

Welcome to The Arc of Oakland County as your Financial Management Service. Attached you will find the New Hire Packet.

**Completed New Hire Packet and all certifications must be submitted BEFORE an employee can provide services!**

**1. Complete New Hire Packet (signatures REQUIRED on pages 4,5,6 and 7 of the Employment Agreement)**

- Fill out all documents provided.
- Include copies of:
  - Social Security Card
  - Valid Driver's License
  - Voided Check or Bank Statement (for direct deposit)
- Send completed packet via:
  - **Email:** [fitimesheet@thearcoakland.org](mailto:fitimesheet@thearcoakland.org) (PDF attachments only)
  - **Fax:** 248-816-3340

**2. Background Check**

- Background check will be run after receiving the packet.
- Once cleared, employees will receive training login details (DOCEBO link, username, password). The employer will be copied on the email.

**3. Required Training (To be completed BEFORE working)**

Please send completed certifications to [Training@thearcoakland.org](mailto:Training@thearcoakland.org)

- **New Hire Recipient Rights** – valid 1 year
- **CPR/First Aid** – valid 2 years (CPR optional unless Child Waiver)
- **Bloodborne Pathogens** – valid 1 year
- **Environmental Emergency Preparedness** – valid 2 years
- **In-Service IPOS Goals** with Support Coordinator

**Important**

- All certifications must be current on the day a service is provided in order to be paid for that service. Any lapse in any certificate will result in non-payment.
- Employees are responsible for keeping track of their certifications and expiration dates.
- Employees **CANNOT** start working until receiving “Approval to Work” Email. (Please allow 5 to 7 business days)

**Electronic Visit Verification (EVV) = electronic clock in/out for shift**

- Required by MDHHS under the Cures Act.
- The Arc uses **Direct Care Innovations (DCI)** to capture EVV.
  - DCI Allows Guardians / Clients can view authorization balances and staff punches.
- Access to DCI will be granted after New Hire Packet and required employee training is complete.

**Questions?**

Email: [fitimesheet@thearcoakland.org](mailto:fitimesheet@thearcoakland.org) | Fax: 248-816-3340 | Phone: 248-816-1900

Thank You!

Financial Management Services Team

***Achieve with us.®***

# 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](mailto: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.**



**AUTHORIZATION TO DISCLOSE  
EMPLOYEE INFORMATION  
AND RELEASE OF LIABILITY**

I, \_\_\_\_\_, authorize Oakland Community Health Network (OCHN) to disclose to  
**(PRINT FULL LEGAL NAME) - name of Direct Hire**  
the PROVIDER listed below any and all information in your possession regarding any violations of recipients' rights  
committed by me. I recognize that any disclosures cannot include confidential client information protected by any Federal,  
State or common law.

I, \_\_\_\_\_, release Oakland Community Health Network, its officers, its agents  
**(PRINT FULL LEGAL NAME) - Name of Direct Hire**  
and its employees from any and all liability, claims, suits and actions of any nature brought against Oakland Community  
Health Network, its officers, its agents and its employees for disclosing the information requested by me and I shall  
indemnify and hold them harmless should any such claims, suits or actions be filed against them.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
APPLICANT SIGNATURE      DATE

\_\_\_\_\_  
APPLICANT'S PREVIOUS NAME/S OR MAIDEN  
NAME (IF APPLICABLE)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
WITNESS SIGNATURE      DATE

\_\_\_\_\_  
APPLICANT'S LAST 4 DIGITS OF SS#

**(Witness to ensure form is complete and  
legible before sending to process.)**

\_\_\_\_\_  
DRIVER'S LICENSE #/STATE ID#

**INFORMATION TO BE SENT TO:**

\_\_\_\_\_  
DATE OF APPLICATION/HIRE

\_\_\_\_\_  
The Arc of Oakland County  
PROVIDER

\_\_\_\_\_  
1641 West Big Beaver Road  
STREET

\_\_\_\_\_  
Troy, MI 48084  
CITY      STATE      ZIP CODE

\_\_\_\_\_  
248-816-1900 option 1 for FMS  
PHONE      CONTACT PERSON

- Please fax this form back at \_\_\_\_\_ Attn: \_\_\_\_\_
- Please mail this form back to the Provider address above, or email to this  
address [fitimesheet@thearcoakland.org](mailto:fitimesheet@thearcoakland.org)

**RIGHTS OFFICE USE ONLY**

The above applicant \*does \_\_\_\_\_ does not \_\_\_\_\_ have substantiated recipient rights violation(s) according to Oakland  
Community Health Network records.

