with the victim whether the medications are available and get it if out of reach.

In case of an allergic reaction, common treatment includes epinephrine, and can be injected through cloth. Verify the expiration date prior to administering.

When dealing with bleeding wound, Priority #1 is to stop the bleeding. Below are several rules to keep in mind:

- Maintain composure, no need to panic
- In most cases, bleeding can be stopped by applying pressure to the wound
- Bleeding generally looks much worse, than it really is. If the bleeding is not stopping, apply clean cloth or bandage to the wound for 15 to 30 minutes with reasonable amount of pressure.

Make sure the cloth stays in place and is not moved during that time, as movement can re-aggravate the wound and cause bleeding to resume. If the bleeding persists, apply the second dressing to the wound and increase the pressure. As mentioned above, you can control or stop the bleeding in majority of the cases with pressure alone. Priority #2 is to keep the wound clean. This will minimize the chance of the victim getting an infection. If water source and soap is available, wash the wound. If not, and there is visible debris, extract it with your hands or tweezers.

Contact emergency services if the bleeding has not stopped or you suspect potential for infection or

internal injuries (fractures, brakes, head injury, etc.) For small wounds and scrapes it is generally advised to use triple antibiotic ointment, which is the best in preventing infections.

Nosebleeds in majority of cases (more than 90%) tend to be benign and can be easily stopped with simple steps that we will outline a little later. The condition is caused by rupture of blood vessel in the nasal septum. However, in certain cases nosebleed is a much more serious event and can indicate life threatening or serious condition. These are relatively rare and usually occur with elderly. These nosebleeds generally originate in the artery located in the back part of the nose, and are much more complicated to treat.

Steps to follow if dealing with common nosebleed:

- Have the victim sit in upright position
- Pinch victim's nose with thumb and index finger, and hold it for about 10 minutes, this generally applies enough pressure to the septum to stop the bleeding

To prevent reoccurrence, advise the victim to avoid picking or blowing the nose, until the bleeding stopped for a couple of hours, and also avoid bending.

If bleeding re-occurs, blow the nose with force to clear out the remaining blood clots, and repeat the pinching procedure described above. It is recommended for the victim to contact a physician for consultation.

Contact emergency services immediately:

- If bleeding persisted uncontrollably for more than 15 minutes
- If the bleeding is the result of an injury, where there is a potential for broken nose.

The skull is a bony structure, and its purpose is protecting the brain from any damage. If the injury to the head occurs there is always a risk of brain damage. Also, it should always be assumed, that if there is a risk of head injury then there is also a risk of spine injury and neck injury.

You should suspect a head, neck or spine injury in case of the following accidents:
- Car or motorcycle accident, even minor bump can cause internal head injury
- Fall from height
- Injury to the head, fight, sporting event, etc.
- Electrocution

You should suspect a head, neck or spine injury if the symptoms below follow the accident:
- Lack of responsiveness or moaning
- Vision problems or confusion
- Trouble walking or moving
- Seizures, Vomiting, or Headache

Steps for administering First Aid:
- As always, make sure the scene is safe for you and the victim(s)
- Phone or ask someone to phone 911
- Hold the neck and head so it does not move, twists, or bend
- Turn the victim only if: *victim is in danger, *if you need to check if the victim is breathing, *if the victim is vomiting

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Let's define first aid: urgent medical care provided to someone who is in need of immediate assistance due to illness or injury, before qualified professional help arrives on the scene. You may be assisting people with injuries that vary in severity. One day you might be helping someone with a paper cut, and tomorrow it could be heart attack or cardiac arrest. The most important thing is to define the situation based on the information available and proceed with medical assistance according to your training and knowledge. This course will prepare you for these types of situations and besides other benefits and requirements could put you in the position to save someone's life. Also, this material should be reviewed on regular basis to refresh your knowledge. We all forget things we do not often use, and refreshing what you already know will only enhance your first aid administration skills.

In case you came in contact with bodily fluids, blood or skin follow the following instructions as soon as you can:

- Take the gloves off, if wearing any
- Wash the area with soap (work up soap lather for 15 seconds) and water, if contact with eyes, nose, or ear rinse with water
- Wash your hands thoroughly with soap, if not available use waterless hand sanitizer, and wash your hands with water later
- Dry your hands with paper towel and use paper towel to close the faucet
- Inform your supervisor/person responsible for emergency response and consult your medical provider as soon as possible
- he first step is to determine the degree of the burn and the damage to the skin.

Burns are categorized as first-, second-, or third-degree.

First-degree burn
The least serious burns are those in which only the outer layer of skin is burned. The skin is usually red, with swelling and painful. The skin is dry without blisters.

