Caregivers:

Please fill out the forms that are included in this packet and return to the CLC Administrative Services fiscal agency by mail, email, or fax:

Email Address:
Fiscal.Agent@charleslea.org

Mailing Address:

The Charles Lea Center~ ATTN: Respite Payroll
195 Burdette Street
Spartanburg, SC 29307

Fax number: 864~562~2118

Caregiver Packet

Do you have?

	Employee Action Notice
	Federal W-4 Form
	State W-4 Form
	I-9 Form (2 pages)
	Copies of Identification listed on Page 2 of I-9 Form
	Direct Deposit Form
	Copy of Voided Check
	Payroll Policy Form
	CLC Waiver Forms

All packets can be returned by email, fax, or mail.

Email Address: Fiscal.Agent@charleslea.org

Fax Number: 864-562-2118

Mailing Address: The Charles Lea Center (ATTN: Respite Payroll), 195 Burdette St., Spartanburg, SC 29307

Employee Action Notice

PLEASE PRINT

Caregiver Name:_____

Individual receiving services:_____

Caregiver Mailing Address:_____

City:_____State:__ Zip Code:_____

Telephone Number:_____

Email:_____

Caregiver Social Security Number:_____

.....

Employer/Family Name:_____

Employer/Family Mailing Address:_____

City: _____ State:_ _ Zip Code:_____

Telephone Number:_____

Employer/Family Signature:_____

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

2023

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.)

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, other details, and privacy.

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) Reserved for future use.

(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 . . . . . ☐

TIP: If you have self-employment income, see page 2.

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

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

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

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

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

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

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

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

Step 5: Sign Here

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

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

Employers Only

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

General Instructions

Section references are to the Internal Revenue Code.

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 2023 if you meet both of the following conditions: you had no federal income tax liability in 2022 **and** you expect to have no federal income tax liability in 2023. You had no federal income tax liability in 2022 if (1) your total tax on line 24 on your 2022 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2023 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2024.

Your privacy. If you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c).

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 income and self-employment taxes through withholding from your wages, you should enter the self-employment income on Step 4(a). Then compute your self-employment tax, divide that tax by the number of pay periods remaining in the year, and include that resulting amount per pay period on Step 4(c). You can also add half of the annual amount of self-employment tax to Step 4(b) as a deduction. To calculate self-employment tax, you generally multiply the self-employment income by 14.13% (this rate is a quick way to figure your self-employment tax and equals the sum of the 12.4% social security tax and the 2.9% Medicare tax multiplied by 0.9235). See Pub. 505 for more information, especially if the sum of self-employment income multiplied by 0.9235 and wages exceeds $160,200 for a given individual.

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.

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 roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

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

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

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2023 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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

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

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . **1** $

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . **2a** $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . **2b** $

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . **2c** $

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3**

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . **4** $

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

1 Enter an estimate of your 2023 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $

2 Enter:
- $27,700 if you're married filing jointly or a qualifying surviving spouse
- $20,800 if you're head of household
- $13,850 if you're single or married filing separately

. . . . . **2** $

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

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

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

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$850	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,870
$10,000 - 19,999	0	930	1,850	2,000	2,200	2,220	2,220	2,220	2,220	2,220	3,200	4,070
$20,000 - 29,999	850	1,850	2,920	3,120	3,320	3,340	3,340	3,340	3,340	4,320	5,320	6,190
$30,000 - 39,999	850	2,000	3,120	3,320	3,520	3,540	3,540	3,540	4,520	5,520	6,520	7,390
$40,000 - 49,999	1,000	2,200	3,320	3,520	3,720	3,740	3,740	4,720	5,720	6,720	7,720	8,590
$50,000 - 59,999	1,020	2,220	3,340	3,540	3,740	3,760	4,750	5,750	6,750	7,750	8,750	9,610
$60,000 - 69,999	1,020	2,220	3,340	3,540	3,740	4,750	5,750	6,750	7,750	8,750	9,750	10,610
$70,000 - 79,999	1,020	2,220	3,340	3,540	4,720	5,750	6,750	7,750	8,750	9,750	10,750	11,610
$80,000 - 99,999	1,020	2,220	4,170	5,370	6,570	7,600	8,600	9,600	10,600	11,600	12,600	13,460
$100,000 - 149,999	1,870	4,070	6,190	7,390	8,590	9,610	10,610	11,660	12,860	14,060	15,260	16,330
$150,000 - 239,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
$240,000 - 259,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
$260,000 - 279,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	18,140
$280,000 - 299,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,870	17,870	19,740
$300,000 - 319,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,470	15,470	17,470	19,470	21,340
$320,000 - 364,999	2,040	4,440	6,760	8,550	10,750	12,770	14,770	16,770	18,770	20,770	22,770	24,640
$365,000 - 524,999	2,970	6,470	9,890	12,390	14,890	17,220	19,520	21,820	24,120	26,420	28,720	30,880
$525,000 and over	3,140	6,840	10,460	13,160	15,860	18,390	20,890	23,390	25,890	28,390	30,890	33,250

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	$310	$890	$1,020	$1,020	$1,020	$1,860	$1,870	$1,870	$1,870	$1,870	$2,030	$2,040
$10,000 - 19,999	890	1,630	1,750	1,750	2,600	3,600	3,600	3,600	3,600	3,760	3,960	3,970
$20,000 - 29,999	1,020	1,750	1,880	2,720	3,720	4,720	4,730	4,730	4,890	5,090	5,290	5,300
$30,000 - 39,999	1,020	1,750	2,720	3,720	4,720	5,720	5,730	5,890	6,090	6,290	6,490	6,500
$40,000 - 59,999	1,710	3,450	4,570	5,570	6,570	7,700	7,910	8,110	8,310	8,510	8,710	8,720
$60,000 - 79,999	1,870	3,600	4,730	5,860	7,060	8,260	8,460	8,660	8,860	9,060	9,260	9,280
$80,000 - 99,999	1,870	3,730	5,060	6,260	7,460	8,660	8,860	9,060	9,260	9,460	10,430	11,240
$100,000 - 124,999	2,040	3,970	5,300	6,500	7,700	8,900	9,110	9,610	10,610	11,610	12,610	13,430
$125,000 - 149,999	2,040	3,970	5,300	6,500	7,700	9,610	10,610	11,610	12,610	13,610	14,900	16,020
$150,000 - 174,999	2,040	3,970	5,610	7,610	9,610	11,610	12,610	13,750	15,050	16,350	17,650	18,770
$175,000 - 199,999	2,720	5,450	7,580	9,580	11,580	13,870	15,180	16,480	17,780	19,080	20,380	21,490
$200,000 - 249,999	2,900	5,930	8,360	10,660	12,960	15,260	16,570	17,870	19,170	20,470	21,770	22,880
$250,000 - 399,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
$400,000 - 449,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
$450,000 and over	3,140	6,380	9,010	11,510	14,010	16,510	18,010	19,510	21,010	22,510	24,010	25,330

