CENTRAL WASHINGTON DISABILITY RESOURCES EMPLOYER/EMPLOYEE AGREEMENT

This Employer/Employee Agreement is entered into this _______ day of __________________________, ___________, between ______________________________ (Veteran) and ______________________________ (Employee).

EMPLOYEE RESPONSIBILITIES

I, ______________________________ (Employee), am aware and agree that my employment is conditioned on my employer's participation in the Central Washington Disability Resources program. If my employer ends his or her participation in the Central Washington Disability Resources 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 ______________________________. 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 Central Washington Disability Resources 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 Premier Financial Management Services 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 Premier Financial Management Services, or any other State or Federal Agency.

8. I agree to not sue Premier Financial Management Services for its role as the financial administrator of my employer's program and for its role in administering the Central Washington Disability Resources program.

9. I agree to the following compensation for the services I shall perform: $ _______ an hour. The Central Washington Disability Resources program has a maximum allowed hourly rate of $20 per hour.

10. I understand that if my employer 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. If I am a POA for the EOR or Veteran, I understand I cannot sign my own timesheets on behalf of the Veteran.

EMPLOYER RESPONSIBILITIES

I, ______________________________ (Employer),

1. Will provide Premier Financial Management Services with the necessary documentation to assure timely compensation of my employee.

2. Will compensate my employee in the following manner: $ _______ an hour. The Central Washington Disability Resources program has a maximum allowed hourly rate of $20 per 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 Advisor before I allow my employee to work additional hours. I understand I am responsible for paying employees for hours worked beyond their spending plan.

4. Payroll will be handled by Premier Financial Management Services 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).

Employee Signature: ____ Date: _____ /_____ /_______

Employer Signature: ____ Date: _____ /_____ /_______

For any questions or concerns, please contact our office at (888) 623-3907. Please submit the completed form to Premier FMS via one of the following options below:

Mail:
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Milwaukee, WI 53226

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CWDR@premier-fms.com

Fax:
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