\*Violation Type(s) \_\_\_\_\_ Date(s) of Violation \_\_\_\_\_

By: \_\_\_\_\_ DATE: \_\_\_\_\_  
Vicki L. Suder, Director of Rights and Advocacy

**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

The Arc of Oakland County

Name of Requester

Monica Knoblock

Address

1641 West Big Beaver Road

City

Troy

State

MI

Zip Code

48236

Email

fitimesheet@thearcoakland.org

Fax

248-816-3340

Phone Number

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.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.

## Employee's Withholding Certificate

Department of the Treasury  
Internal Revenue Service

**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.**

2026

<b>Step 1: Enter Personal Information</b>	(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 <a href="http://www.ssa.gov">www.ssa.gov</a> .
	City or town, state, and ZIP code		
	(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> 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](http://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](http://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](http://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.)

<b>Step 3: Claim Dependent and Other Credits</b>	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	\$	

<b>Step 4: Other Adjustments</b>	(a) <b>Other income (not from jobs).</b> 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) <b>Deductions.</b> 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) <b>Extra withholding.</b> Enter any additional tax you want withheld each pay period . . . . .			4(c) \$

<b>Exempt from withholding</b>	I claim exemption from withholding for 2026, and I certify that I meet <b>both</b> of the conditions for exemption for 2026. See <i>Exemption from withholding</i> on page 2. I understand I will need to submit a new Form W-4 for 2027 . . . . . <input type="checkbox"/>
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<b>Step 5: Sign Here</b>	Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.		
	<b>Employee's signature</b> (This form is not valid unless you sign it.)	<b>Date</b>	

<b>Employers Only</b>	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](http://www.irs.gov/FormW4).

### Purpose of Form

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

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

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

**When to use the estimator.** Consider using the estimator at [www.irs.gov/W4App](http://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](http://www.irs.gov/W4App) to figure the amount to have withheld.

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

## Specific Instructions

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

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

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

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



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

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

### Step 4.

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

**Step 4(b).** Enter in this step the amount from the Deductions Worksheet, line 15, if you expect to claim deductions other than the basic standard deduction on your 2026 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for qualified tips, overtime compensation, and passenger vehicle loan interest; student loan interest; IRAs; and seniors. You (and/or your spouse if married filing jointly) must have the required social security number to claim certain deductions. For additional eligibility requirements, see Pub. 501.

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

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



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

**Note:** If more than one job has annual wages of more than \$120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at [www.irs.gov/W4App](http://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 } . . . . . 9 \$ \_\_\_\_\_  
 { • \$384,350 if you're married filing separately }

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 } . . . . . 11 \$ \_\_\_\_\_  
 { • \$16,100 if you're single or married filing separately }

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

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

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

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

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

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

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

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

**Married Filing Jointly or Qualifying Surviving Spouse**

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

**Single or Married Filing Separately**

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

**Head of Household**

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

# 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?		(mm/dd/yyyy)	
			<input type="checkbox"/> Yes If Yes, enter date of hire.....			
City or Town			State		ZIP Code	
			<input type="checkbox"/> No			
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. <input type="checkbox"/> A Michigan income tax liability is not expected this year.						
b. <input type="checkbox"/> Wages are exempt from withholding. Explain: _____						
c. <input type="checkbox"/> Permanent home (domicile) is located in the following Renaissance Zone: _____						
<b>EMPLOYEE:</b> 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.						
<i>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.</i>						
9. Employee's Signature					▶ Date	

<b>EMPLOYER:</b> 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](http://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	
<p><b>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.</b></p>		Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):				
		<input type="checkbox"/> 1. A citizen of the United States				
		<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)				
		<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)				
<input type="checkbox"/> 4. A noncitizen (other than <b>Item Numbers 2.</b> and <b>3.</b> above) authorized to work until (exp. date, if any)						
If you check <b>Item Number 4.</b> , 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)	<p><b>Additional Information</b></p>    <p>Check here if you used an alternative procedure authorized by DHS to examine documents.</p>				
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)					

**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.

Last Name, First Name and Title of Employer or Authorized Representative		Signature of Employer or Authorized Representative		First Day of Employment (mm/dd/yyyy):
Employer's Business or Organization Name		Employer's Business or Organization Address, City or Town, State, ZIP Code		
				Today's Date (mm/dd/yyyy)