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	$620	$860	$1,020	$1,020	$1,020	$1,020	$1,650	$1,870	$1,870	$1,890	$2,040
$10,000 - 19,999	620	1,630	2,060	2,220	2,220	2,220	2,850	3,850	4,070	4,090	4,290	4,440
$20,000 - 29,999	860	2,060	2,490	2,650	2,650	3,280	4,280	5,280	5,520	5,720	5,920	6,070
$30,000 - 39,999	1,020	2,220	2,650	2,810	3,440	4,440	5,440	6,460	6,880	7,080	7,280	7,430
$40,000 - 59,999	1,020	2,220	3,130	4,290	5,290	6,290	7,480	8,680	9,100	9,300	9,500	9,650
$60,000 - 79,999	1,500	3,700	5,130	6,290	7,480	8,680	9,880	11,080	11,500	11,700	11,900	12,050
$80,000 - 99,999	1,870	4,070	5,690	7,050	8,250	9,450	10,650	11,850	12,260	12,460	12,870	13,820
$100,000 - 124,999	2,040	4,440	6,070	7,430	8,630	9,830	11,030	12,230	13,190	14,190	15,190	16,150
$125,000 - 149,999	2,040	4,440	6,070	7,430	8,630	9,980	11,980	13,980	15,190	16,190	17,270	18,530
$150,000 - 174,999	2,040	4,440	6,070	7,980	9,980	11,980	13,980	15,980	17,420	18,720	20,020	21,280
$175,000 - 199,999	2,190	5,390	7,820	9,980	11,980	14,060	16,360	18,660	20,170	21,470	22,770	24,030
$200,000 - 249,999	2,720	6,190	8,920	11,380	13,680	15,980	18,280	20,580	22,090	23,390	24,690	25,950
$250,000 - 449,999	2,970	6,470	9,200	11,660	13,960	16,260	18,560	20,860	22,380	23,680	24,980	26,230
$450,000 and over	3,140	6,840	9,770	12,430	14,930	17,430	19,930	22,430	24,150	25,650	27,150	28,600

1350

dor.sc.gov

STATE OF SOUTH CAROLINA
DEPARTMENT OF REVENUE

SOUTH CAROLINA EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

SC W-4
(Rev. 11/3/22)
3527
2023

Give this form to your employer. Keep the worksheets for your records. The SCDOR may review any allowances and exemptions claimed. Your employer may be required to send a copy of this form to the SCDOR.

Part I: Employee Information

1 First name and middle initial	Last name	2 Social Security Number

Address

City State ZIP

3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate.
If Married filing separately, check **Married, but withhold at higher Single rate**.

4 Check if **your last name is different** on your Social Security card. ☐
For a replacement card, contact the Social Security Admin at 1-800-772-1213 .

5	Total number of allowances (from the applicable worksheet on page 3)	5	
6	Additional amount, if any, to withhold from each paycheck	6	$
7	I claim exemption from withholding for 2023. Check the box for the exemption reason and write **Exempt** on line 7.		

☐ For tax year 2022, I had a right to a refund of **all** South Carolina Income Tax withheld because I had **no** tax liability, **and** for tax year 2023 I expect a refund of **all** South Carolina Income Tax withheld because I expect to have **no** tax liability.

☐ I elect to use the same state of residence for tax purposes as my military servicemember spouse. I have provided my employer with a copy of my current military ID card and a copy of my spouse's latest Leave and Earning Statement (LES). State of domicile: _____

7

Under penalty of law, I certify that this information is correct, true, and complete to the best of my knowledge.

Employee's signature (required) **Date**

Part II: Employer Information

Complete box 8 and box 10 if sending to the SCDOR. Complete box 8, box 9, and box 10 if sending to the State Directory of New Hires.

8 Employer's name and address	9 First date of employment	10 Employer identification number (EIN)

INSTRUCTIONS

Employee instructions

Complete the SC W-4 so your employer can withhold the correct South Carolina Income Tax from your pay. If you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Determine the number of withholding allowances you should claim for withholding for 2023 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Consider completing a new SC W-4 each year and when your personal or financial situation changes. This keeps your withholding accurate and helps you avoid surprises when you file your South Carolina Individual Income Tax return.

For the latest information about South Carolina Withholding Tax and the SC W-4, visit **dor.sc.gov/withholding**.

Exemptions: You may claim exemption from South Carolina withholding for 2023 for one of the following reasons:

- For tax year 2022, you had a right to a refund of **all** South Carolina Income Tax withheld because you had **no** tax liability, **and** for tax year 2023 you expect a refund of **all** South Carolina Income Tax withheld because you expect to have **no** tax liability.
- Under the Servicemembers Civil Relief Act, you are claiming the same state of residence for tax purposes as your military servicemember spouse. You are only in South Carolina, or a bordering state, to be with your military spouse who is serving in the state in compliance with military orders. Provide your employer with a copy of your current military ID card and a copy of your spouse's latest Leave and Earnings Statement (LES). Your military ID card must have been issued within the last four years. The assignment location on the LES must be in South Carolina or a bordering state. Enter your spouse's state of domicile on the line provided.

If you are exempt, complete **only** line 1 through line 4 and line 7. Check the box for the reason you are claiming an exemption and write **Exempt** on line 7. Your exemption for 2023 expires February 15, 2024. If you are a military spouse and you no longer qualify for the exemption, you have 10 days to update your SC W-4 with your employer.

Filers with multiple jobs or working spouses: You will need to file an SC W-4 for each employer. If you have more than one job, or if you are married filing jointly and your spouse is also working, you may want to consider only claiming allowances on the SC W-4 for the highest earning job and/or adding additional withholding on line 6 to ensure you are having enough withheld.

