The Arc
Oakland County

Serving persons with intellectual and developmental disabilities since 1967

Hello and Welcome to The Arc of Oakland County!

We are the Financial Management Services (FMS) team for Self-Directed individuals choosing the Direct Hire or Employer of Record program! Attached you will find the required New Hire paperwork, as well as training requirements.

Required Direct Support Professional paperwork includes:

- Copy of **Michigan Driver's License**
- Copy of **Social Security Card**
- **Direct Deposit Form** (with copy of voided check or bank statement)

Required Direct Support Professional training certifications **must be completed before starting** & includes:

- **New Hire Recipient Rights** (4 hour webinar)
  - Online *Annual* updates every year (only BEFORE expiration or repeat New Hire class)
- **First Aid** and CPR (optional) In-Person (4 Hours), updated every two years
- **Bloodborne Pathogens** (1hour), updated annually
- **Environmental Emergency Preparedness** (1 Hour), updated every two years
- **In-Service iPOS goals and objectives with Support Coordinator.** Sign-in Sheet submitted.

Note: *All Direct Support Professionals MUST complete all required training BEFORE beginning to work.*

In compliance with the Cures Act that became law in 2016, Michigan Department of Health & Human Services (MDHHS) is requiring the use **of Electronic Visit Verification (EVV)** by September 2024.
EVV is an electronic validation of the date, time, location, type of care, and the individual(s) providing and receiving services. The Arc of Oakland County will be using our billing system, **Direct Care Innovations (DCI)** for Electronic Visit Verification (EVV). See documents in the packet regarding EVV to review.
You will NOT have access to DCI until we've received a completed New Hire Packet, ALL required training certifications, and have properly set you up in the system.
Any questions regarding EVV can be directed to your assigned Client Account Specialist.

Please allow 5-7 business days to process New Hire Packets upon COMPLETION (including all required training certificates). We are unable to process payment for individuals without a complete packet. **You and your employee will be notified with approval to begin working.** It is not suggested that you begin working before this approval, as we cannot guarantee payment.

All documents, certifications, and payroll related questions can be sent to:
fitimesheet@thearcoakland.org or fax: 248-816-3340
Make sure any email attachments are sent as PDFs.

If you need any assistance, please contact me. 248-816-1900, FMS option 1.
Thank you,

Diane McDaniel
Onboarding & Training Manager

Achieve with us.

The Arc
Oakland County

Hello Employer of Record Families and Employers! **Welcome to DCI for EVV!**

EVV (Electronic Visit Verification) is an electronic validation of the date, time, location, type of care, and the individual(s) providing and receiving services. The Arc of Oakland County will be using our billing system, **Direct Care Innovations** (**DCI**) for EVV.

All of this simply means that your employees will be clocking in and clocking out for their work shifts rather than recording on a paper timesheet or invoice! And you, as the employer, have access to all of this information whenever you want! Giving you the ability to manage your own staff!

Important First Steps:
Your Direct Service Professional will need to complete the New Hire Packet and submit to The Arc of Oakland County. Please allow 5 to 7 business days for processing. You will both receive an eligibility email from us giving your new employee approval to begin working.

Getting Started:
Download the **DCI Mobile App** on your smart phone or tablet. The App is free*
OR You can also just use the website on your desktop if you prefer not to have it on your phone!
DCI Website https://thearcoakland.dcisoftware.com/

If it is the first time logging in, you will need the System ID# 1641
User ID: FirstnameLastname
Password: TheArcmmdd!
PIN# mmdd (month and date of birth)
if neither work, you can use the forgot password link or contact me
Please note: you will be unable to log into DCI without the above approval first.

This will allow for you to approve punches that were manually entered in by the employee/s, see hours remaining in current quarters and future quarters, shifts being automatically submitted to The Arc for payment.

Direct Support Professionals will be "clocking in" and "out" in real time via the **DCI Mobile App**. Mileage will also be accounted for while they are clocked in.
If a clock in is missed or incorrect, you have to let us know so we can correct it.
Best most efficient way to make sure corrections are done is to email them to:
FITimesheet@thearcoakland.org AND your FMS Account Specialist

Staff will be getting paid based on their entries in DCI. If there are any errors, you or your staff can notify us to make the correction or cancel the shift before they can re-enter via the web portal.

It is important for you to review staff punches every week and sign off on any punches that were manually entered via the DCI Website (rather than the DCI Mobile App).

Hello Direct Support Professionals! **Welcome to DCI for EVV!**

EVV (Electronic Visit Verification) is an electronic validation of the date, time, location, type of care, and the individual(s) providing and receiving services. The Arc of Oakland County will be using our billing system, Direct Care Innovations (**DCI**) for EVV.

