proPartnerships

SUMMARY OF FORMS TO BE COMPLETED FOR EMPLOYMENT APPLICATION

Employer Name: _________________________**Date:**__________________ **Applicant Name:**______________________________________

Please Note: To avoid delayed processing, please use blue or black ink and be certain all forms are signed before submitting to proPartnerships.

Form Title	Additional Required Documents to include	Date received	Who Keeps this Form?	proPartnerships Receives?
proPartnerships Info & Employment Application			Employer	Yes
BHDDH DSP acknowledgement form			Employer	Yes
Technical Bulletin: Requirements for Employment as Direct Support Professional			Applicant	No
SUPPORT STAFF TRAINING LOG (EMPLOYER LIST RELEVANT TRAININGS)			Employer	Yes
Employee Emergency Contact List			Employer	Yes
Mandatory Reference Check (Employer fills this out, NOT proAbility)			Employer	Yes
How to obtain a BCI	BCI (ORGINAL FORM ONLY)		Employer	Yes
Form I-9: Page 1, Section 1 only Important: Section 2 is completed and signed by proPartnerships, not Employer	Acceptable ID 1 from List A OR 1 *each* from Lists B and C of I-9 list		Employer	Yes
DL/INSURANCE AUTHORIZATION	a) DRIVER'S LICENSE b) AUTO INSURANCE *c) VEHICLE INSPECTION* *d) REGISTRATION*		Employer	Yes
VEHICLE WAIVERS- *only if applicable*			Employer	Yes
CURRENT FEDERAL & RI W-4			Employer	Yes
CURRENT PAYROLL SCHEDULE			Employer	No
EMPLOYEE TIMESHEET			Employer	No
DIRECT DEPOSIT FORM & BANK INFO	Voided check OR other bank account verification		Employer	Yes
Employee Relationship Disclosures			Employer	Yes
Employee Acknowledgement Of Non-Allowable Costs			Employer	Yes
PAYROLL STATUS/CHANGE FORM (Employer must sign & list starting pay rate)			Employer	Yes
CONFIDENTIALITY STATEMENT			Employer	Yes
RI DEPT OF LABOR HANDBOOK RECEIPT			Employer	Yes
FLYERS: 1) DISQUALIFYING BCI INFO 2) INCIDENT REPORTING 3) FIRE SAFETY 4) IRS NOTICE 797			Applicant	No
FLYER RECEIPTS SUMMARY			Employer	Yes

Revised 7/26/24 SRJ

Responsibilities of proPartnerships regarding Employment

I sign this document with the understanding that proPartnerships

(or The Arc of Bristol County) is NOT my EMPLOYER.

I am applying to work as a direct support professional for the following Employer:

____

(please print name of individual you will be working for)

I understand that proPartnerships serves as the Fiscal Intermediary for this individual, and as such is responsible *only* for processing employment applications/verifications and payroll related administration.

The Fiscal Intermediary is *not* responsible for setting pay rates, schedules, hiring or firing. Such tasks are the sole responsibility of the above employer or their guardian.

______________________________________ ____________________

Signature of Applicant **Date**

____

Signature of Employer

STATE OF RHODE ISLAND

Department of Behavioral Healthcare, Developmental Disabilities and Hospitals
DIVISION OF DEVELOPMENTAL DISABILITIES
6 Harrington Road
Cranston, RI 02920-3080

TEL: (401) 462-3421
FAX: (401) 462-2775

Direct Support Professional Acknowledgement Form

About this form:

The Division of Developmental Disabilities (DDD) has a set of rules about hiring and managing Direct Support Professionals (DSP). The rules are for **employers**, or self-directed participants that hire their own DSP. The rules are also for the **employee**, or people hired as DSP. The list of rules is in the following Technical Bulletin:

- Requirements for Employment as a Direct Support Professional in the Self Direction Service Model.

The employer and employee must review the Technical Bulletin. The DSP must sign this Acknowledgement Form after they review the Technical Bulletin. Current DSPs must sign this form and give it back to their employer. The employer must give the form to their FI. New DSPs must sign this form before starting to work. The FI will have this form as part of the onboarding paperwork a new employee has to sign.

Employee Agreement

By signing this form, you agree to the following:

☐ I have received a copy of the Technical Bulletin: Requirements for Employment as a Direct Support Professional in the Self-Direction Service Model.

☐ I have read the Technical Bulletin: Requirements for Employment as a Direct Support Professional in the Self-Direction Service Model.

☐ I agree to follow the terms as outlined in the Technical Bulletin: Requirements for Employment as a Direct Support Professional in the Self-Direction Service Model.

____

Direct Support Professional Name (Print) **Date**

____

Signature of Direct Support Professional **Date**

Becoming A Direct Support Professional (DSP) for Self-Directed Participants

Who can become a DSP?