Second-degree burn
Second-degree burns are more serious and involve the skin layers beneath the top layer. These burns produce blisters, severe pain, and redness.

Third-degree burn
The most serious burn. These burns are painless (due to nerve damage) and involve all layers of the skin. The burned area may be charred brown, leathery or appear dry and white.

- Important:
  - Don't apply butter or ointments to the burn to ensure proper healing of the burned skin.
  - Don't break blisters to prevent infection.
  - Don't use ice to prevent destruction to the skin.
  - Don't immerse large severe burns in cold water to prevent shock.
- For major burns call for emergency medical assistance. Until an emergency unit arrives, follow these steps:

- Make sure the victim is no longer in contact with the burning material or exposed to smoke or heat.
- Don't immerse large severe burns in cold water to prevent shock.
- Check for signs of circulation and if there is no breathing or other sign of circulation, proceed with CPR.

If possible, raise the burned body part above heart level.
- Use a cool, moist bandage to cover the burned area

BASIC FIRST AID

POISONINGS

If someone has ingested or made contact with a potential poison ,contact the Poison Control cCenter immediately. The number is located in the front of the phone book. After you call Poison Control call, 911. Please have as much information you can regarding what was ingested, how much and when.

HEAD INJURY

If someone falls or hits their head and becomes unconscious, DO NOT move the person, call 911.

INSECT STING

If you or someone you know is stung by an insect, do not squeeze out the stinger. If the stinger remains in the skin, scrape it off using a fingernail or credit card. Wash the area that was stung with soap and water. If you start having trouble breathing or know someone is allergic to insect stings, call 911.

SEIZURES

If someone is having a seizure, DO NOT put anything in their mouth and DO NOT try to restrain their movement. Clear the area of hazards and put a pillow under their head if possible. If this is the first time the person has had a seizure or if the person does not stop seizing after several minutes, call 911.

Infection Control

Infection control is preventing the spread of germs that cause illness and infection. Infection control starts with understanding germs and how they are spread.

About Germs

Everyone comes in contact with millions of germs (microorganisms) each day. All germs need warmth, moisture, darkness and oxygen to live and grow. Many germs are harmless and are needed for our bodies to function in a healthy way. For example, certain kinds of germs or bacteria are needed for the digestion of food and for the elimination of waste products (feces and urine) from our bodies. Some germs are very harmful and cause infections, diseases, and illnesses by rapidly multiplying and overwhelming the body's natural defenses. An infection can be local in one spot, like an infected cut, or it can be systemic, throughout the whole body, like food poisoning or pneumonia.

Three Ways Germs Are Spread

Germs are spread in the environment three ways: direct contact, indirect contact, and droplet spread.

1. Direct Contact means that germs are spread from one infected person to another person. An example of direct contact is the person infected with a cold putting his hands to his mouth while coughing or sneezing and then touching or contacting another person before he has washed his hands. A similar situation happens when the person has an infected or open sore or wound or body fluids that are full of germs (feces, urine) or blood (HIV, AIDS, Hepatitis A, B, or C) or saliva that is contaminated, and the other person is contacted directly by the germs.

2. Indirect Contact means that germs are spread from one infected person to another person through an object. The germ from the person infected contaminates the object, and the person who touches the object is then contaminated. Indirect contact is a common way for germs to spread between people who live, work, and play together. The spread of germs through indirect contact can happen when eating contaminated food (E. coli, salmonella), handling soiled linens, soiled equipment, using soiled utensils and cups, and drinking or using contaminated water. Dysentery, a serious gastrointestinal infection, can be spread indirectly. The hepatitis B virus can live up to 10 days in dried blood and can also be spread indirectly.

3. Droplet Spread means that germs are spread through the air from one infected person to another person. The germs are airborne and are carried over short distances. When people talk, cough, or sneeze, they are spreading germs through the air. The germs of the common cold, flu, and even tuberculosis travel from one person to another by droplet spread.

Controlling the Spread of Germs

Knowing how germs are spread is the first step in practicing infection control and preventing illness. Knowing how to control the spread of germs is the second step. You can protect yourself and the individuals with whom you work from germs or contamination by doing the following:

1. Know and practice standard precautions (defined in next section), especially hand washing and gloving.
2. Keep yourself, the individual, and the environment clean.
3. Be aware of the signs and symptoms of illness and infection, and accurately record and report them to the doctor.

Standard Precautions

Standard precautions, including hand washing and using disposable gloves and the wearing of personal protective equipment, protect both the individual you work for and you from the spread of germs and infection. Standard precautions are a set of infection control safeguards. They are especially important to prevent the spread of blood-borne and other infectious diseases (AIDS, Hepatitis A, B, and C).