All of this simply means that you will be clocking in and clocking out for your work shifts rather than recording on a paper timesheet or invoice!

Important First Steps:
New Employees will need to complete the New Hire Packet and submit to The Arc of Oakland County. Please allow 5 to 7 business days for processing. You and your employer will both receive an eligibility email from us giving approval to begin working.

Getting Started
Download the **DCI Mobile App** on your smart phone or tablet. The App is free*
If it is your first time logging into DCI, you will need the System ID# 1641
User ID: firstname.lastname
Password: TheArcmmdd!
PIN# mmdd (month and date of birth)
if neither work, you can use the forgot password link
Please note: you will be unable to log into DCI without the above approval first.

Once you are logged in, you will be ready to clock in on your next shift!
You are automatically linked to your client(s) and their authorized services. Each service will need its own clock in and out, just like each service would be on different lines on the timesheet.
After you hit the "clock in" button, make sure you go through the confirmation screens for your "clock in" to register.
Once you are correctly "clocked in" the only other option on the screen will be "clock out". This means you are active within a work shift!
At this time, you may also start a transportation service if your client is authorized for CLS miles.

After your shift is over, you will hit the "clock out" button. You will then be prompted to enter your CLS logs or notes.
Continue through the confirmation screens to clock out.

At the end of each week (Friday or Saturday), it is your responsibility to review your hours for the week.
If there are any errors, please report them to us so we can make the proper adjustments.

What Do I Do When…?

- I can't clock in!
  - Don't panic! Just make sure to let us know via email and include the reason code it gives you.
    The Arc FMS staff will make any necessary corrections. This may require you to enter the shift via the DCI website rather than the DCI Mobile App.
    Some common reasons for this: authorizations maxed out or not updated, training is expired, etc.
- The service I'm about to work isn't showing in the drop-down menu!
  - Same work around as above.
- My shift reads as "pending".
  - Just let us know! Possible cause - It may need to be signed off by your employer.

AUTHORIZATION AND RELEASE
CRIMINAL BACKGROUND CHECK

I understand in order to provide services, a criminal background check must be completed, *annually*. I have been informed that a criminal history may disqualify me from providing services and understand that The Arc of Oakland County, Inc. will notify me of the results. I further understand that The Arc of Oakland County Inc. will notify the requesting family as to my eligibility to provide services.

I hereby authorize and release from all liability without reservation, The Arc of Oakland County, Inc., any law enforcement agency, administrator, State/Federal agency, or institution gathering or furnishing the above information.

PLEASE INCLUDE A PHOTOCOPY OF A MICHIGAN DRIVER'S LICENSE OR STATE IDENTIFICATION

_____ _____

Signature **Date**

_____ _____

Name (print full name) **Date of Birth (must be 18 yrs or older)**

Male/Female
(Circle One)

Race - White, Black, Asian, Pacific Islander, American Indian or Alaskan Native, Unknown/Other
(Circle One)

_____

_____

Print all other names previously used

_____ _____

Current Address **City**

_____ _____

State **Zip Code**

Providing Services For: _____
Name (print)

Send or fax to: The Arc of Oakland County, Inc.
1641 W. Big Beaver Road
Troy, MI 48084
Email: fitimesheet@thearcoakland.org
Fax (248) 816-3340

This authorization form must be completed before a new background check is run *every year* in order to remain eligible to provide services.

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

* The Arc of Oakland County is *NOT* the direct employer, but is chosen as the Fiscal Intermediary to act as the payroll agent by the client/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
The Arc of Oakland County	Monica Knoblock

Address	City	State	Zip Code
1641 West Big Beaver Road	Troy	MI	48236

Email	Fax	Phone Number
fitimesheet@thearcoakland.org	248-816-3340	248-816-1900

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.

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

2025

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.)

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 (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (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):

Multiply the number of qualifying children under age 17 by $2,000 $ _____

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): 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. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

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

Step 5: Sign Here

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

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

Employers Only

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

General Instructions

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

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2025 if you meet both of the following conditions: you had no federal income tax liability in 2024 **and** you expect to have no federal income tax liability in 2025. You had no federal income tax liability in 2024 if (1) your total tax on line 24 on your 2024 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2025 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 17, 2026.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

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

2. Expect to work only part of the year;

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

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

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

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

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

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

Specific Instructions

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

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

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

Instead, if you (and your spouse) have a total of only two jobs, you may check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

Multiple jobs. *Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.*

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2025 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

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 4. 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 4 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 4 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 (along with any other additional amount you want withheld) . . . . . **4** $