A DSP can be anyone hired by a self-directed participant. The DSP must be able to provide the participant with the services listed in their Individual Support Plan (ISP). DSPs can include a:

- Sibling
- Parent (birth or adoptive), guardian, or step-parent
- Extended family member
- Non-family member, including a friend

The person hired as a DSP must have the skill set to be able to perform the job duties listed in the participant's ISP. This may include helping the participant with activities of daily living, accessing the community, and more.

The DSP must work with the participant to achieve their ISP goals. They must understand and follow any behavioral or medical care plans the participant has.

Onboarding requirements

DSP's must meet the following requirements:

- Be at least 18 years old
- Perform the job tasks listed in the job description and participant's ISP
- Pass a Bureau of Criminal Identification and Investigation (BCI) check
- Be authorized to work in the United States
- Submit proof of the following if providing transportation:
    - Driver's license
    - Clean driving record
    - Vehicle registration
    - Vehicle insurance
    - Vehicle inspection

Expectations and Rights

DSP expectations and rights include:

- Work no more than 40 hours a week.
- Work no more than 12 hours a day.
- Be informed of job duties.
- Sign and comply with the Health Insurance Portability and Accountability Act (HIPPA).
- Work with only one participant at a time.
- Document the services provided each shift.
- Report any changes to driving record and any convictions.
- Can accompany the participant on vacation except when it is out of the Country.
    - Can only be compensated for participant's direct services and not vacation costs.

DATE____/____/____

Achieve with us.

APPLICATION FOR EMPLOYMENT

The Arc of Bristol County dba proAbility is committed to a policy of Equal Employment Opportunity and will not discriminate on any legally recognized basis, including but not limited to, race, age, color, religion, sex, marital status, national origin, citizenship, ancestry, physical or mental disability, veteran status or any other basis recognized by federal, state or local law.

PERSONAL BACKGROUND

Name____
Last *First* *Middle*

Address____
Street *City* *State/Zip*

Phone(________)________________Referred by__________________________________

Cell phone (_____)____________________ Email address__________________________

POSITION APPLYING FOR______________________________ **Start Date___/___/___**

Full Time______ **Part Time**______ **Specify Hours**________________ **Salary Desired**____________

Is there any reason we may not inquire of your present employer or prior employers? If yes, please explain:_______

____

Have you ever applied to this company before?________ Where?___________________ When?____________

Have you ever been employed at The Arc of Bristol County dba proAbility? When? ________________

Are you willing to work overtime? Yes______ No______

If driving is a requirement of the job for which you are applying, do you have a valid driver's license? Y____ N____

If you are a minor, can you produce the work certificate necessary to obtain employment? Y____ N____

Are you able, at the time of employment, to submit verification of your legal right to work in the U.S. Y____ N____
(Verification and completion of form 1-9 must be submitted no later than 3 business days from date of hire.)

LIE DETECTOR NOTICE
It is unlawful in Massachusetts to require or administer a lie detector test as a condition of employment or continued employment. An employer who violates this law shall be subject to criminal penalties and civil liability.

Please note that upon an accepted offer of employment The Arc of Bristol County d/b/a proAbility will conduct both a CORI and BCI background check.

Educational Background	Name and Location of School	Circle Highest Grade Completed	Major Area of Study
High School		9 10 11 12 / GED	
College		1 2 3 4	
Trade, Business or Graduate School			
Specialized Skills			
Certifications / Trainings (Effective/Expiration Dates)	1.	2.	3.

WORK EXPERIENCE

Please list your last three employers, starting with present or last place of employment.
You may include any verifiable work performed on a volunteer basis, internships or military service.

Dates MO / YR	Employer Name, Address & Phone	Position	Supervisor	Reason for Leaving
From ______ To				
From ______ To				
From ______ To				

REFERENCES: **Please give the names of three additional work-related references that we may call. We will need the names and contact information of at least two of your current/previous manager/supervisors to use as references. Please do not list relatives. Individuals with no prior work experience may list school or volunteer-related references.**

Name & Position ______ Company ______ Phone # ______

______

______

______

Applicant Certification – Please Read Carefully

I understand that this application is not a contract, offer, or promise of employment. I acknowledge that employment with the company is on an employment at will basis. This means that my employment with the company can be terminated at any time, with or without cause or advance notice and acceptance of employment is not a contract of employment for any specified time. Similarly I am free to terminate my employment with the company at any time for any reason. This at-will provision may be modified or waived only in a written agreement signed by the company's president and me.

I further understand that I am responsible for being familiar with the Company's policies, rules and regulations and I understand that the company has complete discretion to modify its policies, rules, regulations and practices at any time, to the extent permitted by federal, state and local law, except that it will not modify its policy of employment at will. By my continued employment with the company, I consent to any such changes.

I certify that the above information is complete and accurate to the best of my knowledge. I understand that any falsification, misrepresentation or omission of information on this form or relating to my application of employment may result in my denial of employment, or if employed, my immediate dismissal.