Nonwage income: If you have a large amount of nonwage income not subject to withholding, such as interest or dividends, consider making Estimated Tax payments using the SC1040ES, Individual Declaration of Estimated Tax, or adding additional withholding from this job's wages on line 6. Otherwise, you may owe additional tax. Find the SC1040ES with instructions at **dor.sc.gov/forms**. The fastest, easiest way to make Estimated Tax payments is using our free, online tax portal, **MyDORWAY**, at **dor.sc.gov/pay**. Select **Individual Income Tax Payment** to get started. Do not mail a paper copy of the SC1040ES if you pay online. If you have not yet filed a South Carolina Individual Income Tax return, you must use the SC1040ES and cannot make Estimated Tax payments on MyDORWAY.

Employer instructions
Complete box 8 through box 10, as necessary. Employees do **not** complete this section.

- **New hire reporting:** You must report newly-hired employees within 20 days after the employee's first day of work. For more information, see SC Code Section 43-5-598 and 42 USC Section 653a or visit **newhire.sc.gov.**
- **Box 8:** Enter your name and address. If you are sending a copy of this form to the State Directory of New Hires, enter the address where child support agencies should send income withholding orders.
- **Box 9:** If you are sending a copy of this form to the State Directory of New Hires, enter the employee's first date of employment, which is the date services for payment were first performed by the employee. If you rehired the employee after they had been separated from your service for at least 60 days, enter the rehire date.
- **Box 10:** Enter your Employer Identification Number (EIN).

All employers reporting South Carolina wages or withholdings must submit the W-2s directly to the SCDOR. Submitting the W-2s to the Social Security Administration does not meet this requirement. The fastest, easiest way to submit W-2s is using our free, online tax portal, **MyDORWAY**, at **MyDORWAY.dor.sc.gov**. Sign in to your existing account or create an account to get started. Once you've logged in, select the **More** tab, then click **Upload W-2s,** listed under the **Other** section.

The Withholding Tax Tables and the Withholding Tax Formula are available at **dor.sc.gov/withholding**.

Worksheet instructions
Personal Allowances Worksheet: Complete the worksheet on page 3 to determine the number of withholding allowances to claim.

- **Line C: Head of household -** Generally, you may claim the head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. For more information on filing status, refer to IRS Pub. 501, available at **irs.gov**.
- **Line E: Dependents -** The total number of dependents claimed on your South Carolina return must equal the number of dependents claimed on your federal return. This includes qualifying children and qualifying relatives. Enter the total number of eligible dependents.
- **Line F: Dependents under the age of 6 -** Enter the number of dependents from line E who have **not** reached the age of six by December 31, 2023.

Enter the total from line G of this worksheet on line 5 of the SC W-4.

Deductions, Adjustments, and Additional Income Worksheet: Complete this **optional** worksheet if you plan to itemize or claim adjustments to income and want to reduce your withholding, or if you have a large amount of nonwage income not subject to withholding and want to increase your withholding.

- **Reduce withholding:** Complete this worksheet to determine if you are able to reduce the tax withheld from your paycheck to account for your itemized deductions and other adjustments to income, such as IRA contributions. If you reduce your withholding, your refund at the end of the year will be smaller, but your paycheck will be larger.
- **Increase withholding:** You can also use this worksheet to determine how much to increase the tax withheld from your paycheck if you have a large amount of nonwage income not subject to withholding, such as interest or dividends.

Enter the total from line 10 of this worksheet on line 5 of the SC W-4.

SC W-4 Worksheets

KEEP FOR YOUR RECORDS

Personal Allowances Worksheet

A	Enter 1 for yourself	**A**	
B	Enter 1 if you will file as married filing jointly	**B**	
C	Enter 1 if you will file as head of household	**C**	
D	Enter 1 if: • You are single, or married filing separately, and have only one job; **or** • You are married filing jointly, have only one job, and your spouse doesn't work; **or** • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	**D**	
E	**Dependents:** Enter the number of dependents you will claim on your 2023 federal return	**E**	
F	**Dependents under the age of 6:** Enter the number of dependents from line **E** who are under the age of 6 as of December 31, 2023.	**F**	
G	Add line A through line F	**G**	

For accuracy, **complete all worksheets that apply.**

- **If you plan to itemize** or **claim adjustments to income** and want to reduce your withholding, or if you have a large amount of nonwage income not subject to withholding and want to increase your withholding, see the **Deductions, Adjustments, and Additional Income Worksheet** below.
- If the above situation does not apply, **stop here** and enter the number from line G on line 5 of the SC W-4 on page 1.

Deductions, Adjustments, and Additional Income Worksheet

Note: Use this worksheet **only** if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income not subject to withholding.

1	Enter an estimate of your 2023 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 10% of your income. For more information, refer to IRS Pub. 505, available at **irs.gov**.	**1**	$
2	Enter the 2023 federal standard deduction amount based on your filing status.	**2**	$
3	Subtract line 2 from line 1. If zero or less, enter 0.	**3**	$
4	Enter an estimate of your 2023 adjustments to income and any additional standard deduction for age or blindness. For more information, refer to IRS Pub. 505, available at **irs.gov**.	**4**	$
5	Add line 3 and line 4	**5**	$
6	Enter an estimate of your 2023 nonwage income not subject to withholding (such as dividends or interest)	**6**	$
7	Subtract line 6 from line 5. If zero, enter 0. Enter a negative amount in **brackets**.	**7**	$
8	Divide line 7 by $4,400. Enter a negative amount in **brackets**. Round decimals **down**.	**8**	
9	Enter the number from the **Personal Allowances Worksheet,** line G.	**9**	
10	Add line 8 and line 9. If zero or less, enter 0.	**10**	

Enter the total from line 10 on line 5 of the SC W-4 on page 1.

The Family Privacy Protection Act

Under the Family Privacy Protection Act, the collection of personal information from citizens by the SCDOR is limited to the information necessary for the SCDOR to fulfill its statutory duties. In most instances, once this information is collected by the SCDOR, it is protected by law from public disclosure. In those situations where public disclosure is not prohibited, the Family Privacy Protection Act prevents such information from being used by third parties for commercial solicitation purposes.

Social Security Privacy Act Disclosure

It is mandatory that you provide your Social Security Number on this tax form if you are an individual taxpayer. 42 U.S.C. 405(c)(2)(C)(i) permits a state to use an individual's Social Security Number as means of identification in administration of any tax. SC Regulation 117-201 mandates that any person required to make a return to the SCDOR must provide identifying numbers, as prescribed, for securing proper identification. Your Social Security Number is used for identification purposes.

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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	Other Last Names Used *(if any)*

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

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	**OR**	**List B** Identity	**AND**	**List C** Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear 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.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

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

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

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

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **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 alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
		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:		
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		**10.** School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

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

Refer to the instructions for more information about acceptable receipts.