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

1 Enter an estimate of your 2025 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $

2 Enter:
- $30,000 if you're married filing jointly or a qualifying surviving spouse
- $22,500 if you're head of household
- $15,000 if you're single or married filing separately

. . . . . **2** $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . **3** $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . **4** $

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . **5** $

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$700	$850	$910	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020
$10,000 - 19,999	0	700	1,700	1,910	2,110	2,220	2,220	2,220	2,220	2,220	2,220	3,220
$20,000 - 29,999	700	1,700	2,760	3,110	3,310	3,420	3,420	3,420	3,420	3,420	4,420	5,420
$30,000 - 39,999	850	1,910	3,110	3,460	3,660	3,770	3,770	3,770	3,770	4,770	5,770	6,770
$40,000 - 49,999	910	2,110	3,310	3,660	3,860	3,970	3,970	3,970	4,970	5,970	6,970	7,970
$50,000 - 59,999	1,020	2,220	3,420	3,770	3,970	4,080	4,080	5,080	6,080	7,080	8,080	9,080
$60,000 - 69,999	1,020	2,220	3,420	3,770	3,970	4,080	5,080	6,080	7,080	8,080	9,080	10,080
$70,000 - 79,999	1,020	2,220	3,420	3,770	3,970	5,080	6,080	7,080	8,080	9,080	10,080	11,080
$80,000 - 99,999	1,020	2,220	3,420	4,620	5,820	6,930	7,930	8,930	9,930	10,930	11,930	12,930
$100,000 - 149,999	1,870	4,070	6,270	7,620	8,820	9,930	10,930	11,930	12,930	14,010	15,210	16,410
$150,000 - 239,999	1,870	4,240	6,640	8,190	9,590	10,890	12,090	13,290	14,490	15,690	16,890	18,090
$240,000 - 259,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$260,000 - 279,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$280,000 - 299,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$300,000 - 319,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,170	19,170
$320,000 - 364,999	2,040	4,440	6,840	8,390	9,790	11,100	12,470	14,470	16,470	18,470	20,470	22,470
$365,000 - 524,999	2,790	6,290	9,790	12,440	14,940	17,350	19,650	21,950	24,250	26,550	28,850	31,150
$525,000 and over	3,140	6,840	10,540	13,390	16,090	18,700	21,200	23,700	26,200	28,700	31,200	33,700

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$200	$850	$1,020	$1,020	$1,020	$1,370	$1,870	$1,870	$1,870	$1,870	$1,870	$2,040
$10,000 - 19,999	850	1,700	1,870	1,870	2,220	3,220	3,720	3,720	3,720	3,720	3,890	4,090
$20,000 - 29,999	1,020	1,870	2,040	2,390	3,390	4,390	4,890	4,890	4,890	5,060	5,260	5,460
$30,000 - 39,999	1,020	1,870	2,390	3,390	4,390	5,390	5,890	5,890	6,060	6,260	6,460	6,660
$40,000 - 59,999	1,220	3,070	4,240	5,240	6,240	7,240	7,880	8,080	8,280	8,480	8,680	8,880
$60,000 - 79,999	1,870	3,720	4,890	5,890	7,030	8,230	8,930	9,130	9,330	9,530	9,730	9,930
$80,000 - 99,999	1,870	3,720	5,030	6,230	7,430	8,630	9,330	9,530	9,730	9,930	10,130	10,580
$100,000 - 124,999	2,040	4,090	5,460	6,660	7,860	9,060	9,760	9,960	10,160	10,950	11,950	12,950
$125,000 - 149,999	2,040	4,090	5,460	6,660	7,860	9,060	9,950	10,950	11,950	12,950	13,950	14,950
$150,000 - 174,999	2,040	4,090	5,460	6,660	8,450	10,450	11,950	12,950	13,950	15,080	16,380	17,680
$175,000 - 199,999	2,040	4,290	6,450	8,450	10,450	12,450	13,950	15,230	16,530	17,830	19,130	20,430
$200,000 - 249,999	2,720	5,570	7,900	10,200	12,500	14,800	16,600	17,900	19,200	20,500	21,800	23,100
$250,000 - 399,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$400,000 - 449,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$450,000 and over	3,140	6,490	9,160	11,660	14,160	16,660	18,660	20,160	21,660	23,160	24,660	26,160