You should use these precautions when coming in contact with blood and all body fluids, secretions, and excretions (urine and feces), whether or not they contain visible blood; when touching mucous membranes such as the eyes or nose; and when dealing with skin breakdown such as a cut, abrasion, or wound.

Body fluids include:

Blood
Blood products
Secretions
Semen
Vaginal secretions
Nasal secretions
Sputum
Saliva from dental procedures
Excretions
Urine
Feces
Vomit

Hand Washing

Frequent, thorough, and vigorous hand washing will help in decreasing the spread of infection. **Germs are spread more frequently by hands and fingers than by any other means.**

When employee's Should Wash Their Hands

- Employees should always wash their hands when they come to work and before leaving.
- Hands should be washed at work before touching:
  - Food
  - An individual's medicine
  - Kitchen utensils and equipment
  - Someone's skin that has cuts, sores, or wounds
  - Before putting on disposable gloves
  - Before using the bathroom
- Employee's should always wash their hands after:
  - Using the bathroom.
  - Sneezing, coughing, or blowing one's nose.
  - Touching one's eyes, nose, mouth, or other body parts.
  - Touching bodily fluids or excretions.
  - Touching someone's soiled clothing or bed linens.

Gloving

Practicing standard precautions also includes the wearing of disposable (single use) latex gloves whenever you come in contact with body fluid. (Non-latex gloves should be purchased for people who are allergic to latex.)

Putting on disposable gloves and taking them off correctly is especially important in preventing the spread of germs and infection. Gloves should be used only one time and changed after each use. New gloves should be put on each time you works with a different individual. Used or contaminated gloves should be thrown away. Gloves become contaminated after each use and can spread germs between individuals if used more than once and if they are not properly disposed.

If bodily fluid or blood touches the skin, wash the area vigorously and thoroughly with soap and warm water. If the gloves tear or break, take them off and vigorously and thoroughly wash your hands. Put on a new pair of gloves and continue assisting the individual.

- Employee's should always use gloves when providing or assisting an individual with:
  - Rectal or genital care.
  - Tooth brushing or flossing
  - Shaving with a blade razor
  - Menstrual care
  - Bathing or Showering
  - Cleaning bathrooms
  - Cleaning up urine, feces, vomit, or blood
  - Cleaning toilets, bed pans, urinals
  - Providing wound care
  - Handling soiled linen or clothing
  - Giving care when the caregiver has open cuts or oozing sores on his or her hands
  - Providing first-aid
  - Disposing of waste in leak proof, airtight containers

Always use a new pair of gloves for each activity

Always use a new pair of gloves for each individual

Always wash your hands before and after using gloves

Never wash gloves and use again

Since hand washing can easily dry out a person's skin, remember to apply hand lotion or cream often throughout the day. It is a best practice to keep natural nails short and avoid the use of artificial nails when providing personal care. Many hospitals have banned artificial nails and natural long nails for employees who provide personal care. Research has shown that healthcare workers who wear artificial nails are more likely to harbor germs than those who don't. Employees with long nails are at risk of puncturing or tearing disposable gloves.

Alcohol based hand rubs or hand sanitizers may also be used. They provide a great alternative to hand washing for the following reasons:

- Alcohol-based hand rubs (foam or gel) kill more effectively and more quickly than hand washing with soap and water.
- They are less damaging to skin than soap and water, resulting in less dryness and irritation.
- They require less time than hand washing with soap and water.
- Bottles/dispensers can be placed at the point of care so they are more accessible.

<u>Other Protective Equipment</u>

Depending on your job, you may be expected to wear other **Personal Protective Equipment (PPE)**, such as a face mask or eye shields.

The type of PPE used will vary based on the level of precautions required; e.g., Standard and Contact, Droplet or Airborne Infection Isolation. Employees should always remember to:

- Keep hands away from face
- Limit surfaces touched
- Change gloves when torn or heavily contaminated
- Perform hand hygiene

If you must use PPE you should put the equipment on in the following order:

1. **Gown** - Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back. Fasten in back of neck and waist. Wear a gown during procedures that are likely to generate splashes or sprays of blood, bodily fluids, secretions, or excretions. Remove a soiled gown as soon as possible, and wash hands after removing the gown.

2. **Mask or Respirator** - Secure ties or elastic bands at middle of head and neck. Fit flexible band to nose bridge. Fit snug to face and below chin. Fit-check respirator.

3. **Goggles or Face Shield** - Place over face and eyes and adjust to fit. Wear a mask and eye protection, or a face shield, during procedures that are likely to generate splashes or sprays of blood, bodily fluids, secretions, and excretions.

