

CENTER FOR INDEPENDENCE
 VETERAN CHOICE PROGRAM
 DIRECT CARE WORKER CHECKLIST

DOCUMENT NAME	REQUIRED / OPTIONAL
Direct Care Worker Set-Up	Required
Relationship Form	Required
Live-In Exemption	Required
IRS Form W-4: Federal Withholding	Required
IRS Form I-9: Employment Eligibility Verification	Required
Worker – Veteran Agreement Form	Required
Rate Agreement	Required
Background Check Disclosure	Required
Retirement Opt-Out	Required
Payment Election Form	Required
Wisely Cardholder Agreement	Informational
Wisely Paystub Access – Quick Access	Informational
Timesheet	Required
Accrued Paid Sick Leave Timesheet	Required

QUESTIONS?

If you have questions about the forms, please contact your ResilientSD Account Coordinator.

- **Email:** COCFI@Resilient-SD.com
- **Phone:** 855.613.2898

NOTE:

Please ensure all **REQUIRED** documents are filled out accurately before submitting them for processing.



CENTER FOR INDEPENDENCE
VETERAN CHOICE PROGRAM
DIRECT CARE WORKER SET-UP FORM

INSTRUCTIONS: Please fill out any information in Sections 1 through 3, where applicable. Both the Direct Care Worker and the Veteran, or the Veteran's Authorized Representative, must sign and date the bottom to be considered complete. Please submit completed form to ResilientSD:

Mail

10425 W. North Ave
Suite 345
Milwaukee, WI 53226

Email

Enrollment@Resilient-SD.com

SECTION 1: DIRECT CARE WORKER INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Mobile #: _____ Work #: _____

Email Address: _____

Date of Birth: _____ Social Security Number: _____

SECTION 2: VETERAN INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Mobile #: _____ Work #: _____

Email Address: _____ Date of Birth: _____

SECTION 3: EMPLOYER INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

For any questions or concerns, please contact our office at: **855.613.2898**.

By signing below, you certify that the information on this form is accurate and that you have all supporting documentation that may be needed to verify your selection

Direct Care Worker Signature: _____ Date: _____

Veteran/Authorized Representative Signature: _____ Date: _____



CENTER FOR INDEPENDENCE VETERAN CHOICE PROGRAM RELATIONSHIP FORM

INSTRUCTIONS: Please fill out all the information in Section 1 and select the correct relationship in Section 2. Both the Direct Care Worker and the Veteran, or the Veteran's Authorized Representative, must sign and date the bottom to be considered complete. Please submit completed form to ResilientSD:

Mail

10425 W. North Ave
Suite 345
Milwaukee, WI 53226

Email

Enrollment@Resilient-SD.com

SECTION 1:

Direct Care Worker Full Name: _____ Date of Birth: _____

Veteran Name: _____

Authorized Representative Name: _____

SECTION 2: Please select your legal relationship with the Employer

Parent *±

Spouse *±

Stepparent

Ex-Spouse

Daughter/Son ¥

Grandparent

Grandchild

Other: _____

Friend

Sibling

Stepchild ¥

Worker

Neighbor

* Due to your relationship with the employer and current legislation, you are exempt from payroll taxes for unemployment insurance (FUTA and SUTA). If your employment with the employer is terminated, you will not receive unemployment benefits.

± Due to your relationship with the employer and current legislation, you are exempt from payroll taxes for Social Security and Medicare (FICA). By not paying into Social Security and Medicare (FICA), it means you are not earning Social Security work credits.

¥ Due to your relationship as the child of the employer and current legislation, you are exempt from payroll taxes for Social Security and Medicare (FICA) and unemployment insurance (FUTA and SUTA) **until your 21st birthday.**

For any questions or concerns, please contact our office at: **855.613.2898**.

By signing below, you certify that the information on this form is accurate and that you have all supporting documentation that may be needed to verify your selection. Please be aware that if any changes occur in the relationship you are required to complete a new form.

Direct Care Worker Signature: _____ Date: _____

Veteran/Authorized Representative Signature: _____ Date: _____

Under the Fair Labor Standards Act (FLSA), household employers are required to pay overtime to employees who work more than 40 hours in a single workweek, unless the employee qualifies as a live-in domestic service worker.