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$450	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,870	$1,870	$1,870	$1,890
$10,000 - 19,999	450	1,450	2,000	2,200	2,220	2,220	2,220	3,180	4,070	4,070	4,090	4,290
$20,000 - 29,999	850	2,000	2,600	2,800	2,820	2,820	3,780	4,780	5,670	5,690	5,890	6,090
$30,000 - 39,999	1,000	2,200	2,800	3,000	3,020	3,980	4,980	5,980	6,890	7,090	7,290	7,490
$40,000 - 59,999	1,020	2,220	2,820	3,830	4,850	5,850	6,850	8,050	9,130	9,330	9,530	9,730
$60,000 - 79,999	1,020	3,030	4,630	5,830	6,850	8,050	9,250	10,450	11,530	11,730	11,930	12,130
$80,000 - 99,999	1,870	4,070	5,670	7,060	8,280	9,480	10,680	11,880	12,970	13,170	13,370	13,570
$100,000 - 124,999	1,950	4,350	6,150	7,550	8,770	9,970	11,170	12,370	13,450	13,650	14,650	15,650
$125,000 - 149,999	2,040	4,440	6,240	7,640	8,860	10,060	11,260	12,860	14,740	15,740	16,740	17,740
$150,000 - 174,999	2,040	4,440	6,240	7,640	8,860	10,860	12,860	14,860	16,740	17,740	18,940	20,240
$175,000 - 199,999	2,040	4,440	6,640	8,840	10,860	12,860	14,860	16,910	19,090	20,390	21,690	22,990
$200,000 - 249,999	2,720	5,920	8,520	10,960	13,280	15,580	17,880	20,180	22,360	23,660	24,960	26,260
$250,000 - 449,999	2,970	6,470	9,370	11,870	14,190	16,490	18,790	21,090	23,280	24,580	25,880	27,180
$450,000 and over	3,140	6,840	9,940	12,640	15,160	17,660	20,160	22,660	25,050	26,550	28,050	29,550

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

INSTRUCTIONS TO *EMPLOYEE'S MICHIGAN WITHHOLDING EXEMPTION CERTIFICATE* (Form MI-W4)

You must submit a Michigan withholding exemption certificate (form MI-W4) to your employer on or before the date that employment begins. If you fail or refuse to submit this certificate, your employer must withhold tax from your compensation without allowance for any exemptions. Your employer is required to notify the Michigan Department of Treasury if you have claimed 10 or more personal or dependency exemptions or claimed that you are exempt from withholding.

You MUST provide a new MI-W4 to your employer within 10 days if your residency status changes or if your exemptions decrease because: a) your spouse, for whom you have been claiming an exemption, is divorced or legally separated from you or claims his/her own exemption(s) on a separate certificate, or b) a dependent no longer qualifies under the Internal Revenue Code.

Line 5: If you check "Yes," enter your date of hire.

Line 6: Personal and dependency exemptions. The number of exemptions claimed here may not exceed the number of exemptions you are entitled to claim on a *Michigan Individual Income Tax Return* (Form MI-1040). Dependents include qualifying children and qualifying relatives under the Internal Revenue Code, even if your AGI exceeds the limits to claim federal tax credits for them.

Do not claim the same exemptions more than once or tax will be under-withheld. Specifically, **do not claim:**

- Your personal exemption if someone else will claim you as their dependent.
- Your personal exemption with more than one employer at a time.
- Your spouse's personal exemption if they claim it with their employer.
- Your dependency exemptions if someone else (for example, your spouse) is claiming them with their employer.

Line 7: You may designate additional withholding if you expect to owe more than the amount withheld.

Line 8a: You may claim exemption from Michigan income tax withholding if all of the following conditions are met:

i) Your employment is intermittent, temporary, or less than full time;

ii) Your personal and dependency exemptions exceed your annual taxable compensation;

iii) You claimed exemption from federal withholding; and

iv) You did not incur a Michigan income tax liability for the previous year.

Line 8b: Reasons wages might be exempt from withholding include:

- You are a nonresident spouse of military personnel stationed in Michigan.
- You are a resident of one of the following reciprocal states while working in Michigan: Illinois, Indiana, Kentucky, Minnesota, Ohio, or Wisconsin.
- You are an enrolled member of a federally-recognized tribe that does not have a tax agreement with the state of Michigan, you reside within that tribe's Indian Country (as defined in 18 USC 1151), and compensation from this job will be earned within that Indian Country.

Line 8c: For questions about Renaissance Zones, contact your local assessor's office.

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 07/31/2026

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Additional Information

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

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

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

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

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

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

LISTS OF ACCEPTABLE DOCUMENTS

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Acceptable Receipts

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

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

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

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

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

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

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

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

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

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

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

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

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

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

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

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

Supplement B,

Reverification and Rehire (formerly Section 3)

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

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

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

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

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

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

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

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

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

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

Direct Deposit

Please complete and return along with a canceled check to:

The Arc of Oakland County, Inc
Attn: Accounts Payable
1641 W. Big Beaver Road
Troy, MI 48084
Or fax to: 248.816.3340

I hereby authorize The Arc of Oakland County, Inc. to deposit any amounts owed by initiating credit entries to my accounts at the financial institutions indicated on this form.