CLC ADMINISTRATIVE SERVICES, INC.

DIRECT DEPOSIT AUTHORIZATION

Please accept this as an authorization to deposit my payroll funds into the following account

Date:_____

- PRIMARY ACCOUNT INFORMATION- *all bank information must be completed & provided by the employee*

  ☐ Add as a new account

  ☐ Delete account (Stop Direct Deposit)

Financial Institution Name: _____City:_____State:_____

Routing #: _____ **Checking** or **Savings** (circle one)

Account #: _____Amount/Percent of Deposit: $_____

- SECONDARY ACCOUNT INFORMATION- *all bank information must be completed & provided by the employee*

  ☐ Add as a new account

  ☐ Delete account (Stop Direct Deposit)

Financial Institution Name: _____City:_____State:_____

Routing #: _____ **Checking** or **Savings** (circle one)

Account #: _____Amount/Percent of Deposit: $_____

- SECONDARY ACCOUNT INFORMATION **(NOTE: Maximum of three accounts)**- *all bank information must be completed & provided by the employee*

  ☐ Add as a new account

  ☐ Delete account (Stop Direct Deposit)

Financial Institution Name: _____City:_____State:_____

Routing #: _____ **Checking** or **Savings** (circle one)

Account #: _____Amount/Percent of Deposit: $_____

****Please provide a voided check or information from bank for verifying routing and account number****

Employee Name (please print):_____

Employee Social Security No.:_____ Employee ID: _____

Employee Name Signature:_____

CLC Administrative Services, Inc.

Payroll Policy

This policy is for all employers and caregivers that receive Respite, In-home supports and UAP Attendant Care Services that are paid through CLC Administrative Services, Inc. It is the employer and caregiver's responsibility to abide by this policy when submitting timesheets for processing through the fiscal payroll agent, CLC Administrative Services, Inc. Failure to follow this policy can result in Medicaid fraud and the client losing services. Both the employer and caregiver must review the policy together and sign below.

Understanding Payroll's role

- CLC Administrative Services, is just the payroll agency. We process pay for Respite, In-home support and UAP Attendant Care services. We are not the caregiver's employer. The employer will be who hires the caregiver. The employer is responsible for the hiring, training, scheduling hours, supervision, and termination.
- By CLC Administrative Services being only the payroll agency and not the caregiver's employer, the caregiver is not entitled to any of the agency benefits.

Understanding of How Services are Provided:

- One week is defined by a period between Sunday 12:00 AM/00:00 to Midnight Saturday 12:00 AM/24:00.
  - Example of one week: January 3, 2021 to January 9, 2021
- One day is defined by a period beginning at 12:00 AM/00:00 to midnight 12:00 AM/24:00.
- A caregiver may provide to **only one** client during any given time frame and a client may have **only one** caregiver providing services during any time frame. No overlapping time is permitted, regardless of where services are provided or number of caregivers providing services.
- A client may only receive a **maximum of 16 hours** of services per day. This includes all time from all caregivers (including using multiple caregivers).
- A caregiver may only provide a **maximum of 16 hours** of services per day. This includes all time from all clients (including providing services to multiple clients).
- A caregiver may only provide a **maximum of 40 hours** of services per week. This includes all time for all clients and programs (including providing services to multiple clients).
- The employer is responsible for ensuring that all services are within the client's approved budget. No services are to be provided beyond the approved budget. CLC Administrative Services, Inc. will not be held liable for services being provided beyond the approved budget and cannot be processed through CLC Administrative Services, Inc. Budgets can be weekly, monthly, or yearly. Contact your Case Manager if you need assistance on the client's budget.

Understanding of How to Properly Document a Timesheet:

- All timesheets must include all the following for, In-Home UAP Attendant CareServices:
  - **Name of Caregiver**
  - **Name of Client**
  - **Caregiver's 4-digit ID number (provided from CLC Administrative Services, inc.)**

- Client's 4-digit ID number (provided from CLC Administrative Services, inc.)
- Contact for Employer:
  - Phone number or email address
- Contact for Caregiver:
  - Phone number or email address
- Must complete daily tasks section on timesheet (will need to keep a copy for yourself and send to case management.)

In-Home Support/UAP Attendant Care CAREGIVER Timesheet Payroll B

Caregiver Name: JOHN DOE															Caregiver ID #: 1234				
Client Name: SALLEY SUE															Client ID #: 4321				
Employer Contact: (PHONE NUMBER OR EMAIL ADDRESS)															Caregiver Contact: (PHONE NUMBER OR EMAIL ADDRESS)				
DAILY TASK Write in Dates →																			
PROVIDE/ASSISTANCE WITH ADL'S																			
** Bathing	✓	✓	✓																
** Dressing	✓	✓	✓																
** Grooming	✓	✓	✓																
** Personal Hygiene	✓	✓	✓																
** Transferring and Mobility																			
** Assist with Commode/Urinal/Bedpan																			
PREPARE AND SERVE MEAL/SNACK		✓	✓																
GENERAL HOUSEKEEPING		✓																	
**☐Vacuum ☐Mop ☐Dust	✓																		
**☐Sweep ☐Trash																			
**☐Clean Kitchen ☐Clean Oven/Stove			✓																
**☐Defrost/Clean Refrigerator	✓																		
**☐Laundry ☐Clean Bathroom		✓																	
** Clean Participant's Immediate Living Area																			
SHOPPING ASSISTANCE																			
**☐Errands ☐Escort																			
ASSISTANCE WITH COMMUNICATION																			
MONITORING OF PARTICIPANT'S																			
**☐Vital Signs ☐Skin Condition																			
**☐Fluid Intake ☐Loss of Appetite																			
REMIND TO TAKE MEDICATION	✓	✓	✓																
Other:																			

- Date of service
- Time In, Time out, and total of hours
- Wet signature of Caregiver and Employer with the date of each signature
  - No photocopies or electronic signatures will be accepted.

Date (MM/DD/YYYY)	Time In (HH:MM)	Time Out (HH:MM)	Total Hours	Summary of Client's Condition
1/2/2021	9:00 (AM) PM	2:30 (AM) PM	5:30	
1/3/2021	9:00 (AM) PM	2:30 (AM) PM	5:30	
1/4/2021	9:00 (AM) PM	2:30 (AM) PM	5:30	
	(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)		
		Grand Total Hours:	16:30	

***Please circle AM or PM next to the time that is recorded for the time in and time out

Week runs from Sunday to Saturday

By signing below, both the caregiver and employer have reviewed and agree that the timesheet is correct, and the above hours are within the client's budget and have been worked by the caregiver.