I hereby authorize the company or its agents to confirm all statements contained in this application and/or resume to the extent permitted by federal, state or local law and I agree to complete any requisite authorization forms.* I release all parties from any liability arising out of this provision and the use of such information.

APPLICANT'S SIGNATURE______________________ **DATE** ____________

*Federal law requires a separate release form when obtaining Consumer Credit Reports

Support Staff Training Log

Employer name: ______________________ Employee name: ______________________

Name of Training:	Effective Date:	Expiration Date:	Comments:
1) Review of ISP Goals			

Please add all relevant trainings. ***Expiration date of reviewing ISP goals is the Participants' DD-BHDDH anniversary.***

How to Obtain a BCI

To obtain your BCI, you must go to the Bureau of Criminal Investigation at:

Office of the Attorney General

4 Howard Avenue

(corner of Pontiac Ave. & Howard Ave.)

Cranston, RI 02920

401-274-4400

Hours of Operation

Monday – Friday

8:30 a.m. – 4:30 p.m.

Last registration @ 4:15 p.m.

Walk in service only, register from parking lot and wait to be called in.

Cost: Current cost is $5.00 + fees ($5.60)

At this time they are **ONLY** accepting

Payment by Credit or Debit

NB: PLEASE be certain that the *embossed seal* is present on the Attorney General's signature on bottom left corner before leaving. We cannot accept your BCI without it.

Sj:10/23/23

State of Rhode Island Division of Taxation
Employee's Withholding Allowance Certificate

Federal Form W-4 can no longer be used for Rhode Island withholding purposes. You must complete Form RI W-4 for your employer(s). Once you have completed Form RI W-4 for your employer, Form RI W-4 only needs to be completed if you are making changes to your withholding allowance or have a new employer. Form RI W-4 must be completed each year if you claim "EXEMPT" or "EXEMPT-MS" on line 3 below.

If you have more than one job or your spouse works, you should figure the total number of allowances you are entitled to claim. Your withholding usually will be more accurate if you claim all of your allowances on the Form RI W-4 for the highest-paying job and claim zero on all of your other RI W-4 forms. You may reduce the number of allowances or request that your employer withhold an additional amount from your pay, which may help avoid having too little tax withheld. Also, keep in mind that if your annual wages exceed $274,650, your exemption amount will be phased out and be equal to zero.

Line 1: Figure your personal allowances (including allowances for dependents)

A. No one else can claim me as a dependent. If yes, enter "1" on line 1A.. 1A. __________
B. I can claim my spouse as a dependent. If yes, enter "1" on line 1B.. 1B. __________
C. Enter the number of dependents (other than you or your spouse) you will claim on your tax return...... 1C. __________
D. Enter any additional allowances (review carefully to avoid underwithholding) .... 1D. __________
E. Add lines A, B, C and D and enter here. However, if line E is more than 10, enter 10.
This is the total number of personal allowances to which you are entitled. Enter on line 1 below......... 1E. __________

Line 2: Additional withholding amounts

If you want additional withholding taken out of your pay, enter that dollar amount which is to be withheld **each pay period** on line 2 below.

Line 3: Exempt Taxpayer

Exempt Status #1

If you meet both of the conditions below, you may claim exemption from Rhode Island withholding for 2024:

a) Last year I had a right to a refund of all Rhode Island income tax withheld because I had **no** tax liability **AND**
b) This year I expect a refund of all Rhode Island income tax because I expect to have **no** tax liability.
If you meet both of the above conditions, write "EXEMPT" on line 3 below.

Exempt Status #2

If you are the spouse of a servicemember stationed in Rhode Island, your wages may be exempt under the Military Spouses Residency Relief Act. If you meet both of the conditions below, you may claim exemption from Rhode Island withholding for 2024.

a) You moved to Rhode Island solely to be with your servicemember spouse in compliance with military orders sending the servicemember to Rhode Island **AND**
b) You have the same non-Rhode Island domicile as your servicemember spouse.
If you meet both of the above conditions, write "EXEMPT-MS" on line 3 below.

RI W-4 — State of Rhode Island Division of Taxation Employee's Withholding Allowance Certificate — 2024

PLEASE PRINT

Name - first, middle initial, last	1. Enter the number of allowances from line 1E above ...... 1. ________
Present home address (Number and street, including apartment number or rural route)	2. Enter any additional dollar amount which you would like withheld from your pay .... 2. $ ________
City, town or post office / State / ZIP code	3. If you meet the conditions above, write "EXEMPT" or "EXEMPT-MS" whichever applies .... 3. ________
Your social security number	**Employee:** File this form with your employer to indicate the number of dependents or other personal exemptions to be claimed as allowances for your Rhode Island withholding. You should make a copy for your own records. **Employer:** Keep this certificate with your payroll records. The form must be available to the Division of Taxation upon request.