This authorization to remain in full force and effect until The Arc of Oakland County and the bank have received written notice from me to terminate.

Name_____

Address, City, ST, Zip_____

Signature_____Date_____

Account Information:

Direct Deposit #1 $ _____	Direct Deposit #2 $ _____	Direct Deposit #3 $ _____
☐ Checking ☐ Savings	☐ Checking ☐ Savings	☐ Checking ☐ Savings
Bank Routing # _____	Bank Routing # _____	Bank Routing # _____
Account # _____	Account # _____	Account # _____

You must provide a valid Email Address and phone number:

Email Address: _____ Phone: _____

Please note:

This form requires a voided check or printout with account numbers from your banking institution be submitted before we can process this request.

The Arc
Oakland County

PAY SCHEDULE – FISCAL YEAR 2025

Using DCI for EVV – PLEASE NOTE:

- Punches must be in DCI (App or Portal) according to the schedule below to be paid on time.
- Please alert your FMS Client Account Specialist via email of any necessary corrections to punches BEFORE Due Date!
- CLS Logs and Respite Notes must be recorded in the DCI Mobile App at clock out OR uploaded to the DCI Website Portal later.
- Medicaid requires all employees to be current in required certifications on the date a service is provided to be paid for that service. Employees can see their current/expiring certifications in DCI.

Clients that are allowed "EVV Exemptions" PLEASE NOTE:

- Timesheets must be completed in full to be processed for payment, including a Pay Rate and *both* EMPLOYEE and EMPLOYER Signatures.
- CLS Logs must be submitted with timesheets to be processed for payment. Respite Notes must be included on the timesheet.
- Timesheets must be submitted every two weeks according to the Pay Schedule. We are unable to process claims older than 30 days.
- Medicaid requires all employees to be current in required certifications on the date a service is provided to be paid for that service.
- Timesheets received after the 9am deadline are considered LATE and will be processed with the following Pay Period.

Please submit documents via EMAIL fitimesheet@thearcoakland.org or FAX # 248-816-3340

PAY PERIOD Dates of Service (Saturday – Friday)	Submitted BY Monday 9AM	PAY DATE - FRIDAY
9/28 - 10/11/2024	October 14, 2024	October 25, 2024
10/12 - 10/25/2024	October 28, 2024	November 8, 2024
10/26 - 11/8/2024	November 11, 2024	November 22, 2024
11/9 - 11/22/2024	November 25, 2024	December 6, 2024
11/23 - 12/6/2024	December 9, 2024	December 20, 2024
12/7 - 12/20/2024	December 23, 2024	January 3, 2025
12/21 - 1/3/2025	January 6, 2025	January 17, 2025
1/4 - 1/17/2025	January 20, 2025	January 31, 2025
1/18 - 1/31/2025	February 3, 2025	February 14, 2025
2/1 - 2/14/2025	February 17, 2025	February 28, 2025
2/15 - 2/28/2025	March 3, 2025	March 14, 2025
3/1 - 3/14/2025	March 17, 2025	March 28, 2025
3/15 - 3/28/2025	March 31, 2025	April 11, 2025
3/29 - 4/11/2025	April 14, 2025	April 25, 2025
4/12 - 4/25/2025	April 28, 2025	May 9, 2025
4/26 - 5/9/2025	May 12, 2025	May 23, 2025
5/10 - 5/23/2025	May 26, 2025	June 6, 2025
5/24 - 6/6/2025	June 9, 2025	June 20, 2025
6/7 - 6/20/2025	June 23, 2025	July 4, 2025
6/21 - 7/4/2025	July 7, 2025	July 18, 2025
7/5 - 7/18/2025	July 21, 2025	August 1, 2025
7/19 - 8/1/2025	August 4, 2025	August 15, 2025
8/2 - 8/15/2025	August 18, 2025	August 29, 2025
8/16 - 8/29/2025	September 1, 2025	September 12, 2025
8/30 - 9/12/2025	September 15, 2025	September 26, 2025
9/13 - 9/26/2025	September 29, 2025	October 10, 2025
9/27 - 10/10/2025	October 13, 2025	October 24, 2025

Individuals Name: _____

CONID: _____

Employment Agreement to Self-Direct Services
(For Direct Hire Staff)

This agreement was made on _____day of _____, by and between _____ (an Individual Self-Directing services) or _____ (Legal Representative on behalf of _____) residing at _____, both separately and collectively hereinafter referred to as the Employer, and _____ (Direct Support Professional or "Employee"). The purpose of this agreement is to describe the general tasks and related duties of the Behavioral Health and Intellectual and Development Disability Supports and Services ("Supports and Services") that the employee will provide to the employer and the terms and conditions of employment as it relates to compensation using Medicaid/Public Funding.