4. **Gloves** - Extend to cover wrist of isolation gown. You should use gloves when hands may become contaminated with blood, body fluids, excretions, or secretions or when touching mucous membranes or non-intact skin, or contaminated surfaces or objects.

If this equipment is required in your work setting you should receive training on the location, proper use and disposal of the PPE.

Cleaning and Disinfecting

The second way for employee's to prevent the spread of germs is through cleaning and disinfecting the environment. Employees should be careful not to transfer infection to others and equally important, the employee should be careful not to be infected by others. This can be done by being clean themselves, keeping the home clean and germ free, and assisting the individuals in the home to maintain good personal hygiene. Routine, daily cleaning of household surfaces and other items with soap and water is the most effective method for removing germs. Sometimes, an additional cleaning is needed to be germ free. This extra step is called disinfection.

Disinfection is the process of killing germs after cleaning with soap and water, then rinsing with clear water. Disinfecting usually requires soaking or drenching the surface or item for several minutes with a special cleaning solution. This soaking allows the cleaning solution to kill the remaining germs. One of the most common cleaning solutions is household bleach and water. Remember, this solution will discolor fabric and carpeting. The solutions lose effect very quickly and must be made fresh every 24 hours or daily.

Household Hints for Reducing the Spread of Infection

- Clean most surfaces with soap and water to remove germs.
- Always clean up spills from the less soiled to the most soiled to limit the spread of germs.
- Handle soiled laundry as little as possible.
- Wash soiled clothing and linens separately from other clothes.
- Use paper towels throughout the house.
- Make sure everyone follows good hand-washing practices (for example, before touching food, after using the bathroom).

- Keep clean hands away from the face and other areas of the body.
- Make sure individuals use their own toiletries and equipment (for example, combs, brushes, razors, etc.)

Safety And Fire Prevention

Emergency Information and Supplies:
During orientation you should become familiar with the specific needs of the individual(s) residing in the home. Make sure you are familiar with safety needs pointed out in the PCP. If you have a suggestion to improve safety in the home, or recognize an area of concern discuss it with your employer or their guardian.

What supplies are recommended at minimum?
- Latex (or similar gloves), are ideal for clean up and help prevent spread of illness or disease when accidents or emergencies may occur.
- A first aid kit, battery powered radio, flashlights and extra batteries can keep you informed and able to move about safely in a power outage!

Severe storms and tornado safety
Have a discussion about the safest place in the home to be if a severe storm or tornado occurred. If a basement is not available or practical for use, the safest place is usually the smallest centrally located room without windows.

A **"watch"** means: conditions are favorable for a severe storm or tornado to occur.

A **"warning"** means: that a severe storm or tornado is actually happening and you should take cover. If you are traveling when conditions are favorable for a tornado, drive to the nearest large building that can be used as a shelter. Stay near a shelter until the threat has passed. If you are driving and a warning is issued, seek shelter in a large building. If a building is not available, you may need to lie down in a ditch or ravine. Do not try to outrun a tornado in your vehicle!

Winter storms
Winter storms call for special precautions. Snowfall, blizzards and ice storms can trap people inside for days. Snow and ice can break power lines and cause loss of electricity and heat. A winter storm may also cause utility failure. Extended exposure to cold temperatures may cause injury or death.

What precautions can you take?
- A battery-powered radio is your best source of information in an emergency.
- Draw water into as many containers as possible. Gather battery-powered lanterns, flashlights, etc. in case you lose your power. Make sure you have a home has a corded phone or cell phone!
- If candles are used, **BE CAUTIOUS!** Candle-holders should surround the candle totally (like a glass globe or a fish bowl). Do not leave a candle burning unattended. Battery operated candles or camp lights are good ideas!.
- If you experience heat failure, dress in layers and keep moving!
- If your home has fuel delivery, remember to assure an adequate supply of fuel is available at all times, especially if a winter storm is predicted!

Notes:

- If you experience a heating failure you may need to keep a steady trickle of water flowing from each faucet to prevent the pipes from freezing.
- If the temperature inside falls to below 55 degrees it may be necessary to contact someone so that you can evacuate.

Floods

Floods usually occur in Michigan during the Spring and Fall when rainfall and water runoff are at their peak. Floods can interrupt power and make roads impassable. Severe floods occur rarely, but knowing how to prepare and respond can prevent disaster.

Notification and warning

Notification of a flood **watch** or **warning** is received by:

Radio and television
Sirens and alert monitors
Emergency personnel who go door to door
National Weather Service or local emergency jurisdiction

If a flood warning is issued for your area, local government officials will issue evacuation instructions over the television or radio. Never drive through an area where water is covering the road or moving swiftly across the road. Turn around and find another route.