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

Employee Signature ⇨ ____________________ Date __________

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

2024

Step 1: Enter Personal Information

(a) First name and middle initial | Last name | (b) Social security number

Address

City or town, state, and ZIP code

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.*

(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.)

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 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)

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)			**Additional Information**		
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)			☐ 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
the Arc of Bristol County dba proAbility	25 Thurber Blvd. Unit 1, Smithfield, RI 02917

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

1. U.S. Passport or U.S. Passport Card
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa
4. Employment Authorization Document that contains a photograph (Form I-766)
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole:
   a. Foreign passport; and
   b. Form I-94 or Form I-94A that has the following:
      (1) The same name as the passport; and
      (2) An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI

OR

LIST B

Documents that Establish Identity

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
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
3. School ID card with a photograph
4. Voter's registration card
5. U.S. Military card or draft record
6. Military dependent's ID card
7. U.S. Coast Guard Merchant Mariner Card
8. Native American tribal document
9. Driver's license issued by a Canadian government authority

For persons under age 18 who are unable to present a document listed above:

10. School record or report card
11. Clinic, doctor, or hospital record
12. Day-care or nursery school record

AND

LIST C

Documents that Establish Employment Authorization

1. A Social Security Account Number card, unless the card includes one of the following restrictions:
   (1) NOT VALID FOR EMPLOYMENT
   (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION
   (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Native American tribal document
5. U.S. Citizen ID Card (Form I-197)
6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
7. Employment authorization document issued by the Department of Homeland Security

   For examples, see Section 7 and Section 13 of the M-274 on uscis.gov/i-9-central.

   The Form I-766, Employment Authorization Document, is a List A, Item Number 4. document, not a List C document.

Acceptable Receipts

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

List A		List B	List C
• 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.

CONFIDENTIALITY STATEMENT

In accordance with all state and federal applicable laws, proPartnerships maintains all records pertaining to the employer within a locked file cabinet to safeguard confidentiality.

All information in the employer's file is treated in a confidential fashion. When necessary, a release of information will be obtained from the employer. Only information deemed necessary in implementing support services is released and only to authorized persons.

All employees and providers must understand the need for confidentiality and are asked to respect the sensitive nature of such information. The written emergency information that is given to employees and providers must be kept confidential. proPartnerships encourages employees and providers to have the emergency information accessible in case of an emergency but in a place to which others will not have access.

Any employee or provider, who has knowledge of another employee or provider breaking confidentiality, must report this information to their immediate supervisor.

I have reviewed the preceding information regarding confidentiality.

____
Signature

____
Date

DRIVER'S LICENSE/INSURANCE AUTHORIZATION

I attest that as of this date, I have a current and valid driver's license and automobile insurance that meets the State of Rhode Island's minimum insurance requirements. My vehicle has a current and valid registration and inspection. I understand that both my license and vehicle must be maintained in this manner and that I am to notify my employer immediately with any changes.

I further understand that failure to do so may result in disciplinary action up to and including termination.

If requested, I may receive a copy of this requirement for my own records.

____________________________ ____________________________

Employee's Name: Employee's Signature

Date: ________________________

Please attach a copy of:

- ☐ **Unexpired driver's license**
- ☐ **Unexpired insurance policy**
- ☐ **Unexpired vehicle registration (photo of valid sticker acceptable)**
- ☐ **Unexpired vehicle inspection**

STATE OF RHODE ISLAND
Department of Behavioral Healthcare, Developmental Disabilities and Hospitals
DIVISION OF DEVELOPMENTAL DISABILITIES
6 Harrington Road
Cranston, RI 02920-3080
TEL: (401) 462-3421
FAX: (401) 462-2775

Non-Driving Direct Support Professional Form

The purpose of this form is to note that the person hired as a Direct Support Professional (DSP) will not drive as part of their job. The DSP and their employer must sign this form. The DSP's employer is the self-directed participant. If the person self-directing their services has a guardian or designated representative, then the guardian or designated representative must also sign this form.

The DSP employee will not need to share a copy of their auto insurance. They will also not need to sign the "Authorization and Consent to Request and Disclose Motor Vehicle Report" form.

____

Name of Employee *(person hired as DSP)*

____

Name of Employer *(person self-directing their services or designated representative)*

Please describe the employee job duties. Explain why they will not need to provide transportation.