Article I Employee Responsibilities

1. Provide support to the employer by performing duties outlined in this agreement, any attachments to it, and the Individual Plan of Service (IPOS).
2. Acknowledge that employment is dependent on the Employer's participation in a Self-Directed arrangement through Oakland Community Health Network (OCHN).
3. Submit documentation verifying that the minimum hiring requirements are satisfied as a pre-condition for employment and complete prior to working alone with the Individual and then update annually unless stated otherwise.
4. Agree to document services in a manner that fully discloses the extent of the services provided as required by Medicaid rules and as outlined in the Individual's IPOS. Documentation must correspond with timesheets, be complete, concise, accurate, and include the face-to-face time spent providing services. Documentation must be legible (i.e. easy to read), signed, and dated.
5. Maintain sufficient documentation of the services provided as required by my employer, Oakland Community Health Network, and as outlined in the Individual's Plan of Service.
6. All information in the record will be kept confidential and released only upon the written consent of the Employer. Acknowledge that all records are the property of the Employer and shall be returned to him/her at the time the employment relationship terminates.
7. Agree to assist the employer in filing Recipient Rights complaints upon request. Understand that I have a responsibility to report rights violations of which I am aware 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 his or her rights. Complete Incident Reports when unusual incidents happen.
8. Agree to record real time hours worked through the Electronic Visit Verification (EVV) system or to submit signed and dated payroll documentation to the employer to support payment of wages for services rendered if no EVV is available. Paychecks shall be issued by the Financial Management Service Agency according to their contract with OCHN on behalf of the employer.
9. Authorize the Financial Management Services Agency to make payments outlined in the Employer's Budget. Payments may include Provider payments, employer tax payments, worker's compensation insurance, mileage, etc.

10. Understand and acknowledge that the Employer is the "sole" employer and that I am not an employee of Oakland Community Health Network (OCHN) which acts as the Pre-Paid Inpatient Health Plan (PIHP) and pays for services to the Financial Management Services agency, the Financial Management Service Agency, which is the financial administrator of funds used, or the Self-Determination Administration provider if any. All agencies will be held harmless for their role in administering Self- Directed services.

11. Understand that this employment is an at will relationship, which can be terminated by me or by the employer at any time. However, the employer cannot terminate my employment based on my race, religion, sex, disability, or other protected status under federal or Michigan law. In addition, I agree to give 14 days' written notice to my employer if I plan to terminate employment.

12. Understand that all timesheets and documentation to support the service must be submitted to the FMS no later than 30 days after the service was provided or Medicaid dollars cannot be used to pay for the service.

13. I agree to execute a Medicaid Provider Agreement (**Attachment A**) with OCHN and acknowledge that this agreement does not alter the fact that OCHN is only the PIHP. I understand that my employment is contingent on completing this agreement.

14. Acknowledge and sign **(Attachment B)**.

Article II Employer Responsibilities (Employer of Record)

1. Provide the Financial Management Service Agency with the necessary documentation to assure timely compensation for my employee, as identified by their payroll schedule. Timesheets and documentation must be submitted no later than 30 days after the service was provided, or Medicaid dollars cannot be used to pay for the service.

2. If the Financial Management Service (FMS) is utilizing an Electronic Visit Verification system (real time electronic timesheets), the employer will monitor the real time electronic signed time sheets and authorize payment for the delivery of services as specified in this agreement and not to exceed the authorizations as identified in the IPOS and individual budget. If the employee is required to submit timesheets to the FMS, the employer will verify supports and services indicated on the timesheet prior to signing and submitting to FMS for payment.

3. Maintain copies of timesheets, employment agreements, training records, and service documentation that is complete, concise, accurate, and include the face-to-face time spent providing services. Documentation must be recorded in a manner that discloses the full extent of the services provided, be legible, signed, and dated.

4. Acknowledge and agrees that the Financial Management Services Agency is acting only as a financial administrator and shall in no way be considered the employer, Oakland Community Health Network is acting only as the Pre-paid Inpatient Health Plan (PIHP) to pay the authorized services through the Financial Management Services Agency and is not the employer, and the provider organization acting as a Self-Determination Administrator, if any, is not the employer. The Employee agrees to hold the Financial Management Services Agency, the Self-Determination Administrator (if any), and OCHN harmless for their roles within this arrangement.

5. The Employer shall delegate duties to the Financial Management Services Agency to adhere to all federal and state employment obligations including but not limited to: maintaining worker's compensation insurance, complying minimum wage standards and overtime regulations, withholding and payment of employment taxes, unemployment taxes, and all reasonable employer responsibilities.