DEFINITION OF A DOMESTIC SERVICE WORKER:

A worker resides on the employer's premises permanently when he or she lives, works, and sleeps on the employer's premises seven (7) days per week and therefore has no home of his or her own other than the one provided by the employer under the employment agreement.

(OR)

A worker resides on the client's premises for an extended period when he or she lives, works, and sleeps on the client's premises for five (5) days a week (120 hours or more). If a domestic worker spends less than 120 hours per week working and sleeping on the client's premises but spends five (5) consecutive days or nights residing on the premises, this also constitutes an extended period.

Does your employee qualify as a live-in worker?

Yes

No

Veteran/Employer Name: _____

Authorized Representative Name: _____

This is only required if the Veteran is not the employer.

Direct Care Worker/Provider Name: _____

Please note that it is your responsibility to let ResilientSD know when the employee no longer lives with the employer.

For any questions or concerns, please contact our office at: **855.613.2898**.

Direct Care Worker Signature: _____ Date: _____

Veteran/Authorized Representative Signature: _____ Date: _____

Please submit completed form to ResilientSD:

Mail

10425 W. North Ave
Suite 345
Milwaukee, WI 53226

Email

Enrollment@Resilient-SD.com

Employee's Withholding Certificate

OMB No. 1545-0074

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****Step 1:**
Enter
Personal
Information

(a) First name and middle initial	Last name	(b) Social security number
Address		Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov .
City or town, state, and ZIP code		
(c) ☐ Single or Married filing separately ☐ Married filing jointly or Qualifying surviving spouse ☐ Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		
Caution: To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.		

TIP: Consider using the estimator at www.irs.gov/W4App to determine the most accurate withholding for the rest of the year if you: are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at www.irs.gov/W4App.

Step 2:
Multiple Jobs
or Spouse
Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

- (a) Use the estimator at www.irs.gov/W4App for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**
- (b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**
- (c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(b) is more accurate ☐

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits	If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly):			
	(a) Multiply the number of qualifying children under age 17 by \$2,000	3(a)	\$	
	(b) Multiply the number of other dependents by \$500	3(b)	\$	
	Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here	3	\$	
Step 4: Other Adjustments	(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income	4(a)	\$	
	(b) Deductions. Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) Enter the result here	4(b)	\$	
	(c) Extra withholding. Enter any additional tax you want withheld each pay period	4(c)	\$	

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

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

General Instructions

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

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 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 if you:

1. Are submitting this form after the beginning of the year;
2. Expect to work only part of the year;
3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;
4. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or
5. Prefer the most accurate withholding for multiple job situations.

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

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

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

Specific Instructions

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

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

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

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

- 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: $\left\{ \begin{array}{l} \bullet \$768,700 \text{ if you're married filing jointly or a qualifying surviving spouse} \\ \bullet \$640,600 \text{ if you're single or head of household} \\ \bullet \$384,350 \text{ if you're married filing separately} \end{array} \right\}$	9 \$ _____
10	If line 9 is greater than line 8b, enter the amount from line 7. Otherwise, multiply line 7 by 94% (0.94) and enter the result here	10 \$ _____
11	Standard deduction.	
Enter:	$\left\{ \begin{array}{l} \bullet \$32,200 \text{ if you're married filing jointly or a qualifying surviving spouse} \\ \bullet \$24,150 \text{ if you're head of household} \\ \bullet \$16,100 \text{ if you're single or married filing separately} \end{array} \right\}$	11 \$ _____
12	Cash gifts to charities. If you take the standard deduction, enter cash contributions up to \$1,000 (\$2,000 if married filing jointly)	12 \$ _____
13	Add lines 11 and 12. Enter the result here	13 \$ _____
14	If line 10 is greater than line 13, subtract line 11 from line 10 and enter the result here. If line 13 is greater than line 10, enter the amount from line 12	14 \$ _____
15	Add lines 2, 4, 5, and 14. Enter the result here and in Step 4(b) of Form W-4	15 \$ _____

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

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

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

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

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



Employment Eligibility Verification

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

USCIS
Form I-9

OMB No.1615-0047

Expires 05/31/2027

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. An alien 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		☐ Check here if you used an alternative procedure authorized by DHS to examine documents.			
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.					First Day of Employment (mm/dd/yyyy):
Last Name, First Name and Title of Employer or Authorized Representative			Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)
Employer's Business or Organization Name			Employer's Business or Organization Address, City or Town, State, ZIP Code		

For reverification or rehire, complete [Supplement B, Reverification and Rehire](#) on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.