____

Signature of Employee *(person hired as DSP)* **Date**

____

Signature of Employer *(person self-directing or designated representative)* **Date**

____

Signature of Legal Guardian *(if any)* **Date**

PROPARTNERSHIPS

2024 PAYROLL PERIODS

Payroll Period	Timesheet Due Date	Pay Date
12/24/23– 01/06/24	01/08/24	01/12/24
01/07/24 – 01/20/24	01/22/24	01/26/24
01/21/24 – 02/03/24	02/05/24	02/09/24
02/04/24 – 02/17/24	02/19/24	02/23/24
02/18/24 – 03/02/24	03/04/24	03/08/24
03/03/24 – 03/16/24	03/18/24	03/22/24
03/17/24 – 03/30/24	04/01/24	04/05/24
03/31/24 – 04/13/24	04/15/24	04/19/24
04/14/24 – 04/27/24	04/29/24	05/03/24
04/28/24 – 05/11/24	05/13/24	05/17/24
05/12/24 – 05/25/24	05/27/24	05/31/24
05/26/24 – 06/08/24	06/10/24	06/14/24
06/09/24 – 06/22/24	06/24/24	06/28/24
06/23/24 – 07/06/24	07/08/24	07/12/24
07/07/24 – 07/20/24	07/22/24	07/26/24
07/21/24 – 08/03/24	08/05/24	08/09/24
08/04/24 – 08/17/24	08/19/24	08/23/24
08/18/24 – 08/31/24	09/02/24	09/06/24
09/01/24 – 09/14/24	09/16/24	09/20/24
09/15/24 – 9/28/24	9/30/24	10/04/24
9/29/24 – 10/12/24	10/14/24	10/18/24
10/13/24 – 10/26/24	10/28/24	11/01/24
10/27/24 – 11/09/24	11/11/24	11/15/24
11/10/24 – 11/23/24	11/25/24	11/29/24
11/24/24 – 12/07/24	12/9/24	12/13/24
12/08/24 – 12/21/24	12/23/24	12/27/25
12/22/24 – 01/04/25	01/06/25	01/10/25

ALL TIMESHEETS MUST BE SUBMITTED BY 1:00 P.M. ON THE DUE DATES LISTED ABOVE.

TIMESHEETS RECEIVED AFTER 1:00 P.M. ON THE DUE DATE
WILL NOT BE PROCESSED UNTIL THE FOLLOWING PAYROLL PERIOD.

Employee Timesheet

proPartnerships

Employee Name (please print clearly)

Reporting Pay Period
to

EMPLOYER NAME:

Time In	Time Out	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Total Week 1	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Total Week 2
								Week One Total								Week Two Total	

Timesheet Calculations - EMPLOYER USE ONLY

Hours:

Rate:

*Grand Total:

Employee Signature: ______ Date: ______ Employer Approval: ______

(By signing, I confirm that I worked all of the above referenced hours.)

Employee Relationship Disclosure

X ______________________________
Employee Name (Please Print):

X ______________________________
Employee Address

X ______________________________
Social Security Number

X ______________________________
Name of Employer

Instructions:

Please select any of the below boxes that apply if a relationship exists between you as the employee and the employer. There are some tax exemptions for certain domestic employer & employee relationships.

__ None (no relation to employer)
__ Spouse of the employer
__ Child of the employer
__ Parent of the employer
__ Legal Guardian of the employer
__ Other:____________________

If Parent (employee) is selected the following taxes are exempt: FICA (Social Security), FUTA, SUTA, Medicare and TDI. *I also acknowledge as Parent or Legal Guardian that I cannot work more than 40 hours per week. If a second Parent or Legal Guardian is on staff, our* ***combined*** *total of hours worked weekly also cannot exceed 40.*

The fine print: Under IRS guidelines. Publications 15 (circular E) Section 3, employees are not subject to Social Security, Medicare and Federal Unemployment Tax (FUTA) if these relationships exist. The exemptions are as follows: parent employed by son/daughter – payments for the services of a parent employed by his or her child in other than a trade or business such as domestic services, are not subject to Social Security, Medicare and FUTA tax if the above conditions apply. (IRS PUB. 15, Section 3, Paragraph 4)

X ____
Employee Signature Date

Employee Acknowledgment

Non-Allowable Costs / Out of Home Care

I understand that as an employee being reimbursed by the Medicaid funded proPartnerships self-directed support program, I cannot be reimbursed when my Employer is receiving out-of-home services/care paid for by Medicaid/Medicare even when I, the employee, spend time with the Employer in those out-of-home situations.

Examples of out-of-home care paid for by Medicaid/Medicare are, but not limited to:

- Hospitals or nursing home admissions. Even if you spend time with the Employer while at the facility while employer is admitted.
- Assisted Living
- Rehabilitation Center
- Adult Day Services (Employees can be paid for transportation to and from the site)

In those circumstances in which the Employer is receiving any type of out-of-home residential care as identified above, you must inform proPartnerships immediately. At no time will an employee be reimbursed for services provided under these or any other circumstances where direct physical support has not been rendered to the Employer.

Violations of the above will result in suspension/termination from the proPartnerships program and will be reported to the State of Rhode Island Attorney General Office and/or other legal authorities as potential Medicaid/Medicare Fraud.