**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
<ol style="list-style-type: none"> <li>1. U.S. Passport or U.S. Passport Card</li> <li>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</li> <li>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</li> <li>4. Employment Authorization Document that contains a photograph (Form I-766)</li> <li>5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole:               <ol style="list-style-type: none"> <li>a. Foreign passport; and</li> <li>b. Form I-94 or Form I-94A that has the following:                   <ol style="list-style-type: none"> <li>(1) The same name as the passport; and</li> <li>(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.</li> </ol> </li> </ol> </li> <li>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</li> </ol>	OR	<ol style="list-style-type: none"> <li>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</li> <li>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</li> <li>3. School ID card with a photograph</li> <li>4. Voter's registration card</li> <li>5. U.S. Military card or draft record</li> <li>6. Military dependent's ID card</li> <li>7. U.S. Coast Guard Merchant Mariner Card</li> <li>8. Native American tribal document</li> <li>9. Driver's license issued by a Canadian government authority</li> <li style="text-align: center;"><b>For persons under age 18 who are unable to present a document listed above:</b></li> <li>10. School record or report card</li> <li>11. Clinic, doctor, or hospital record</li> <li>12. Day-care or nursery school record</li> </ol>	AND	<ol style="list-style-type: none"> <li>1. A Social Security Account Number card, unless the card includes one of the following restrictions:               <ol style="list-style-type: none"> <li>(1) NOT VALID FOR EMPLOYMENT</li> <li>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</li> <li>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</li> </ol> </li> <li>2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)</li> <li>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</li> <li>4. Native American tribal document</li> <li>5. U.S. Citizen ID Card (Form I-197)</li> <li>6. Identification Card for Use of Resident Citizen in the United States (Form I-179)</li> <li>7. Employment authorization document issued by the Department of Homeland Security               <p style="margin-left: 20px;">For examples, see <a href="#">Section 7</a> and <a href="#">Section 13</a> of the M-274 on <a href="https://uscis.gov/i-9-central">uscis.gov/i-9-central</a>.</p> <p style="margin-left: 20px;">The Form I-766, Employment Authorization Document, is a List A, <b>Item Number 4</b>, document, not a List C document.</p> </li> </ol>
<p><b>Acceptable Receipts</b></p> <p>May be presented in lieu of a document listed above for a temporary period.</p> <p>For receipt validity dates, see the M-274.</p>				
<ul style="list-style-type: none"> <li>• Receipt for a replacement of a lost, stolen, or damaged List A document.</li> <li>• Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual.</li> <li>• Form I-94 with "RE" notation or refugee stamp issued to a refugee.</li> </ul>	OR	<p>Receipt for a replacement of a lost, stolen, or damaged List B document.</p>	AND	<p>Receipt for a replacement of a lost, stolen, or damaged List C document.</p>

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

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

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

Date of Rehire ( <i>if applicable</i> )	New Name ( <i>if applicable</i> )		
Date ( <i>mm/dd/yyyy</i> )	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) ( <i>mm/dd/yyyy</i> )
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**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 ( <i>mm/dd/yyyy</i> )
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Additional Information (Initial and date each notation.)	Check here if you used an alternative procedure authorized by DHS to examine documents.
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Date of Rehire ( <i>if applicable</i> )	New Name ( <i>if applicable</i> )		
Date ( <i>mm/dd/yyyy</i> )	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) ( <i>mm/dd/yyyy</i> )
----------------	--------------------------	--

**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 ( <i>mm/dd/yyyy</i> )
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Additional Information (Initial and date each notation.)	Check here if you used an alternative procedure authorized by DHS to examine documents.
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Date of Rehire ( <i>if applicable</i> )	New Name ( <i>if applicable</i> )		
Date ( <i>mm/dd/yyyy</i> )	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) ( <i>mm/dd/yyyy</i> )
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**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 ( <i>mm/dd/yyyy</i> )
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Additional Information (Initial and date each notation.)	Check here if you used an alternative procedure authorized by DHS to examine documents.
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# **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.



# PAY SCHEDULE – FISCAL YEAR 2026

- Michigan Department of Health & Human Services (MDHHS) is now *requiring* the use of **Electronic Visit Verification (EVV)**!
- The Arc of Oakland County is using a third-party system for EVV called **Direct Care Innovations (DCI)**!
- Timesheets are no longer accepted unless you have a signed exemption form.
- Employees should clock in/out for their shift using the DCI Mobile App. (The DCI Portal should be using sparingly for historical punches.) ALL 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 training certifications on the date a service is provided to be paid for that service. We are unable to make exceptions.
- Employers should check their DCI profile at least weekly for employee punch accuracy, and authorization availability.