Water Shortage Precautions

- Keep a supply of bottled water in case of an emergency.
- Fill bathtubs if a water shortage is possible. This will allow water for filling toilets, washing dishes, personal care, etc.

Power Outage Concerns

Air Conditioning Failure:

Air conditioning failure can pose a serious threat to the elderly or those with other health conditions. The following tips will help you keep cool in an air conditioning failure:

- Shut all curtains
- Don't open windows unless it will let cooler air in.
- Go to a lower level of the home if possible to stay cool.

Foods that spoil:

If a power failure continues for a long time, food may begin to spoil. A loaded freezer will keep foods frozen 36-48 hours if the door is kept shut. Avoid opening freezer and refrigerator doors more than necessary. Transfer foods you will use soon to an insulated chest type freezer. If you can obtain ice, transfer as much as possible into coolers.

Gas Leaks:

If you think there is a gas leak do the following:

1. Evacuate immediately!
2. Do not turn any electrical switches on or off.
3. Do not use the telephone.
4. Do not use any matches or lighters.
5. Go to a neighbor's and call the gas company right away.

Carbon Monoxide Poisoning:
Carbon monoxide is a clear, odorless gas. The symptoms may be headaches, dizziness, and sleepiness. Carbon monoxide detectors are recommended. If your carbon monoxide detector goes off, or you suspect carbon monoxide poisoning, you must evacuate immediately!

Other emergencies:

- Know the symptoms and treatment of frostbite and hypothermia.
- Know the procedures for responding to a suspected poisoning.

Fire safety and prevention:
Immediate evacuation is the key to safety in a fire or smoke emergency. If a smoke detector goes off you should assist people out of the home immediately. Fighting a fire is never recommended.

Discuss safety concerns with your employer or their guardian. Things to consider and discuss are:

- Will your employer hear the alarm? Would a bed shaker or other assistive device help?
- Are their barriers in the home to a fast exit? Would rearranging a room be helpful?
- Does everyone know where they would meet when they exit the home?
- Does everyone know they should not re-enter the home once they are out?

Fire extinguishers:
An ABC (multi-purpose) extinguisher will put out most fires that start in a home. An extinguisher is useless unless you know how to operate it!

Using a fire extinguisher:

1. Hold extinguisher upright. Pull the pin out.
2. Stand at least 6-8 feet from the fire. Do not get closer!
3. Aim the nozzle at the base of the fire and squeeze the handles.
4. Sweep side to side slowly, moving closer as the flames diminish.

Fire extinguishers last only about 8-10 seconds! Fires can and do re-ignite. Fires can double in size every 19 seconds. Assisting people out is important. Fighting fires is not recommended.

Protection plans and considerations:
You should know how to assist or evacuate a person before an emergency. Are you confident in your ability to do this?

Fire prevention is the key to a safer environment!

- Are there enough working smoke detectors to provide sufficient warning? At minimum there should be one on every level and outside sleeping areas.
- Are detectors properly placed according to manufacturer instructions.
- Are detectors tested regularly?
- Are batteries replaced at least once a year?
- Don't take the battery out of a smoke detector because it keeps going off due to cooking, etc. If you are having nuisance alarms check to see if the detector is located too close to an area that would cause problems such as the kitchen or bathroom.

Monitoring provides opportunity for preventative measures!

___ Is a smoking policy available and in effect?
___ Are safety ashtrays used?
___ Fire extinguishers – minimum of one per floor and basement?
___ Is the extinguisher a 5 lb. ABC? (A 10 lb. is recommended).
___ Are hallways, stairways, egress routes clear of obstacles & storage?
___ Do all exit doors open easily?
___ Is there a special alarm for people who are deaf?
___ Are stairway handrails secure, steps in good condition?
___ Does the main floor have two separate means of egress?
___ If wheelchairs are used, is there a ramp at both exits?
___ Is the mechanical room free of stored items?
___ Is the furnace filter clean?
___ Are flammable or combustible items properly stored?
___ Is emergency lighting available?
___ Is the dryer vent solid or flexible metal?
___ Is the dryer filter cleaned after use?
___ Is the stove vent screen clean?
___ Does the oven door shut tightly?
___ Are electrical outlets overloaded?
___ Are there any frayed, hanging or exposed electrical cords?

Recipient Rights

THE RIGHTS OF INDIVIDUALS
RECEIVING MENTAL HEALTH
SERVICES

1

LEGAL BASIS OF RIGHTS

- Persons who receive mental health service have the same rights as you.
- It is important to understand where rights come from, what they are, and what additional rights are granted to recipients of mental health services in Michigan.
- Rights are defined by law and have a legal means of being protected.