X ______________________ X ______________________

Signature Date

X ______________________

Please print name

X ______________________ X ______________________

proPartnerships Administrator Signature Date

Employee Direct Deposit Form

Employee Name:____
(Please Print)

Social Security No.__ __ __/__ __/__ __ __ __

Check one: □ New or Additional Account □ Change Account

I would like my wages/salary deposited to the following account(s)

Bank Account #1
Bank Name:_______________________________________

Check one: □ Checking □ Savings

Routing#___________________________________

Account#________________________________

□ Entire Net Pay □ Specific Dollar Amount $ ________

Bank Account #2
Bank Name:_______________________________________

Check one: □ Checking □ Savings

ABA#___________________________________

Account#________________________________

□ Entire Net Pay □ Specific Dollar Amount $ ________

_______________________________ ____________________
Employee Signature Date

PLEASE PROVIDE VOIDED CHECK OR OTHER PRINTED CONFIRMATION OF BANK ROUTING AND ACCOUNT NUMBER TO PREVENT TYPOS. DIRECT DEPOSIT WILL NOT BE PROCESSED OTHERWISE.

EMPLOYEE EMERGENCY

CONTACT INFORMATION

Primary Employee Contact: ____

Relationship to Employee: ____

Telephone: ______________________ home ______________________ cell

______________________ work ______________________ other

Secondary Emergency Contact: ____

Relationship to Employee: ____

Telephone: ______________________ home ______________________ cell

______________________ work ______________________ other

RHODE ISLAND DEPARTMENT OF LABOR

EMPLOYER HANDBOOK

I, ______________________________ (EMPLOYEE) HAVE RECEIVED A COPY OF THE CURRENT RHODE ISLAND DEPARTMENT OF LABOR EMPLOYER HANDBOOK FROM ________________________ (EMPLOYER).

Signature: ____________________________________

Date: ____

The employer (Employer's Name)__________________________________ has provided me with the following informational or instructional flyers:

1. DISQUALIFYING BCI INFORMATION
2. INCIDENT REPORTING BROCHURE
3. FIRE SAFETY
4. IRS NOTICE 797

Employee Signed:____

Dated:______________________

LIST OF DISQUALIFYING BCI INFORMATION

Information discovered during the course of this criminal background investigation and driver's record check may result in The Arc of Bristol County rescinding an offer of employment on a case by case basis.

An employment offer will automatically be rescinded if it is discovered that the employee has been found guilty of a felony in the past 10 years or a misdemeanor in the past 5 years.

This includes the pleading of nolo contendere, to Driving While Intoxicated (DWI) or Driving Under the Influence (DUI) within the prior 5 years.

Exclusion of employment will also occur to any person who has been convicted or arrested pending disposition: of child abuse or of a felony of sexual or physical assault and any other specific felony as outlined by Federal and State Law.

What Must I Report?

Incidents involving developmentally disabled adults and disabled individuals between the ages of 18 and 59 who are victims of abuse, neglect, mistreatment, and exploitation, including:

- Physical Abuse
- Sexual Abuse
- Sexual Exploitation
- Verbal/Psychological Abuse
- Financial Exploitation
- Human Rights Violations
- Deaths
- Serious Injuries
- Unplanned Hospitalizations
- Police Involvement
- Serious Medication Errors
- Missing Persons
- Suicide Attempts
- Unauthorized Restraints
- Aversive Interventions
- Communicable Diseases

If you are not sure if something should be reported, call the hotline, and talk to a Quality Assurance staff member.

The Office of Quality Assurance

The Office of Quality Assurance works to build a collaborative community of support with participants, providers, and families to ensure person-centered approaches to providing support, ensuring health and safety, fostering independence, dignity, respect, productivity, integration, and self-determination. Working as a team while collaborating and consulting with providers helps to ensure that individuals served can live with dignity and respect in the community.

- Assure the quality of services provided by agencies or individuals to participants
- Provide for the protection and promotion of the legal and civil rights of participants.
- Investigate and evaluate, or cause to be investigated and evaluated, reports made pursuant to 40.1-27.2.

Office of Quality Assurance
Division of Quality Management

14 Harrington Road
Cranston, RI 02920
(401) 462-2629

YOU MUST REPORT ABUSE & SERIOUS INCIDENTS

Office of Quality Assurance
Division of Quality Management

14 Harrington Road
Cranston, RI 02920
(401) 462-2629
www.bhddh.ri.gov

Abuse And Serious Incidents Must Be Reported

You Have a Duty to Report

RI General Laws 40.1-27-2 and BHDDH Licensing Rules and Regulations state:

"Any person who has knowledge of or reasonable cause to believe that a person has been a victim of abuse, neglect, mistreatment, a human rights violation, or a serious incident shall make a report, within 24 hours or before the end of the next business day, to the Office of Quality Assurance (QA)."

There may be situations where it is difficult to report incidents which involve co-workers, supervisors, friends, or family members. Your ***primary responsibility*** is to ensure that the ***person with a disability, substance use, and/or mental health condition*** is safe and protected from harm.

How Do I Report an Incident?