6. Agree that OCHN or a delegated entity may suspend or terminate Medicaid/public funding for services provided by an employee if it is determined that the employee has failed to fulfill the terms outlined in the Employment Agreement, or if the employee has jeopardized the individual's health or safety or has misused the individual's funds.
7. Assure the employee maintains the required training. Training includes knowledge of Basic First Aid, Bloodborne Pathogens, Recipient Rights, and my employer's annual IPOS.
8. Assure the employee executes a **Medicaid Provider Agreement** with OCHN **(Attachment A)**.
9. Acknowledge and sign the Employer of Record training **(Attachment C).**

Article III Staff Compensation for Covered Services

The services must be covered. Services are covered when they are:

- Submitted for payment within 30 days of providing the service;
- Authorized in the Individual Plan of Service (IPOS) and provided face-to-face;
- Provided in a manner that meets Medicaid requirements;
- Provided in keeping with the Individual's IPOS and Individual Budget for the purpose of reasonably achieving the goals in the Individual's IPOS;
- Provided in keeping with this agreement (including attachments); and
- Documented appropriately.

The employee shall provide and will be compensated:

☐ **H2015/H2X15 Comprehensive Community Support Services**
☐ *Hourly rate of $_____ which is inclusive of mileage.
☐ *Hourly rate of $_____ with _____ of milage per week at a rate of $_____per mile.
☐ IPOS supports the rate is shared with other employers ☐ Rate is not shared with other employers

☐ **T2027/T2X27 Overnight Health and Safety Supports**
☐ *Hourly rate of $_____.
☐ IPOS supports the rate is shared with other employers ☐ Rate is not shared with other employers

☐ **T1005 Respite**
☐ *Hourly rate of $_____.
☐ IPOS supports the rate is shared with other employers ☐ Rate is not shared with other employers

☐ **H0045 (Daily) Respite Camp**
Daily rate of $_____.

☐ **Other**
CPT _____ Rate $_____ CPT _____ Rate $_____
CPT _____ Rate $_____ CPT _____ Rate $_____

Direct hire will ensure all health and safety needs are met as detailed in the Individuals Plan of Services. The employee is expected to perform services listed according to the goals/objective identified in the IPOS.

*Pay rates and mileage cannot exceed the OCHN standardized rate for H2015, T2027, and T1005. These rates are authorized in units not hours (i.e. 4 units = 1hr).

Article IV Term and Termination

This agreement will be in effect until such time as it is terminated or changed. This is an "at-will employment" relationship, which may be terminated by Employer, at any time. However, the employer cannot terminate employment based on race, religion, sex, disability, or other protected status under federal or Michigan law. The agreement may be terminated immediately if there has been substantiated cause of abuse, neglect, or fraud.

_____ _____

Employee's Signature Date

Printed Name: _____

_____ _____

Employer's Signature Date

Printed Name: _____

_____ _____

Legal Representative's Signature Date

Printed Name: _____

Relationship to the Individual _____

Attachment A
Medicaid Provider (42 CFR 431.107) Agreement

This agreement is made on _____ between Oakland Community Health Network (OCHN) the Pre-paid Inpatient Health Plan (PIHP) and _____ (Medicaid Provider/Employee).The purpose of the agreement is to define the roles and responsibilities of the above name parties and 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. This agreement should not be finalized until the provider has met any additional requirements to provide Medicaid Services (i.e. background check, training). Should the provider fail to meet Medicaid requirements, OCHN may suspend or suspend or terminate this agreement.

OCHN Agrees to the following:

1. Upon receipt of this agreement, to certify the Medicaid Provide as available to provide Supports and Services to individuals Self-Directing their Supports and Services financed through Michigan's Medicaid Specialty Pre-paid Mental Health Plan.

The Medicaid Provider agrees to the following:

1. To keep any records necessary to disclose the extent of services the provider furnishes to the individual who receives services.
2. On request, to furnish any information maintained under paragraph (1) of this section and any information regarding payments claimed for furnishing services under the person-centered plan to OCHN, 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 which state that I must disclose if I own 5% of another provider entity.
4. To comply with the advance directive requirements specified in 42 CFR 489, Subpart 1 and 42 CFR 417.436 (d), as applicable. This regulation requires that the provider acknowledge the doctrine of informed consent whereby any and all forms of medical treatment, including life-sustaining treatment may be declined by the consumer as specified.

Both parties expressly acknowledge that the sole purpose of this agreement is to assure compliance with 42 USC 1902 (a) 27. (The Social Security Act, that requires an agreement with each provider.) Further both parties recognize and reaffirm that OCHN is not the employer of the Medicaid provider of services.

