Consumer Directed Services

Wage and Benefits Plan
Employee Compensation

Employee Name (Last, First, Middle Initial)		Social Security No.
Date of Hire	First Date of Work	☒ Initial Wage and Benefit Plan ☐ Plan Change – Effective Date:

Name of Program Service Being Provided: Program:

Compensation:

Regular Hourly Wage

☐ Employee = $

☐ Respite = $

Calculation of Overtime Hourly Wage

Hourly $ + $ 0 (50%) = $ 0

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Benefits: *Optional*

☐ **Hepatitis B Vaccination** (Attach completed Form 1727 if vaccination is requested by the employee.)

Employer: List other optional benefits here. (Attach additional sheet, if required.)

Transportation:

Withholdings:

☒ **W-4 Employee's Withholding Allowance Certificate** (Attach completed Form W-4.)

☐ **Required Garnishments**

Type:	Amount:
Frequency:	Payment To:

☐ **Voluntary Withholdings** (not related to W-4)

Type:	Amount:
Frequency:	Payment To:

☐ **Other** (specify):

Acknowledgement/Agreement:

Time Sheets/Service Delivery Logs must be completed accurately each work shift/day. Payment for services delivered is made from state and/or federal funds. Falsification of a time sheet is considered fraud and is punishable under the law.

Accurate, signed time sheets are due: by NOON Tuesday, Bi-weekly

Paychecks are distributed by (method): Direct Deposit/Paycard at least twice a month on Friday, Bi-weekly

or every other week starting .

Employee and employer mutually agree to the compensation, benefits, withholdings and all information above and agree that any changes or revisions must be documented and provided to the employee, the employer and the Financial Management Services Agency.

Signature - Employer or Designated Representative

Date

Signature - Employee

Date