Caregiver/Employee Signature: (handwritten signature)	Date: 1/4/2021
Guardian/Employer Signature: (handwritten signature)	Date: 1/4/2021

- All timesheets must include all the following for Respite Services:
  - **Name of Caregiver**
  - **Name of Client**
  - **Caregiver's 4-digit ID number (provided from CLC Administrative Services, inc.)**
  - **Client's 4-digit ID number (provided from CLC Administrative Services, inc.)**
  - **Phone Number for Caregiver**
  - **Phone Number for Employer**
  - **Address of Caregiver**
  - **Address of Client**
  - **Email of Caregiver**
  - **Email of Employer**

Respite CAREGIVER Timesheet Payroll B

Caregiver Name: John Doe	Caregiver ID #: 1234
Street Address: 123 lane	Caregiver Phone: (864) 123-4567
City, State ZIP: Spartanburg, SC, 29306	Caregiver Email: abc@gmail.com

Client Name: Salley Sue	Client ID #: 4321
Street Address: 456 Drive	Employer Phone: (864) 123-7890
City, State ZIP: Spartanburg, SC, 29307	Employer Email:123@gmail.com

  - **Date of service**
  - **Time In, Time out, and total of hours**
  - **Wet signature of Caregiver and Employer with the date of each signature**
    - **No photocopies or electronic signatures will be accepted.**

Date (MM/DD/YYYY)	Time In (HH:MM)	Time Out (HH:MM)	Total Hours	Summary of Client's Condition
1/2/2021	9:00 (AM) PM	2:30 AM (PM)	5:30	
1/3/2021	9:00 (AM) PM	2:30 AM (PM)	5:30	
1/4/2021	9:00 (AM) PM	2:30 AM (PM)	5:30	
	(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)		
		Grand Total Hours:	16:30	

Please circle AM or PM next to the time that is recorded for the time in and time out

Week runs from Sunday to Saturday

By signing below, both the caregiver and employer have reviewed and agree that the timesheet is correct, and the above hours are within the client's budget and have been worked by the caregiver.

Caregiver/Employee Signature: (handwritten signature)	Date: 1/4/2021
Guardian/Employer Signature: (handwritten signature)	Date: 1/4/2021

- All time in and time out must include either "AM" or "PM". **Midnight** should be written as **12:00 AM/00:00** and noon should be written as **12:00 PM. (Time will be processed as what is seen on the timesheet.)**
  - Failure to provide the "AM" or "PM" to indicate times will result in the timesheet not being processed and would need to be corrected and resubmitted.
- If a caregiver works past midnight, the time past midnight must be reported on a separate line due to this being a new day.
  - Example-a caregiver starts work on **1/2/2021** at **11:00PM** and works until **4:00 AM** the next morning, **1/3/2021**. It would be written like the example below:

Date (MM/DD/YYYY)	Time In (HH:MM)	Time Out (HH:MM)	Total Hours
1/2/2021	11:00 (AM / PM)	12:00 (AM / PM)	1.00
1/3/2021	12:00 (AM / PM)	4:00 (AM / PM)	4.00

- The timesheet must be signed and dated by the caregiver and employer. The date must be the last date of services being provided or submission date.
- Neither the employer nor the caregiver can sign for one another. These signatures are to be authentic (handwritten) and cannot be photocopied or a PDF electronic signatures. Any signatures that looks as if it is photocopied will result in the timesheet not being processed.
- Separate timesheets are to be submitted for each client and for each week services are provided.

Understanding Timesheet Deadline:

- Timesheets can be provided to CLC Administrative Services, Inc. by:
  a. **Email (preferred method):**
     pr.respite@charleslea.org
  b. **Fax:**
     (864) 562-2118
  c. **Mail:**
     Attention-Respite Payroll
     195 Burdette Street
     Spartanburg, SC 29307
- Timesheets are to be submitted on a weekly basis.
- Timesheets are to be sent to the case manager
- Timesheets must be received by Respite Clerk (or designee) **no later than 4:00 PM on Monday** each week regardless of which payroll the services are processed on (Payroll A or Payroll B).
- It is the employer and caregiver's responsibility to ensure that the timesheets are turned in before this deadline as **NO EXCEPTIONS** will be made.
  a. Confirmations cannot be provided due to the size of payroll.
- **Timesheets are to be within the current pay period for processing only. Timesheets that have previous dates that are not within the current pay period will need to be signed off by the client's**

case manager or financial board designee stating they are aware of the dates being previous dates and that it is approved for those dates to be paid out.

- If errors are found after the submission deadline then time sheets involved will not be processed and will need to be corrected and re-submitted. No exceptions.
- A time sheet that has been returned will need to be re-sent/re-submitted with the word "COPY" written across the top of the re-sent/re-submitted timesheet. Failure to make this note on the timesheet can result in the timesheet not being processed at all.

Important Resource:

https://www.charleslea.org/programs/respite-services.html

Payroll for Respite and In-home Supports and UAP Attendant Care services, cannot be processed without acknowledgement of the policy by both the caregiver and the employer they are providing care for.

By signing below, the employer and caregiver, both have reviewed and understand the above policy.

Employer Signature: _____ Date: _____

Care Provider Signature: _____ Date: _____

This form can be returned by email, fax, or mail. The email address is pr.respite@charleslea.org, the fax number is 864-562-2118, and the mailing address is The Charles Lea Center (ATTN: Respite Payroll), 195 Burdette St., Spartanburg, SC 29307.

SCDDSN PARTICIPANT- DIRECTED SERVICES RESPONSIBILITIES AGREEMENT (Participant-Directed Employee)

Participant's Name:		Medicaid #:	
Participant - Directed Service Employee:		WCM Provider:	

The purpose of this form is to outline the responsibilities you have as a participant-directed service employee. The service you are providing is directed by the participant or their representative which means they are your Employer. For the purposes of this form, attendant care workers, in-home support caregivers and/or respite caregivers will be referred to as participant-directed service employees (PDE).