* Documents extended by the issuing authority are considered unexpired.

Employees may present one selection from List A or a combination of one selection from List B and one selection from List C.

Examples of many of these documents appear in the Handbook for Employers (M-274).

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card 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		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, sex, 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, sex, 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	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.			
• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	OR	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

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



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

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

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 05/31/2027

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 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 05/31/2027

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 (<i>Family Name</i>)	First Name (<i>Given Name</i>)	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>)	
Additional Information (Initial and date each notation.)			☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

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

CENTER FOR INDEPENDENCE
VETERAN CHOICE PROGRAM
WORKER-VETERAN AGREEMENT FORM

This Worker-Veteran Agreement is entered on _____ between _____
(Veteran/Authorized Representative) and _____ (Direct Care Worker).

DIRECT CARE WORKER RESPONSIBILITIES

I, _____ (Worker), am aware and agree that my employment is conditioned on my employer's participation in the Center for Independence Veteran Choice Program. If my employer ends his or her participation in the Center for Independence Veteran Choice Program, my employment may end. I agree to the following terms of employment:

1. During the term of this Agreement, I shall provide support to my employer by performing the duties outlined in this agreement and any attachments to it.
2. I agree to assist my employer in maintaining the documentation and records required by my employer or ResilientSD. I agree to complete all necessary paperwork to secure mandatory payroll deductions from my pay.

All records I may have or assist in maintaining are the property of my employer. I will keep these records confidential, release them only with the consent of my employer, and return them to my employer if my employment ends.

3. I shall immediately notify a physician or call 9-1-1 if my employer experiences a medical emergency or illness.
4. I agree to participate in any meetings if requested to do so by my employer.
5. I agree to abide by all of my employer's rules regarding my employment duties to the employer through the Center for Independence Veteran Choice Program and I acknowledge receipt of the following rules:

I am 18 years old or older, and a US Citizen or Legal Alien.

I am able to demonstrate an ability to perform tasks employer requests.

I will document time-in and time-out for each shift and must use a standardized form, which my employer or ResilientSD will supply.

6. I understand that this is an employment at will relationship, which can be terminated by me or my employer at any time. However, my employer cannot terminate my employment on the basis of my race, religion, sex, disability, or other protected status under Federal or state law. In addition, I agree to give seven days written notice to my employer if I terminate my employment.
7. I understand and acknowledge that my employer is my sole employer and that I am not an employee of ResilientSD, Center for Independence or any other State or Federal Agency.

CENTER FOR INDEPENDENCE
VETERAN CHOICE PROGRAM
WORKER-VETERAN AGREEMENT FORM

8. I agree to not sue ResilientSD for its role as the financial administrator of my employer's program and for its role in administering the Center for Independence Veteran Choice Program.
9. I agree to the following compensation for the services I shall perform: _____ an hour.
10. I understand that if my Veteran goes into the hospital, or other medical care setting, I cannot be paid during their absence.
11. I will not submit timesheets for any hours of work I have not performed, if so, falsifying timesheets will cause legal proceedings to be pursued.
12. As an employee, I understand I cannot sign timesheets on behalf of my employer – even if I am the POA.