2

Civil Rights

- Religious Expression
- Legal Protection
- Freedom of Speech
- Discrimination
- Search and Seizure
- Voting
- Due Process
- Education

3

Mental Health Code Rights

- **The right to have a written plan of service developed through a person-centered process. Person-centered planning means a process for planning and supporting the individual receiving services that builds upon the individual's preferences and choices, and abilities and promote community life. The person-centered planning process involves families, friends, and professionals, as the individual desires or requires.**
- **The right not to be required to receive treatment unless the law allows it and a court orders it.**

4

Confidentiality

Information about a recipient and his or her treatment is confidential. It is important to understand what is meant by confidentiality, to know what the Mental Health code requires of you, to recognize instances when the confidentiality of a recipient has been violated, and to know what you should do if this happens.

5

Mental Health Code Requirements Regarding Confidentiality

- Every recipient is informed about the law requiring confidentiality.
- A record is maintained of any information about the recipient that is disclosed. This record must indicate what information was released, to whom it was released and the reason for release.
- Some information can be provided to legal and medical personnel who are providing services to the recipient without obtaining a release of information. However, this information is limited to that which relates to the services being provided.
- There are times when it is appropriate to disclose information about a recipient.

6

Release of Information

- Is not pressured in any way to give consent
- Is able to understand what information he or she is agreeing to release.
- Understands the risks, benefits and consequences of agreeing, or not agreeing, to the release of information requested.

*A person who has a guardian is not legally capable of giving informed consent. In most cases involving children, informed consent must be obtained from their parents.

7

If you have questions about releasing information, or if someone is authorized to receive information, check with your supervisor.

8

Examples of Unknowingly Violating Confidentiality and Privacy

- Talking about recipients outside of work.
- Referring to recipients by name when discussing work with family or friends.
- Giving information over the phone to persons who say they are relatives.
- Taking photographs or videotapes of recipients without permission.
- Listening in on a recipient's phone call.
- Discussing information in a recipient's record with other mental health or service professionals who are not authorized to receive information.
- Referring to a recipient by name in another recipient's report for another recipient.
- Referring to a recipient by full name when speaking with another recipient's family or teachers.

9

Abuse & Neglect

- The abuse or neglect of a recipient is not acceptable and will not be tolerated. It is important to understand what is meant by abuse and neglect, to recognize a situation that is abusive or neglectful, and to know what the law requires you to do when you become aware that a recipient has been abused or neglected.
- Abuse and Neglect are defined in the Administrative Rules of the Department of Community Health. These rules supplement the Mental Health Code and have the force of the law.
- Abuse and Neglect definitions have several classes and are based upon the action taken and the severity of the injury to the recipient.

10

ABUSE – CLASS I

A non-accidental act or provocation of another to act by an employee, volunteer, or agent of a provider that caused or contributed to the death, or sexual abuse of, or serious physical harm to a recipient.

11

Abuse Class II

- A non-accidental act or provocation of another to act by an employee, volunteer, or agent of a provider that caused or contributed to non-serious physical harm to a recipient.
- Any action or provocation of another to act that causes or contributes to emotional harm to a recipient.
- An action taken on behalf of a recipient by a provider who assumes the recipient is incompetent, despite the fact that a guardian has not been appointed, that results in substantial economic, material, or emotional harm to the recipient.
- The exploitation of a recipient. Exploitation means an action taken by an employee that involves the misappropriation or misuse of a recipient's property or funds for the benefit of an individual or individuals other than the recipient.

12

Abuse Class II – Unreasonable Force

Unreasonable force means physical management or force that is applied by an employee to a recipient in one or more of the following circumstances:

- There is no imminent risk of serious or non-serious physical harm to the recipient, staff or others.
- The physical management used is not in compliance with techniques approved by the provider and the responsible mental health agency.
- The physical management used is not in compliance with the emergency interventions authorized in the recipient's individual plan of service.
- The physical management or force is used when other less restrictive measures were possible but not attempted immediately before the use of physical management or force.

13

ABUSE – CLASS III

Abuse Class III is the use of language or other means of communication by an employee to degrade, threaten, or sexually harass a recipient.

14

Examples of Abuse

- Any sexual contact with a recipient.
- Sexually harassing a recipient.
- Making remarks which could be emotionally harmful to a recipient.
- Causing or prompting others to commit any of the actions listed above.
- Hitting, slapping, biting, poking, or kicking a recipient.
- Use of weapons on a recipient.
- Swearing at, using foul language, racial or ethnic slurs, or other means of communication to degrade, or threaten, the recipient.