Contact BHDDH's Office of
Quality Assurance (QA)
24-hour Intake Hotline at:

Voice: 401- 462-2629
Relay RI: TTY711 or 1-800-745-5555
Fax: 401-462-0393

Calls can be received outside of normal business hours and on weekends to answer any questions and to provide support or guidance. ***Translation Services are available.***

Important Telephone Numbers

QA Hotline	**462-2629**
Eligibility Unit	**462-3421**
Attorney General	**274-4400**

What Happens After I Report an Incident?

Incident information is entered into the Therap Incident Management System. All BHDDH-licensed service providers enter incidents directly into this confidential tracking system. Incidents are triaged and reviewed daily. Each case is discussed and classified by incident type and the level of follow-up required. A QA unit staff member may contact you for additional information.

If there is a suspicion of ***mistreatment, abuse, neglect, financial exploitation, etc.*** a decision may be made by the agency, QA and/or the Department of BHDDH to initiate a formal investigation.

Only authorized investigators from BHDDH-licensed provider agencies, the Office of Quality Assurance, the Office of the Attorney General, or the police may conduct formal investigations.

Your responsibility is to respect the privacy of the person who is involved in the incident and to discuss information about the incident only with an assigned investigator and/or the administrative staff from your agency.

Additional information can be found online at: **https://bhddh.ri.gov/about-us/quality-management-unit**

Fire Safety for People With Disabilities

Millions of Americans live with physical and mental disabilities. It is important to know your risk and build your fire prevention plans around your abilities.

- Have smoke alarms on every level of your home, inside bedrooms and outside sleeping areas. Interconnect your alarms, so when one sounds, they all sound.
- If you are deaf or hard of hearing, use smoke alarms with a vibrating pad, flashing light or strobe light. These accessories start when your alarm sounds.
- Test your alarms every month.

Plan your escape around your abilities.

- Know two ways out of every room.
- If possible, live near an exit.
- You'll be safest on the ground floor if you live in an apartment building.
- If you live in a multistory home, sleep on the first floor.
- Being on the ground floor and near an exit will make your escape easier.

For more information and free resources, visit

www.usfa.fema.gov

2023 Employee Tax Information

Notice 797 (Rev. December 2022)

Possible Federal Tax Refund Due to the Earned Income Credit (EIC)

What Is the EIC?

The EIC is a refundable tax credit for certain workers.

What Is the Purpose of This Notice?

Your employer sent you this notice to make you aware of an important federal tax benefit. Even if you had no income tax withheld from your wage during the year, you may be eligible for the EIC.

How Much Is the EIC?

For 2022, the EIC can be as much as $3,733 if you have one qualifying child who has a valid SSN; $6,164 if you have two qualifying children who have valid SSNs; $6,935 if you have three or more qualifying children who have valid SSNs; and $560 if you have no qualifying children who have a valid SSN.

How Do You Claim the EIC?

To claim the EIC, you must:

1. Be eligible for the EIC, and
2. File a 2022 tax return (including Schedule EIC if you have a qualifying child).

To figure out if you are eligible, see Pub. 596 or visit *IRS.gov/EITC*.

If eligible, you can claim the EIC to get a refund even if you had no tax withheld from your pay or owe no tax. For example, if you had no tax withheld in 2022 and owe no tax but are eligible for a credit of $800, you must file a 2022 income tax return to get the $800 refund.

Most people qualify for free tax preparation. If you earned less than $73,000, you can file for free online at *IRS.gov/FreeFile*. In addition, IRS-certified volunteers can prepare your return for free in person if you have earned less that $60,000 or are age 60 or older. To find locations, visit *IRS.gov/VITA* or call 800-906-9887.

More Information

Refer to instructions for the tax return you are filing, Pub. 596, or *IRS.gov/EITC* for details on the EIC. You can download IRS forms and publications at *IRS.gov/Forms*, and you can get printed copies mailed to you by going to *IRS.gov/OrderForms* or by calling 800-829-3676.

Notice 1015 (Rev. December 2022)

Have You Told Your Employees About the Earned Income Credit (EIC)?

What Is the EIC?

The EIC is a refundable tax credit for certain workers.

Which Employees Must I Notify About the EIC?

You must notify each employee who worked for you at any time during the year and from whose wages you did not withhold income tax. However, you do not have to notify any employee who claimed exemption from withholding on Form W-4, Employee's Withholding Allowance Certificate.

Note: You are encouraged to notify all employees whose wages for 2022 are less than $59,187 that th may be eligible for the EIC.

How and When Must I Notify My Employees?

You must give the employee one of the following.

- The IRS Form W-2, Wage and Tax Statement, which has the required information about the EIC o the back of Copy B.
- A substitute Form W-2 with the same EIC information on the back of the employee's copy that is o Copy B of the IRS Form W-2.
- Notice 797, Possible Federal Tax Refund Due to the Earned Income Credit (EIC).
- Your written statement with the same wording as Notice 797.