VETERAN/EMPLOYER RESPONSIBILITIES

I, _____ (Employer),

1. Will provide ResilientSD with the necessary documentation to assure timely compensation of my employee.
2. Will compensate my employee in the following manner: _____ an hour.
3. I understand I am approved for a specific number of hours a month for service(s) and I will only use the amount authorized on my plan. If I need additional hours, I will consult with my Coach before I allow my employee to work additional hours.
4. Payroll will be handled by ResilientSD which will withhold all necessary taxes, unemployment, and other withholdings from the employee's paycheck.
5. I will assure my employee receives appropriate training.
6. I will evaluate the performance of my employee and provide appropriate feedback to assure that I am receiving quality supports.
7. I understand that if I go into the hospital or other medical care setting, my employee cannot be paid during that time.
8. I will sign off/approve any timesheets for hours worked by my employee(s). I understand falsifying timesheets will cause legal proceedings to be pursued.
9. I understand I must treat my employee(s) with respect and that I cannot solicit them for anything or harass them in any way (sexually or verbally).

Direct Care Worker Signature: _____ Date: _____

Veteran/Authorized Representative Signature: _____ Date: _____



CENTER FOR INDEPENDENCE VETERAN CHOICE PROGRAM RATE AGREEMENT

INSTRUCTIONS: Please fill out each section as appropriate. Both the Direct Care Worker and the Veteran, or the Veteran's Authorized Representative, must sign and date the bottom to be considered complete. Please submit completed form to ResilientSD:

Mail

10425 W. North Ave
Suite 345
Milwaukee, WI 53226

Email

Enrollment@Resilient-SD.com

SECTION 1: DIRECT CARE WORKER INFORMATION

Name: _____ Last 4 Digits of SSN: _____

Veteran's Full Name: _____

Employer of Record Name: _____

SECTION 2: RATE AGREEMENT INFORMATION

Service Type	Wage	Per	Effective Date
Personal Assistance Services & Supports		Hour	

For any questions or concerns, please contact our office at: **855.613.2898**.

Direct Care Worker Signature: _____ Date: _____

Veteran/Authorized Representative Signature: _____ Date: _____



CENTER FOR INDEPENDENCE VETERAN CHOICE PROGRAM BACKGROUND CHECK DISCLOSURE

As part of Veteran Directed Care Program, ResilientSD is required to conduct applicable background checks before workers are eligible to begin working for a Veteran. Successfully passing these background checks is a condition of employment with the Veteran.

INSTRUCTIONS: Please fill out all the information in Section 1 and Section 2. The Direct Care Worker must sign and date to be considered complete.. Please submit completed form to ResilientSD:

Mail

10425 W. North Ave
Suite 345
Milwaukee, WI 53226

Email

Enrollment@Resilient-SD.com

SECTION 1: VETERAN INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

SECTION 2: DIRECT CARE WORKER INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Physical Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Mobile #: _____ Work #: _____

Email Address: _____

Date of Birth: _____ Social Security Number: _____

For any questions or concerns, please contact our office at: **855.613.2898**.

AUTHORIZATION

By signing below, I certify that the information provided above is accurate. I authorize ResilientSD to conduct a background check now and to automatically conduct future background checks – without notice – based on contractual requirements for as long as I serve as a paid worker for the Veteran. Furthermore, I understand that the results of the background checks will be shared with the Veteran Directed Care Program Operations Manager and the Veteran/Authorized Representative.

Direct Care Worker Signature: _____ Date: _____



CENTER FOR INDEPENDENCE VETERAN CHOICE PROGRAM RETIREMENT OPT-OUT FORM

INSTRUCTIONS: Please fill out all the information in Sections 1, 2 and 3. The Direct Care Worker must sign and date to be considered complete. Please submit completed form to ResilientSD:

Mail

10425 W. North Ave
Suite 345
Milwaukee, WI 53226

Email

Enrollment@Resilient-SD.com

SECTION 1: DIRECT CARE WORKER INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Social Security Number: _____

SECTION 2: VETERAN/AUTHORIZED REPRESENTATIVE INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

SECTION 3: AUTHORIZATION

I understand that I have not been enrolled in my employer's retirement plan. I elect to opt-out of my employer's retirement plan. I understand that opting out is effective immediately.

I understand that if I choose to opt in, I must contact my employer's Financial Management Services provider, ResilientSD, to notify them of my decision to opt in.

Direct Care Worker Signature: _____ Date: _____

For any questions or concerns, please contact our office at: **855.613.2898**.