15

NEGLECT – CLASS I

- Acts of commission or omission by an employee that result from a noncompliance with a standard of care or treatment required by law, rules, policies, guidelines, written directives, procedures, or individual plan of service and that causes or contributes to the death, or sexual abuse of, or serious physical harm to a recipient.

- The failure to report Abuse Class I or Neglect Class I.

16

NEGLECT – CLASS II

- Acts of commission or omission by an employee that result from noncompliance with a standard of care or treatment required by law, rules, policies, guidelines, written directives, procedures, or individual plan of service and that cause or contribute to non-serious physical harm or emotional harm to a recipient.
- The failure to report Abuse Class II or Neglect Class II.

17

NEGLECT – CLASS III

- Acts of commission or omission by an employee that result from noncompliance with a standard of care or treatment required by law, rules, policies, guidelines, written directives, procedures, or individual plan of service and that either placed or could have placed a recipient at risk of physical harm or sexual abuse, or
- The failure to report Abuse Class III or Neglect Class III.

*Note: No actual harm has to occur to the recipient in Class 3 neglect; it is only required that the recipient be placed in a situation where there is, or could be, a risk of harm.

18

Examples of Neglect

- Leaving a recipient, who is not able to care for himself, unattended.
- Not providing the proper medication or the correct dosage of a medication.
- Being aware of an abusive or neglectful situation and not reporting that to the Recipient Rights Office and to your supervisor.

19

REPORTING ABUSE AND NEGLECT

WHEN YOU SEE OR HEAR ABOUT A RECIPIENT BEING ABUSED OR NEGLECTED, IT IS IMPORTANT THAT YOU TAKE ACTION QUICKLY!

- **Protecting the recipient is your primary responsibility. The failure to report abuse or neglect will result in your being charged with neglect as well.**
- **All violations must be verbally reported immediately and followed up by a written report within 24 hours or at the end of your shift.**

20

Dignity & Respect

Dignity
To be treated with esteem, honor, politeness, or honesty; to be addressed in a manner that is not patronizing, condescending, or demeaning, to be treated as an equal; to be treated the way the individual wants to be treated.

Respect
To show differential regard for; to be treated with esteem, concern, consideration, or appreciation; to protect the individual's privacy, to be sensitive to cultural differences; to allow the individual to make choices.

21

Services Suited to Condition

Encompassing the Person Centered philosophy, a recipient is entitled to treatment suitable to his or her own condition, medical care, and medication for mental and physical health, as needed.

22

Freedom of Movement

- The recipient shall not be restricted more than what is necessary to provide services, to prevent injury, or to prevent substantial property damage. Any limitations on freedom of movement must be clinically justified on a time-limited basis and entered into the recipient's record.
- Recipients shall receive services in the **LEAST** restrictive setting.

23

Restraint & Seclusion

Seclusion
Temporary placement of a recipient in a room alone, where egress is prevented by any means. Seclusion is NOT to be used in community treatment settings.

Restraint
The use of physical devise to restrain an individual's movement. Restraint shall NOT be used in any programs under contract with BABH.

24

Personal Property

- The recipient is entitled to receive, possess, and use all personal property, including clothing, except for those items prohibited including: weapons, drugs, etc.
- Any exclusion of personal property shall be written and posted in each setting. Additional limitations may be imposed in the recipient's plan of service.

25

Entertainment Materials

- Recipients shall have the right to entertainment material, information, and news. The recipient shall not be prevented from obtaining, reading, viewing, listening to material at his or her own expense.
- Any limitations must be specifically approved in the recipient's plan of service.

26

Communication, Telephone, Visitors, Mail

- A recipient shall be provided access to a telephone for incoming and outgoing calls during hours stated in the house rules, unless the recipient is otherwise restricted in an approved treatment plan.
- A recipient shall be guaranteed regular visiting hours, unless the recipient is otherwise restricted in an approved treatment plan. Visiting hours shall be scheduled to be least disruptive of normal treatment activity and to occur on no less than three days weekly.
- A recipient shall be provided daily distribution of mail unless the recipient is restricted and limitations have been incorporated into the recipient's treatment plan. A postal box or daily pickup and deposit of mail shall be provided.

27

INVESTIGATING RIGHTS ALLEGATIONS

- Anyone can file a complaint on behalf of a recipient. If you become aware that a recipient's rights are being violated, you must report this to the Rights Office.
- The Rights Officer from the CMH Board reviews all allegations of rights violations and all incident reports involving recipients in their jurisdiction.
- The Office of Recipient Rights may investigate and can make recommendations about remedial action, the service provider, and the responsible CMH Services Program.
- Rights Officers often serve as advocates for individuals and groups of recipients.