<b>PAY PERIOD Dates of Service</b> (Saturday – Friday)	<b>Submitted BY Monday 9AM</b>	<b>PAY DATE - FRIDAY</b>
09/27/25 - 10/10/25	October 13, 2025	October 24, 2025
10/11/25 - 10/24/25	October 27, 2025	November 7, 2025
10/25/25 - 11/07/25	November 10, 2025	November 21, 2025
11/08/25 - 11/21/25	November 24, 2025	December 5, 2025
11/22/25 - 12/05/25	December 8, 2025	December 19, 2025
12/06/25 - 12/19/25	December 22, 2025	January 2, 2026
12/20/25 - 01/02/26	January 5, 2026	January 16, 2026
01/03/26 - 01/16/26	January 19, 2026	January 30, 2026
01/17/26 - 01/30/26	February 2, 2026	February 13, 2026
01/31/26 - 02/13/26	February 16, 2026	February 27, 2026
02/14/26 - 02/27/26	March 2, 2026	March 13, 2026
02/28/26 - 03/13/26	March 16, 2026	March 27, 2026
03/14/26 - 03/27/26	March 30, 2026	April 10, 2026
03/28/26 - 04/10/26	April 13, 2026	April 24, 2026
04/11/26 - 04/24/26	April 27, 2026	May 8, 2026
04/25/26 - 05/08/26	May 11, 2026	May 22, 2026
05/09/26 - 05/22/26	May 25, 2026	June 5, 2026
05/23/26 - 06/05/26	June 8, 2026	June 19, 2026
06/06/26 - 06/19/26	June 22, 2026	July 3, 2026
06/20/26 - 07/03/26	July 6, 2026	July 17, 2026
07/04/26 - 07/17/26	July 20, 2026	July 31, 2026
07/18/26 - 07/31/26	August 3, 2026	August 14, 2026
08/01/26 - 08/14/26	August 17, 2026	August 28, 2026
08/15/26 - 08/28/26	August 31, 2026	September 11, 2026
08/29/26 - 09/11/26	September 14, 2026	September 25, 2026
09/12/26 - 09/25/26	September 28, 2026	October 9, 2026
09/26/26 - 10/09/26	October 12, 2026	October 23, 2026

Individual's Name: \_\_\_\_\_  
OCHN CON ID: \_\_\_\_\_



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

This Agreement was made on \_\_\_\_\_, by and between \_\_\_\_\_ (the Individual Self-Directing services) or \_\_\_\_\_ (Legal Representative on behalf of Individual, \_\_\_\_\_) 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 precondition 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 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 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, workers' 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 support 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 includes 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:

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

The employee shall provide and will be compensated:

**All wages must be between the state minimum and maximum wage allowable within the employer's Self-Determination Budget. Wages should not exceed OCHN's standardized rate, which is inclusive of all applicable taxes and insurance costs.**

**Select CWP or HSW if applicable:**

- Children's Waiver Program (CWP)                       Habilitation Supports Waiver (HSW)

**Living Arrangements:**

- Employer lives alone.
- Employer shares staff with others in the home.  
Number of employers/individuals sharing staff \_\_\_\_\_.

**H2015 Comprehensive Community Support Services/XX402 Transportation for CLS**

- \*Hourly rate of \$ \_\_\_\_\_ which is inclusive of mileage for MI only.
- \*Hourly rate of \$ \_\_\_\_\_ with \_\_\_\_\_ miles per week. Mileage is paid at the current Federal rate.

**T2027 Overnight Health and Safety Supports**

- \*Hourly rate of \$ \_\_\_\_\_.

**T1005 Respite**

- \*Hourly rate of \$ \_\_\_\_\_.

**H0045 (Daily) Respite Camp**

Daily rate is OCHN's standardized rate (if requesting a rate over the standardized rate, prior approval is needed).

**Other** (All services will be paid at OCHN's standardized rate. If requesting a rate over the standardized rate, prior approval is needed).

CPT Code: \_\_\_\_\_ Type of Service: \_\_\_\_\_

CPT Code: \_\_\_\_\_ Type of Service: \_\_\_\_\_

CPT Code: \_\_\_\_\_ Type of Service: \_\_\_\_\_

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 = 1 hour).

**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 the 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**                      **Printed Name**                      **Date**

**Relationship to the Employer** \_\_\_\_\_

\_\_\_\_\_  
**Employer's Signature**                      **Printed Name**                      **Date**

\_\_\_\_\_  
**Legal Representative's Signature**                      **Printed Name**                      **Date**

**Relationship to the Employer** \_\_\_\_\_

**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). The purpose of the agreement is to define the roles and responsibilities of the above-mentioned parties and to ensure 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 Provider 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, it is 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 all forms of medical treatment, including life-sustaining treatment may be declined by the consumer as specified.

Both parties acknowledge that the sole purpose of this agreement is to assure compliance with 42 USC 1902 (a) 27. (The Social Security Act 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 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 the 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                      Printed Name                      Date

\_\_\_\_\_  
OCHN Representative’s Signature                      Printed Name                      Date

<b>***Internal Review Only***</b>	
_____ MCA Reviewer Name	_____ Review Date