CENTER FOR INDEPENDENCE VETERAN CHOICE PROGRAM PAYMENT ELECTION FORM

INSTRUCTIONS: Please check the appropriate box in Section 1 and fill out applicable information in Section 2. If Paycard box is checked, skip Section 3. If Paper Check box is checked, skip Sections 3 and 4. If neither Paycard box nor Paper Check box is selected, please proceed to fill out Sections 3 and 4. After entering the Financial Institution information in Section 3, please attach the required documentation as listed. Review Sections 4 and 5, then sign and date. The form must be signed and dated to be considered complete. Please submit completed form to ResilientSD:

Mail

10425 W. North Ave
Suite 345
Milwaukee, WI 53226

Email

Enrollment@Resilient-SD.com

For any questions or concerns, please contact our office at: **855.613.2898**.

SECTION 1: Check one box ONLY

Effective Date: _____

New Direct
Deposit Set-Up

New Paycard
Set-Up

Existing Paycard
Set-Up

Paper Check

Cancel
DD/Paycard

SECTION 2 (Please print clearly)**Veteran Information**

Veteran Name: _____

Direct Care Worker Information

Direct Care Worker Name: _____ Last 4 Digits of SSN: _____

Vendor Information

Vendor Name: _____ Contact Number: _____

Contact Name: _____ Email Address: _____

SECTION 3

Name of Financial Institution: _____

Type of Account: Checking Savings Percentage: _____%

For Checking Account

Tape a voided check here.
(No starter check or deposit slip.)

For Savings Account

Attach letter from bank with routing and account numbers.
(Letter must be typed on bank's letterhead.)



CENTER FOR INDEPENDENCE VETERAN CHOICE PROGRAM PAYMENT ELECTION FORM

Optional for split deposit:

Name of Financial Institution: _____

Type of Account: Checking Savings Percentage: _____%



For Checking Account

Tape a voided check here.
(No starter check or deposit slip.)

For Savings Account

Attach a letter from bank with routing and account numbers.
(Letter must be typed on bank's letterhead.)



SECTION 4

Check Stubs:

I hereby elect to receive my check stubs via mail, not online.

SECTION 5 (Check one box ONLY)

Authorization for Set-Up, Change or Cancellation

I hereby authorize ResilientSD to **deposit** any amount owed to me for wages and/or reimbursements. ResilientSD is not responsible for any erroneous information provided. Also, I grant ResilientSD permission to correct and/or adjust any electronic funds transfer resulting from an erroneous overpayment by debiting my account. This authorization is to remain in full force and effect until ResilientSD receives written notification from me to terminate the agreement.

I hereby elect and consent to receive my wages to a **paycard** by electronic transfer. I also grant ResilientSD permission to correct and/or adjust any electronic funds transfer resulting from an erroneous overpayment by debiting my account. I acknowledge I have received a copy of the terms, conditions, and fees associated with using the aforementioned paycard. This authorization is to remain in full force and effect until ResilientSD receives written notification from me to terminate the agreement.

I hereby authorize ResilientSD to stop making electronic transfers to my account. I understand that I will now receive physical payroll checks rather than a direct deposit.

Signature: _____ Date: _____

***Please note, your first payment may be a paper check.**

If you choose to receive your payment through a paycard, you will be issued a card through Wisely.

Please see below for a brief overview of any related fees to using the card. The complete cardholder agreement can be found here: <https://tinyurl.com/RSDWiselyE>

You do not have to accept this payroll card.
Ask your employer about other ways to receive your wages.

Monthly fee	Per purchase	ATM withdrawal	Cash reload
\$0	\$0	\$0 in-network \$3.00 out-of-network	\$5.95*

ATM balance inquiry (in-network or out-of-network)	\$0
Customer service (automated or live agent)	\$0
Inactivity (after 90 days with no transactions)	\$4.00 per month

We also charge 6 other types of fees.

*This fee can be lower depending on how and where this card is used.

No overdraft/credit feature.

Your funds are eligible for FDIC insurance.

For general information about prepaid accounts, visit cfpb.gov/prepaid.