28

INVESTIGATING RIGHTS ALLEGATIONS

You can contact the local Rights Office Monday – Friday between 8:00 am – 5:00pm at (989) 895-2317:

Recipient Rights Staff

Melissa Prusi, Recipient Rights Manager

Janelle Steckley, Recipient Rights Advisor

Vicki Atkinson, Recipient Rights Secretary

- If the actions of the local officer do not solve the problem, you can contact the Department of Community Health Office of Recipient Rights. Write or Call:

  Office of Recipient Rights, Michigan DCH

  Lewis Cass Bldg.

  Lansing, MI 48913

  (800) 854-9090

29

The Investigative Process **See Handout**

- The Recipient Rights Officer has access to all documentation and any staff necessary to complete the investigation.
- You are expected to answer questions about work related matters asked by the Rights Officer, the State Police, DCH, or DHS and Industry authorities who are conducting a review or investigation.
- You have the right to talk to an attorney before giving answers to others.
- You have the right to have any attorney or personal representative present during questioning by the police.
- The Mental Health Code requires an investigation be completed within 90 days of receipt of the complaint.
- A "Report of Investigative Findings" will be given to the Executive Director of the CMH agency and to the service provider.
- The CMH Executive Director is responsible to issue a report summarizing the investigation to the complainant and the recipient within 10 days after receiving the Rights Officer's investigate report.

30

RESULTS OF SUBSTANTIATED INVESTIGATION

The decision about what happens to a staff person who has committed abuse or neglect, or otherwise violated the rights of a recipient, rests with the employer. Each provider should have policies and procedures for dealing with offenses. These should emphasize the seriousness of improper actions.

31

The Appeal Process

- **Upon completion of a recipient rights investigation, the recipient, his or her guardian, the parent of a minor, and, of course, the person who made the compliant, have the right to appeal the decision. This appeal can be made for the following reasons:**
- **The findings of the investigation are inconsistent with the law, facts, rules, and policies or guidelines;**
- **The action, or plan of action, is inadequate; or,**
- **The investigation was untimely.**

***NOTE: Staff are not eligible to file an appeal unless they were the complainant.**

32

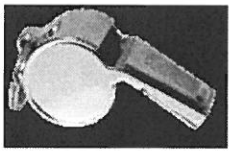
Employee Rights

You have rights that protect you from actions based on incorrect or malicious information. There are laws which protect employees when they report rights violations.

The **Mental Health Code** mandates that complainants, staff of the Office of Recipient Rights, and any staff acting on behalf of a recipient will be protected from harassment or retaliation resulting from recipient rights activities and that appropriate disciplinary action will be taken if there is evidence of harassment or retaliation.

33

WHISTLEBLOWERS PROTECTION ACT



- Protects employees who report rights violations.
- The law states it is illegal for employers in Michigan to discharge, threaten, or otherwise discriminate against you regarding compensation, terms, conditions, locations, or privileges of employment because you, or a person acting on your behalf:
  - Reports, or is about to report a violation, or a suspected violation.
  - Takes part in a public hearing, investigation inquiry, or court action.

34

BULLARD-PLAWECKI EMPLOYEE RIGHT TO KNOW ACT

This act requires that you be notified when an employer or former employer divulges:

- **A Disciplinary Report**
- **Letter of Reprimand**
- **Other disciplinary action to a third party, to a party who is not a part of the employers organization, or to a party who is not a part of a labor organization representing the employee without written notice.**

***NOTE: The written notice to the employee shall be by first-class mail to the employee's last known address, and shall be mailed on or before the day the information is divulged from the personnel record.**

35

Incident Reports

Circumstances in which an Incident Report is required:

- Any explained or unexplained injury of a recipient
- An unusual or first time medically related occurrence, such as seizures
- Environmental emergencies
- Problem behaviors not addressed in the treatment plan such as breaking things, attacking people, or setting fires
- Suspected abuse or neglect (a complaint form should also be completed)
- Inappropriate sexual acts (excessive masturbation, inappropriate touching of others, etc.)
- Medication errors or refusals
- Suspected criminal offenses involving recipients
- Use of physical intervention
- Involvement of other agencies (police, hospital, fire, etc.)
- Any unauthorized leave of absence of a recipient
- The death of a recipient

36

If you have any questions regarding Recipient Rights, please contact your local Recipient Rights Office.

37

Plan of Service Training Form

Consumer Name: ______________________________

Consumer ID Number: ______________________________

Plan Type: (choose all that apply)

Plan of Service (Case Mgmt/Outpt)   Dietary Plan   Nursing Plan   Behavior Treatment Plan   OT/PT/SLP Plan

Other: ____________________

Staff Name (Print)	Signature of Staff	Trainer Name (Print)	Trainer Signature	Date of Training