If you give an employee a Form W-2 on time, no further notice is necessary if the Form W-2 has the required information about the EIC on the back of the employee's copy. If you give an employee a substitute Form W-2, but it does not have the required information, you must notify the employee withi 1 week of the date the substitute Form W-2 is given. If Form W-2 is required but is not given on time, you must give the employee Notice 797 or your written statement by the date Form W-2 is required to given. If Form W-2 is not required, you must notify the employee by February 6, 2023.

You must hand the notice directly to the employee or send it by first-class mail to the employee's la known address. You will not meet the notification requirements by posting Notice 797 on an employee bulletin board or sending it through office mail. However, you may want to post the notice to help infor all employees of the EIC. You can download copies of the notice at www.irs.gov/FormsPubs. Or you ca go to www.irs.gov/OrderForms to order it.

How Will My Employees Know If They Can Claim the EIC?

The basic requirements are covered in Notice 797. For more detailed information, the employee need to see Pub. 596, Earned Income Credit (EIC), or the instructions for Form 1040 and 1040-SR.

How Do My Employees Claim the EIC?

Eligible employees claim the EIC on their 2022 tax return. Even an employee who has no tax withheld from wages and owes no tax may claim the EIC and ask for a refund, but they must file a tax return to so. For example, if an employee has no tax withheld in 2022 and owes no tax but is eligible for a credi of $800, they must file a 2022 tax return to get the $800 refund.

Item# Y889924 ED-IRS 1222 © 2004-2023 AIO [illegible]

TELEPHONE CALL EMPLOYMENT REFERENCE CHECK

I give permission for the reference to release information about me either verbally and/or in writing to ____________________________. I consent to allowing the Self-Directed Employer to call or write the reference in order to confirm reference information.

____ __________________

Signature of applicant Date

Applicant Name: ____

Reference's Name: ________________________________ Phone: __________________

Reference's Title: ___________________________ Company: ______________________

Dates of Employment: From _____________________ To ___________________________

Position(s): Hired ___________________________ Last ___________________________

Was Applicant punctual and ready for work? _______________________________________

____

Describe job duties and overall performance. _______________________________________

____

____

Describe overall reliability. ____

____

Why did applicant leave your employ? ____

Would you rehire applicant? If not, why? ____

____

Is the applicant suitable for the type of work for proPartnerships, why or why not? ____________________

____

Did reference refuse to give reference over the phone? _________________________________

Additional Comments: ____

____

____

____

Reference completed by: ____________________________________ Date: ________________

REFERENCE CHECKS ARE A PRE-HIRE REQUIREMENT. This document must be fully completed, dated and signed for each applicant and returned with the packet. No new employee will be processed for hire without the reference check completed by the employer.

THANK YOU

Achieve with us.

Mailing Reference Release Form

I, (NAME) ________________________________, SSN# ______-_____-______,
am applying for employment with the proPartnerships Program request that the following information be released to the Self-Directed Employer ________________________.
I give permission for the reference to release information about me either verbally and/or in writing to __________________________. I consent to allowing the Self-Directed Employer to call or write the reference in order to confirm reference information.

____ ________________

Signature of applicant Date

PLEASE COMPLETE THE FOLLOWING AND MAIL TO: ________________

____

Name of reference/Company/Organization: ______________________________

Address: ____

Dates of employment: ____

Title(s) or Position(s) held: ____________________________________

Please rate the following on a scale from 1 – 5, with 5 being the highest

Punctuality	1	2	3	4	5
Reliability	1	2	3	4	5

Is applicant eligible for rehire within your agency? ______________________

Additional comments:

____

____

____

Reference completed by:

____

Signature Print Name Date Phone Number

REFERENCE CHECKS ARE A PRE-HIRE REQUIREMENT. This document must be fully completed, dated and signed for each applicant and returned with the packet. No new employee will be processed for hire without the reference check completed by the employer.

Achieve with us.

THANK YOU

PROPARTNERSHIPS

PAYROLL STATUS/CHANGE FORM

EMPLOYER TO COMPLETE

Employee Name [ ]

New Hire [ ] Per Diem [ ] Resigned [ ]

Eligible for Rehire Yes / No

Lay Off [ ] Termination [ ]

Change [ ] Effective Date of Payroll Status/Change [ ]

New Hire Information

Address [ ]

Phone Number [ ]

Job Title: DOMESTIC SERVICE WORKER

Full Time (35-40 hrs) [ ] Part Time (20-34 hours) [ ] Limited Part Time (< 20 hrs) [ ]

Exempt [ ] Non-Exempt [ ] Total hrs. per week [ ]

Changes Completed	From	To	Commments
Name			
Address			
Phone			
Status			
Hours of Work			
Job Title			
Pay Rate 1			
Pay Rate 2			
Pay Rate 3			

Employer Signature ______________________ Date ______________