Find details and conditions for all fees and services in the cardholder agreement and in the "List of all fees for the Wisely® Pay Card."

The Wisely® Pay Mastercard® is issued by Pathward®, National Association, Member FDIC, pursuant to license by Mastercard International Incorporated. Card is serviced by Global Cash Card, Inc.

Si elige recibir su pago a través de una tarjeta de pago, se le emitirá una tarjeta a través de Wisely.

A continuación, se ofrece una breve descripción de las comisiones relacionadas con el uso de la tarjeta. El acuerdo completo del titular de la tarjeta se encuentra aquí: <https://tinyurl.com/RSDWiselyS>

No es necesario que acepte esta tarjeta de nómina. Pregúntele a su empleador sobre otras formas de recibir su salario.			
Tarifa mensual	Por compra	Retiro en ATM	Recarga con dinero en efectivo
\$0	\$0	\$0 dentro de la red \$3.00 fuera de la red	\$5.95*
Consulta de saldo en ATM (dentro o fuera de la red)			\$0
Servicio al cliente (automatizado o agente en vivo)			\$0
Inactividad (después de 90 días sin transacciones)			\$4.00 por mes
También cobramos otros 6 tipos de tarifas.			
*Esta tarifa puede ser menos dependiendo de cómo y dónde se use esta tarjeta.			
No hay función de sobregiro/crédito. Sus fondos son elegibles para el seguro de la FDIC.			
Para obtener información general sobre las cuentas prepagadas, visite cfpb.gov/prepaid .			
Encuentre detalles y condiciones para todas las tarifas y los servicios en el acuerdo del titular de la tarjeta y en la "Lista de todas las tarifas para la tarjeta Wisely® Pay".			

La tarjeta Wisely® Pay Mastercard® es emitida por Pathward®, National Association, miembro de la FDIC, de conformidad con licencia de Mastercard International Incorporated. La tarjeta es administrada por Global Cash Card, Inc.

Please find below step-by-step instructions on how to access your online pay stubs.

- When logging in, **Client ID is: gw5prem944**
- For questions, please contact your Account Coordinator: 855.613.2898 or COCFI@Resilient-SD.com

1. Login to Paystub Portal: <https://www.mywisely.com/app/main/gccnchregistration>

Note: If you previously have had a My Wisely, ADP, or Global Cash card, log in at: <https://www.mywisely.com/app/main/login/>



2. Get Started

3. Enter Personal Information

4. Set-Up Username and Password

5. Enter/Verify Phone No.

6. Enter/Verify Email

7. Login to Account

8. Access Paystub

Questions? Contact your ResilientSD Account Coordinator
Phone: 855.613.2898
Email: COCFI@Resilient-SD.com

TIMESHEET SUBMISSION

Mail: 10425 W. North Ave., Suite 345
 Milwaukee, WI 53226
Email: Timesheets@Resilient-SD.com
Fax: 1.855.325.4668

Direct Care Worker Name: _____

Veteran Name: _____

Authorized Representative Name: _____ AR Phone: _____

Pay Period Begins: (MM/DD/YYYY) _____ Pay Period Ends: (MM/DD/YYYY) _____

Service Date (MM/DD)	Time In		Time Out		Time In		Time Out		Total Hours
/	:	AM PM	:	AM PM	:	AM PM	:	AM PM	
/	:	AM PM	:	AM PM	:	AM PM	:	AM PM	
/	:	AM PM	:	AM PM	:	AM PM	:	AM PM	
/	:	AM PM	:	AM PM	:	AM PM	:	AM PM	
/	:	AM PM	:	AM PM	:	AM PM	:	AM PM	
/	:	AM PM	:	AM PM	:	AM PM	:	AM PM	
/	:	AM PM	:	AM PM	:	AM PM	:	AM PM	
/	:	AM PM	:	AM PM	:	AM PM	:	AM PM	
/	:	AM PM	:	AM PM	:	AM PM	:	AM PM	
/	:	AM PM	:	AM PM	:	AM PM	:	AM PM	
/	:	AM PM	:	AM PM	:	AM PM	:	AM PM	
/	:	AM PM	:	AM PM	:	AM PM	:	AM PM	
/	:	AM PM	:	AM PM	:	AM PM	:	AM PM	
/	:	AM PM	:	AM PM	:	AM PM	:	AM PM	
/	:	AM PM	:	AM PM	:	AM PM	:	AM PM	
/	:	AM PM	:	AM PM	:	AM PM	:	AM PM	
/	:	AM PM	:	AM PM	:	AM PM	:	AM PM	
/	:	AM PM	:	AM PM	:	AM PM	:	AM PM	
/	:	AM PM	:	AM PM	:	AM PM	:	AM PM	
Service Hours Total									