As a PDE, I understand that:

1. I must have a PPD Tuberculin skin tests completed annually unless I have a documented history of a positive PPD. In that case, I will complete a questionnaire for signs and symptoms of TB annually.
2. PDE services may include:
   a. Support of daily living activities, e.g. assistance with bathing, dressing, feeding, personal grooming, personal hygiene, transferring and mobility;
   b. Meal or snack preparation, planning and serving, cleaning up afterwards, following specially prescribed diets as necessary and encouraging participants to adhere to any specially prescribed diets;
   c. General housekeeping including cleaning (such as sweeping, vacuuming, mopping, dusting, taking out the trash, changing bed linens, defrosting and cleaning the refrigerator, cleaning the stove or oven, cleaning bathrooms) and activities as needed to maintain the participant in a safe and sanitary environment. Housekeeping only includes areas specific to the participant such as the participant's bedroom, bathroom, etc.;
   d. Shopping assistance, essential errands, and escorting participant to medical services;
   e. Assistance with communication, which includes, but is not limited to placing a phone within participant's reach and physically assisting participant with the use of the phone, and orientation to daily events;
   f. Monitoring medication, e.g. consists of informing the participant it is time to take medication as prescribed by the physician. It does not mean that the PDE is responsible for giving the medicine; however, it does not preclude the PDE from handing the medicine container or medicines already set up in daily containers to the participant.
   g. General supervision.
3. I am responsible for maintaining individual participant records. These records are subject to the confidentiality rules for all Medicaid Providers and health care providers and shall be made available to DDSN and its contracted providers upon request. Records shall include the following:
   a. current and historical Service Authorization and Termination Forms
   b. the Daily Log which will include any records of occurrences in which the attendant did not provide services for the specified number of hours
   c. a copy of the participant's back-up plan for service provision when the primary attendant is unable to provide services. These may be formal or informal supports.
4. If the participant, responsible party, or I identify PDE duties that would be beneficial to the participant's care but are not specified on the Authorization Form from the DDSN Waiver Case Manager, the DDSN Waiver Case Manager must be contacted to discuss the possibility of adding those duties. **These duties MAY NOT include skilled medical care.** It will be the DDSN Waiver Case Manager's responsibility to decide whether the participant's Plan should be amended/new authorization completed including these duties. The DDSN Waiver Case Manager will have three (3) working days of the receipt of my or the participant's request to modify/amend the Authorization or complete the appropriate assessment.
5. PDEs are not provided with any liability insurance coverage or benefits, are not bonded, and are not licensed by any state or local agency.
6. Injury to the PDE or to the participant is not the responsibility of any local or state agency. The employer's homeowner's insurance policy may provide some protection, but likely would require additional coverage. The employer can check with their insurance agent

and explain what service is being provided so s/he can advise the employer relative to their policy. Homeowner's policies usually only provide additional liability protection.

7. I am required to report any suspected abuse, neglect or exploitation of the participant to Adult Protective Services by contacting the Department of Social Services in the county in which the participant lives, and the participant's waiver case manager.

8. PDEs have the right to terminate employment with or without cause. It is important that both parties are treated professionally and fairly. Should the PDE decide to terminate employment, 2 weeks notice will be given unless personal safety is threatened.

9. Termination or laying off an employee because of an employee's age, race, color, religion, sex, national origin or disability is not acceptable and against the law.

10. It is my responsibility to notify the DDSN Waiver Case Manager of the following:

    a. a change in the participant's condition
    b. the death of the participant
    c. a participant's relocation out of service area
    d. the participant no longer wishes to participate in this service
    e. knowledge of participant's Medicaid ineligibility
    f. my wish to terminate as the provider of PDE services
    g. the responsible party's desire to no longer serve in that role
    h. my inability to provide PDE services as authorized ***THIS MUST BE DONE IMMEDIATELY BY TELEPHONE**

11. In the event that I am unable to reach the participant, the responsible party, or the DDSN Waiver Case Manager, it is my responsibility to notify the participant's designated emergency contact until the participant, responsible party, and the DDSN Waiver Case Manager can be reached.
    The designated emergency contact is: _____
    (provide name and number)

12. When two consecutive attempted visits occur, I must notify the DDSN Waiver Case Manager. Prior to notifying the DDSN Waiver Case Manager, I must attempt to locate the participant or family member and or responsible party.

13. I must adhere to basic infection control procedures at all times while providing PDE services.

14. I am responsible for signing and completing all paperwork required by the Fiscal Agent.

15. All hours should be totaled and biweekly comments written **prior** to obtaining the participant's signature on the PDE Daily Log. I am also responsible for maintaining copies of the completed and signed Daily Log for Medicaid and tax audit purposes. I am responsible for sending copies of the completed and signed Daily Logs to the DDSN Waiver Case Manager for review on a monthly basis. I am responsible for submitting the Daily Logs to the Fiscal Agent as specified; they will be responsible for issuing my checks and taking out my taxes.

16. The PDE Daily Log(s) will be used for reimbursement purposes. **The PDE Daily Log(s) cannot be filed and reimbursement will not be paid until the DDSN Waiver Case Manager authorizes the service and I have provided the service.**

17. Health information must be kept confidential as indicated by HIPAA rules and regulations.

18. I understand that no services may be provided while a participant is in the hospital/nursing home/jail.

19. I understand that I will be unable to serve the participant if I am or become the participant's legal guardian.

20. Services provided to a participant with no Medicaid eligibility will not be reimbursed by Medicaid.

21. I understand the participant or responsible party is my employer of record. I understand I am **not** an employee of the South Carolina Department of Disabilities and Special Needs (SCDDSN), the Fiscal Agent or any other state agency.

22. I certify I am fully ambulatory.

23. I verify I can read, write, and speak English

24. I understand I cannot be enrolled as a Medicaid provider or an individual DDSN provider.

25. I hereby grant permission for the following to be requested on my behalf and that information may be shared with all potential participants:
    SLED Background Check
    DSS Child Abuse and Neglect Central Registry Check

26. I understand it is against federal law to delegate my role as a PDE to another caregiver.

27. I will provide references to my employer upon request.

My signature below indicates I understand and acknowledge all of the above requirements.

Participant-Directed Service Employee (PRINT NAME):	
Participant-Directed Service Employee Signature:	
Date:	

SCDDSN PARTICIPANT- DIRECTED SERVICES LIABILITY STATEMENT (Participant/Responsible Party)

Participant's Name:		Medicaid #:	
Responsible Party/Employer Name (if not the participant):			

*For the purpose of this form, attendant care workers, in-home support caregivers and/or respite caregivers providing a waiver funded participant-directed service will be referred to as participant-directed service employees (PDEs).