This agreement sets forth the entire understanding between parties with respect to the subject matters, and supersedes any and all other agreements, either oral or in writing between parties, pertaining to these matters. No 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 as specified on the foregoing page, and so signify by affixing their signatures below.

_____ _____
Medicaid Provider's Signature -Employee Signs Date
Printed Name: _____

_____ _____
OCHN Representative's Signature Date
Printed Name: _____

Attachment B

Employee acknowledgement (Employer of Record Training)

1. Self-Directing services and the Individual Plan of Service was discussed with me and I had the opportunity to ask any questions.
2. Services authorized in the Individual Plan of Service (IPOS) has been reviewed with me.
3. The services I will provide were reviewed with me and I understand that I cannot bill OCHN for services above the services authorization outlined in my employer's IPOS.
4. I understand that all services I provide must be face-to-face while the person is in my presence. If services I provide are intermittent throughout the day, my electronic timesheets through Electronic Visit Verification shall accurately reflect such start and stop times.
5. I understand I cannot provide paid care if the person is admitted to the hospital.
6. I understand I must renew all trainings prior to them expiring or I cannot be paid using Medicaid funds. Trainings include Basic First Aid, Bloodborne Pathogens, Recipient Rights, and my employer's annual IPOS. Additional trainings are at my employer's discretion.
7. If the Financial Management Service (FMS) is utilizing an Electronic Visit Verification system (real time electronic timesheets), I have been provided a user name and password. Otherwise, I have received documentation on how to complete timesheet. I have also been provided training materials and payroll submission guidelines.
8. I understand my electronic timesheets through Electronic Visit Verification are a legal admission that the service was provided. Falsifying timesheets is Medicaid fraud and would need to be reported at the state and federal level and jeopardize the ability to work with this person and others receiving services.
9. I have the Financial Management Services Agency payroll schedule and I understand that I have to turn in my signed and dated payroll documentation according to the due dates in order to be paid. Payroll documentation beyond 30 days will not be paid using Medicaid dollars.
10. I must provide documentation as required including any documents pertaining to employment.
11. I understand OCHN will only pay for hours that have been authorized in the IPOS. I understand any services I provide outside of the authorization is the responsibility of my employer.

My signature below confirms that the above information was discussed with me and I understand and accept my role as an Employee for a person participating in a Self-Directed Arrangement.

_____ _____

Employee's Signature Date

Printed Name: _____

Attachment C

Employer acknowledgement Employer of Record Training

1. Self-Directing services and the Individual Plan of Service was discussed with me and I had the opportunity to ask any questions.
2. My services authorized were reviewed with me and I understand that it is my responsibility to stay within the service authorization or as the employer; I will be responsible to pay for the difference.
3. I understand that all services I provide must be face-to-face while in my presence. If services are intermittent throughout the day, my electronic timesheets through Electronic Visit Verification shall accurately reflect such start and stop times.
4. I understand I cannot have paid staff to provide service if I am admitted in the hospital.
5. I understand my staff must renew all trainings prior to them expiring or they cannot be paid using Medicaid dollars. Trainings include Basic First Aid, Bloodborne Pathogens, Recipient Rights, and my annual IPOS. Additional trainings are at my discretion.
6. Upon request a user name and password for the Electronic Visit Verification real time electronic timesheets and training material may be provided. I have been provided the submission guidelines. I understand that my signature and date on the payroll documentation verifies the accuracy of the real time electronic timesheets in regard to services provided.
7. I understand real time electronic timesheets are a legal admission that the service was provided. Falsifying timesheets is Medicaid fraud and would need to be reported at the state and federal level and jeopardize my ability to continue receiving services under the Self-Direction of services arrangement.
8. I have the Financial Management Services Agency payroll schedule and I understand that I have to turn in my staff's signed and dated payroll documentation according to the due dates in order for them to be paid. Payroll documentation beyond 30 days will not be paid.
9. I understand my Self-Directed budget and acknowledge that it is my responsibility to review the monthly budget reports that are sent to me every month. I understand I can contact my Financial Management Services Agency if I have any question related to my budget or monthly budget reports.
10. I understand that no staff can start working with me or be paid for services prior to receiving a formal approval from the Financial Management Service Agency to begin work.
11. I understand that my failure to comply with all responsibilities as the Employer of Record will jeopardize my ability to continue in this role.

My signature below confirms that the above information was discussed with me and I understand and accept my responsibility as the Employer of Record participating in a Self-Direct Arrangement.

_____ _____

Employer's Signature Date

(Individual or Legal Representative, if applicable)

Printed Name: _____