The Authorized Representative and Worker certify that the information provided on this timesheet is a true and accurate statement of the services provided. The Authorized Representative and Worker understand that payment for services provided are subject to payroll taxes.

Direct Care Worker Signature: _____ Date: _____

Veteran/Authorized Representative Signature: _____ Date: _____

CENTER FOR INDEPENDENCE – VETERAN CHOICE PROGRAM

TIMESHEET INSTRUCTIONS

TIMESHEET CHECKLIST

Is my legal name on the Timesheet?

Is my Veteran's legal name on the Timesheet?

Did I fill in the correct pay period with the correct start and end dates?

Example (See schedule for dates):

Pay Period Begins: (MM/DD/YYYY)	10/01/2025	Pay Period Ends: (MM/DD/YYYY)	10/15/2025
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Did I fill in the dates for each day worked?

Did I use the correct 15-minute increments to record my work time?

15 min. | 30 min. | 45 min. | 60 min.

Did I sign and date my Timesheet?

Example: If the last day you worked was July 23rd, you would sign and date the Timesheet as 7/23/20xx.

Did my Veteran/employer sign and date my Timesheet?

Did I make sure hours submitted are worked on or before the Timesheet due date and signed date?

Did I make sure the dates on the Timesheet are for one pay period ONLY and do not cross with any other pay periods?

Did I make sure I did NOT use white-out to make corrections?

PLEASE NOTE: Timesheets received that are missing any of the above information will be rejected and returned for correction. They may result in delay of payment.

MARKING INSTRUCTIONS

Write in **BLACK** or **BLUE** ink only. Write as large and legible as possible without touching the sides of the boxes.

Do not write outside of the boxes.

X NO	X NO	✓ YES
5 15	5 : 15	5 : 15

TIMESHEET SUBMISSION

Mail: 10425 W North Ave
Suite 345
Milwaukee, WI 53226

Email: Timesheets@Resilient-SD.com

Fax: 855.325.4668

HOW DO I RECORD MY HOURS

If you only work one shift a day, your hours should be recorded in the first Time In and Time Out columns.

Service Date (MM/DD)	Time In	Time Out
09 / 22	8 : 00 ☐ AM ☐ PM	1 : 30 ☐ AM ☐ PM

If you work more than one shift per day, your hours for the additional shift should be recorded in the second Time In and Time Out columns.

Service Date (MM/DD)	Time In	Time Out	Time In	Time Out
09 / 22	8 : 00 ☐ AM ☐ PM	1 : 30 ☐ AM ☐ PM	3 : 00 ☐ AM ☐ PM	7 : 00 ☐ AM ☐ PM

What should I do if I work past midnight on any given day?

- The hours worked past midnight **MUST** be recorded on the next day.

Example: If you work Monday from 6:00pm to Tuesday 6:00am, your timesheet should look as follows

Service Date (MM/DD)	Time In	Time Out
09 / 22	6 : 00 ☐ AM ☒ PM	12 : 00 ☒ AM ☐ PM
09 / 23	12 : 00 ☒ AM ☐ PM	6 : 00 ☒ AM ☐ PM