In connection with my use of a participant-directed service provided through a home and community-based waiver under the South Carolina Medicaid Program, I acknowledge that I have been informed, and understand, the following:

1. Participant-Directed Employees (PDEs) ARE EMPLOYED BY THE PARTICIPANT or RESPONSIBLE PARTY (RP). PDEs do not work for the South Carolina Department of Disabilities and Special Needs (SCDDSN), the Fiscal Agent or any other state or local agency, and are not authorized to speak or act on behalf of any of these organizations.
2. No state or local agency is responsible for the acts or omissions of PDEs.
3. Under South Carolina law, if the participant/responsible party/RP employs four or more PDE providers, the participant/RP is required to get a workers compensation policy at the participant's/RP's expense.
4. PDEs are not provided with any liability insurance coverage or benefits, are not bonded, and are not licensed by any state or local agency.
5. Injury to the PDE or to the participant is not the responsibility of any local or state agency. The employer's homeowner's insurance policy may provide some protection, but likely would require additional coverage. The employer should check with their insurance agent and explain what service is being provided so s/he can advise the employer relative to their policy. Homeowner's policies usually only provide additional liability protection.
6. Health information must be kept confidential as indicated by HIPAA rules and regulations.
7. The Participant/RP is required to report any suspected abuse, neglect or exploitation of the participant to Adult Protective Services by contacting the Department of Social Services in the county in which the participant lives, and the participant's waiver case manager.
8. Use of a specific PDE caregiver is the participant's/RP's choice. Participants/RPs have the right to terminate employment with or without cause. It is important that both parties are treated professionally and fairly. Should either one decide to terminate employment, 2 weeks notice will be given unless our personal safety is threatened. Termination or laying off an employee because of an employee's age, race, color, religion, sex, national origin or disability is not acceptable and against the law.
9. The PDE must not be a legal guardian for the participant or RP.
10. As the participant/RP, my signature on this statement authorizes the release of any medical or other information necessary to process Medicaid claims on my behalf. I request payment of Medicaid benefits to this party who provides PDE services as a Medicaid Waiver services provider and agrees to accept the established rate of reimbursement from Medicaid.

Participant/Responsible Party's Signature — Date

CLC Administrative Services, Inc.

Time Sheet Guideline

Understanding of How Services are Provided:

- One week is defined by a period between Sunday 12:00 AM/00:00 to Midnight Saturday 12:00 AM/24:00.
    - Example of one week: January 3, 2021 to January 9, 2021
- One day is defined by a period beginning at 12:00 AM/00:00 to midnight 12:00 AM/24:00.
- A caregiver may provide to **only one** client during any given time frame and a client may have **only one** caregiver providing services during any time frame**. No overlapping time is permitted, regardless of where services are provided or number of caregivers providing services.**
- A client may only receive a **maximum of 16 hours** of services per day. This includes all time from all caregivers **(including using multiple caregivers).**
- A caregiver may only provide a **maximum of 16 hours** of services per day. This includes all time from all clients (including providing services to multiple clients).
- A caregiver may only provide a **maximum of 40 hours** of services per week. This includes all time for all clients and programs (including providing services to multiple clients).
- The employer is responsible for ensuring that all services are within the client's approved budget. No services are to be provided beyond the approved budget. CLC Administrative Services, Inc. will not be held liable for services being provided beyond the approved budget and cannot be processed through CLC Administrative Services, Inc. Budgets can be weekly, monthly, or yearly. Contact your Case Manager if you need assistance on the client's budget.

Timesheet Instructions:

- All timesheets must include all the following for, In-Home UAP Attendant Care Services:
    - **Name of Caregiver**
    - **Name of Client**
    - **Caregiver's 4-digit ID number (provided from CLC Administrative Services, inc.)**
    - **Client's 4-digit ID number (provided from CLC Administrative Services, inc.)**
    - **Contact for Employer:**
        - **Phone number or email address**
    - **Contact for Caregiver:**
        - **Phone number or email address**
    - **Must complete daily tasks section on timesheet. (Will need to keep a copy for yourself and send to case management.)**

Please see figure 1:

In-Home Support/UAP Attendant Care CAREGIVER Timesheet

Caregiver Name: JOHN DOE	**Caregiver ID #: 1234**
Client Name: SALLEY SUE	**Client ID #: 4321**
Employer Contact: (PHONE NUMBER OR EMAIL ADDRESS)	**Caregiver Contact: (PHONE NUMBER OR EMAIL ADDRESS)**

DAILY TASK **Write in Dates →**														
PROVIDE/ASSISTANCE WITH ADL'S														
** Bathing	✓	✓	✓											
** Dressing	✓	✓	✓											
** Grooming	✓	✓	✓											
** Personal Hygiene	✓	✓	✓											
** Transferring and Mobility														
** Assist with Commode/Urinal/Bedpan														
PREPARE AND SERVE MEAL/SNACK		✓	✓											
GENERAL HOUSEKEEPING		✓												
**☐Vacuum ☐Mop ☐Dust	✓													
**☐Sweep ☐Trash														
**☐Clean Kitchen ☐Clean Oven/Stove			✓											
**☐Defrost/Clean Refrigerator	✓													
**☐Laundry ☐Clean Bathroom		✓												
** Clean Participant's Immediate Living Area														
SHOPPING ASSISTANCE														
**☐Errands ☐Escort														
ASSISTANCE WITH COMMUNICATION														
MONITORING OF PARTICIPANT'S														
**☐Vital Signs ☐Skin Condition														
**☐Fluid Intake ☐Loss of Appetite														
REMIND TO TAKE MEDICATION	✓	✓	✓											
Other:														

Figure 1:

- **Date of service**
- **Time In, Time out, and total of hours**
- **Signature of Caregiver and Employer with the date of each signature.**

Please see figure 2:

Date (MM/DD/YYYY)	Time In (HH:MM)	Time Out (HH:MM)	Total Hours	Summary of Client's Condition
1/2/2021	9:00 (AM / PM)	2:30 (AM / PM)	5:30	
1/3/2021	9:00 (AM / PM)	2:30 (AM / PM)	5:30	
1/4/2021	9:00 (AM / PM)	2:30 (AM / PM)	5:30	
	(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)		
		Grand Total Hours:	16:30	

Please circle AM or PM next to the time that is recorded for the time in and time out

Week runs from Sunday to Saturday

By signing below, both the caregiver and employer have reviewed and agree that the timesheet is correct, and the above hours are within the client's budget and have been worked by the caregiver.

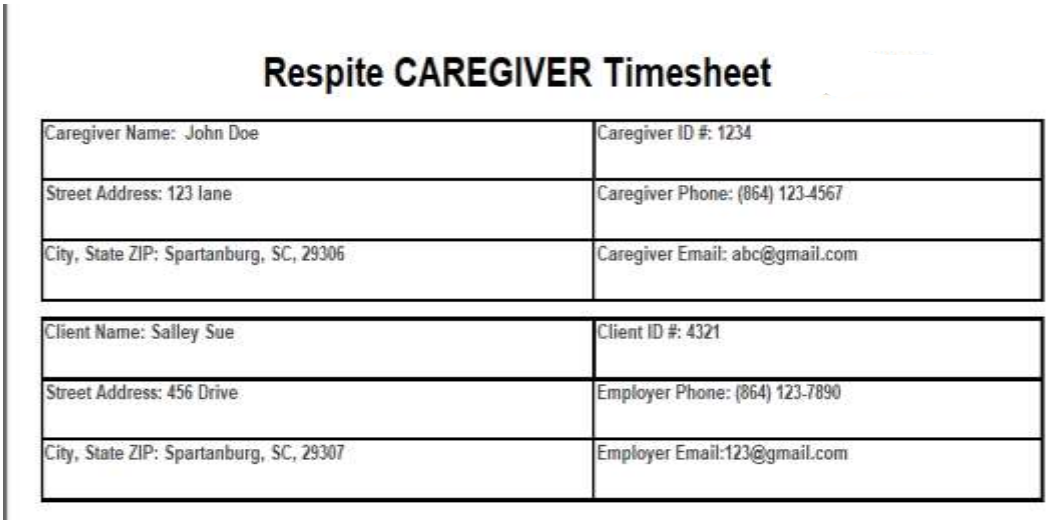
Caregiver/Employee Signature: (handwritten signature)	**Date: 1/4/2021**
Guardian/Employer Signature: (handwritten signature)	**Date: 1/4/2021**

Figure 2:

- All timesheets must include all the following for Respite Services:
  - **Name of Caregiver**
  - **Name of Client**
  - **Caregiver's 4-digit ID number (provided from CLC Administrative Services, inc.)**
  - **Client's 4-digit ID number (provided from CLC Administrative Services, inc.)**
  - **Phone Number for Caregiver**
  - **Caregiver Email address**
  - **Phone Number for Employer**
  - **Employer Email address**

Please see figure 3:

Figure 3:



Respite CAREGIVER Timesheet

Caregiver Name: John Doe	Caregiver ID #: 1234
Street Address: 123 lane	Caregiver Phone: (864) 123-4567
City, State ZIP: Spartanburg, SC, 29306	Caregiver Email: abc@gmail.com

Client Name: Salley Sue	Client ID #: 4321
Street Address: 456 Drive	Employer Phone: (864) 123-7890
City, State ZIP: Spartanburg, SC, 29307	Employer Email:123@gmail.com

- **Date of service**
- **Time In, Time out, and total of hours**
- **Signature of Caregiver and Employer with the date of each signature**

Please see figure 4:

Date (MM/DD/YYYY)	Time In (HH:MM)	Time Out (HH:MM)	Total Hours	Summary of Client's Condition
1/2/2021	9:00 (AM / PM)	2:30 (AM / PM)	5:30	
1/3/2021	9:00 (AM / PM)	2:30 (AM / PM)	5:30	
1/4/2021	9:00 (AM / PM)	2:30 (AM / PM)	5:30	
	(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)		
		Grand Total Hours:	16:30	

By signing below, both the caregiver and employer have reviewed and agree that the timesheet is correct, and the above hours are within the client's budget and have been worked by the caregiver.

Caregiver/Employee Signature: (handwritten signature)	Date: 1/4/2021
Guardian/Employer Signature: (handwritten signature)	Date: 1/4/2021

Figure 4:

- All time in and time out must include either "AM" or "PM**"**. **Midnight** should be written as **12:00 AM/00:00** and noon should be written as **12:00 PM. (Time will be processed as what is seen on the timesheet.**)
  - Failure to provide the "AM" or "PM" to indicate times will result in the timesheet not being processed and would need to be corrected and resubmitted.
- If a caregiver works past midnight, the time past midnight must be reported on a separate line due to this being a new day.
  - Example-a caregiver starts work on **1/2/2021** at **11:00PM** and works until **4:00 AM** the next morning, **1/3/2021**. It would be written like the example below:

Date (MM/DD/YYYY)	Time In (HH:MM)	Time Out (HH:MM)	Total Hours
1/2/2021	11:00 (AM / PM)	12:00 (AM / PM)	1.00
1/3/2021	12:00 (AM / PM)	4:00 (AM / PM)	4.00

- The timesheet must be signed and dated by the caregiver and employer. The date must be the last date of services being provided or submission date.
- Neither the employer nor the caregiver can sign for one another. No photocopied signatures are allowed. Any signatures that look as if it is photocopied will result in the timesheet not being processed.
- Separate timesheets are to be submitted for each client and for each week services are provided.

Timesheet Deadline:

- Timesheets must be received by Respite Clerk (or designee) **no later than 12 PM on Monday** of each week.
- Timesheets are to be submitted on a weekly basis.
- Timesheets are to be sent to the case manager.
- Timesheets can be provided to CLC Administrative Services, Inc. by:
    a. **Email (preferred method):**
    pr.respite@charleslea.org
    b. **Fax:**
    (864) 562-2118
    c. **Mail:**
    Attention-Respite Payroll
    195 Burdette Street
    Spartanburg, SC 29307

- It is the employer and caregiver's responsibility to ensure that the timesheets are turned in before this deadline as **NO EXCEPTIONS** will be made.
    a. Confirmations cannot be provided due to the size of payroll.
- **Timesheets are to be within the current pay period for processing only. Timesheets that have previous dates that are not within the current pay period will need to be signed off by the client's case manager or financial board designee stating they are aware of the dates being previous dates and that it is approved for those dates to be paid out.**
- If errors are found after the submission deadline then time sheets involved will not be processed and will need to be corrected and re-submitted. No exceptions.
- A time sheet that has been returned will need to be re-sent/re-submitted with the word "corrected" written across the top of the re-sent/re-submitted timesheet. Failure to make this note on the timesheet can result in the timesheet not being processed at all.

Important Resource:

All forms (timesheets, pay schedules, etc…) can be found on the website below:

https://www.charleslea.org/programs/respite-services.html