ACCRUED PAID SICK LEAVE FORM

CENTER FOR INDEPENDENCE

VETERAN CHOICE PROGRAM

Form ONLY to be used for Accrued Paid Sick Time

Direct Care Worker Name: _____

Veteran Name: _____

Authorized Representative Name: _____ AR Phone #: _____

Pay Period Begins: (MM/DD/YYYY) _____

Pay Period Ends: (MM/DD/YYYY) _____

Service Date (MM/DD)	PTO Start Time		PTO End Time		# of Hours Requested
/	:	AM PM	:	AM PM	
/	:	AM PM	:	AM PM	
/	:	AM PM	:	AM PM	
/	:	AM PM	:	AM PM	
/	:	AM PM	:	AM PM	
/	:	AM PM	:	AM PM	
/	:	AM PM	:	AM PM	
/	:	AM PM	:	AM PM	
/	:	AM PM	:	AM PM	
/	:	AM PM	:	AM PM	
/	:	AM PM	:	AM PM	
/	:	AM PM	:	AM PM	
/	:	AM PM	:	AM PM	
/	:	AM PM	:	AM PM	
/	:	AM PM	:	AM PM	
/	:	AM PM	:	AM PM	
Total Hours					

The Veteran/Authorized Representative and Direct Care Worker certify that the information provided on this form is a true and accurate statement of the services being requested. The Veteran/Authorized Representative and Direct Care Worker understand that payment for services provided are subject to payroll taxes.

Direct Care Worker Signature: _____ Date: _____

Veteran/Authorized Representative Signature: _____ Date: _____

TIMESHEET SUBMISSION

Mail

10425 W North Ave
Suite 345
Milwaukee, WI 53226

Email

Timesheets@Resilient-SD.com

Fax

855.325.4668

Timesheet Checklist

Is my legal name on the TS?

Is my Veteran's legal name on the TS?

Did I fill in the correct pay period with the correct start and end dates?

Example (See schedule for dates):

Pay Period Begins: (MM/DD/YYYY) Pay Period Ends: /DD/YYYY)

07 / 05 / 2024 07 / 18 / 2024

Did I fill in the dates for the correct day of the week?

Example: July 9th is a Sunday - you would fill the first Sunday as 07/09

Did I review that all my hours are accurate?

Did I sign and date my TS?

Example: If the last day you worked was July 23rd - you would sign and date the TS as 7/23/yr.

Did my employer sign and date my TS?

Did I make sure hours submitted are worked on or before the TS due date and signed date?

Did I use standard time (not military time)?

Did I make sure the dates on the TS are for one pay period **ONLY** and do not cross with any other pay periods?

Did I make sure I did **NOT** use white-out to make corrections?

MARKING INSTRUCTIONS FOR TIMESHEET

- Write in **BLACK** or **BLUE** ink only.
- Write as large and legible as possible without touching the sides of the boxes.

Do not write outside of the boxes.

Timesheets received that are missing any of the above information will be rejected and returned for correction. This may result in a delay of payment.

Once all check boxes are checked, please submit your timesheet to ResilientSD.

Healthy Families & Workplaces ACT (HFWA)

- The Colorado Healthy Families and Workplaces Act (HFWA) requires Colorado employers to provide two types of paid sick leave to their employees: accrued leave and public health emergency (PHE) leave (not currently in effect). The following points apply to both PHE and accrued leave.
- Paid sick leave must be paid for time off work, and at the same pay rate the employee earns during time worked.
- Paid sick leave can't be counted against employees as absences that may lead to firing or other negative action.
- Employee can generate up to 48 hours of paid sick time per calendar year.

Acceptable Reasons to Use Accrued Sick Time

- Inability to work due to a mental or physical illness, injury, or health condition.
- Obtaining preventive medical care (including vaccination), or medical diagnosis/care/treatment.
- Needs due to domestic abuse, sexual assault, or criminal harassment including medical attention, mental health care or other counseling, legal or other victim services, or relocation.
- Care for a family member who needs the sort of care listed above.
- During a PHE, a public official closed the employee's workplace, or the school or place of care of the employee's child.
- Effective Aug. 7, 2023: Bereavement, or financial/legal needs after a death of a family member; or
- Effective Aug. 7, 2023: Due to inclement weather, power/heat/water loss, or other unexpected event, the employee must evacuate their residence, or care for a family member whose school or place of care was closed.

For any questions or concerns, please contact our office at: **855.613.2898**.