

MFP/Mental Health Waiver

**SELF DIRECTED
RECOVERY ASSISTANT**

APPLICATION PACKET

Welcome to the MFP/Mental Health Waiver Program services. By completing this application you could be approved to become a Self Directed Recovery Assistant for a Participant in the MFP Mental Health Waiver program. This Participant will become your employer and will direct your employment services.

Advanced Behavioral Health, Inc (ABH) will act as the Fiscal Agent on behalf of the employer by processing the application, conducting the background checks, and administrating the payroll services. ABH is not your employer and has no control over your schedule, hours, hourly wage or employment status.

Please complete the following documents to become approved as Self Directed Recovery Assistant:

- Application
- Provider Agreement
- Voluntary Disclosure and Consent for Background Check
- IRS Form 1-9
- IRS Form W-4
- Form W-4 CT

All form must be completed accurately and mailed or faxed to
Kristie Scott, Program Manager:

ABH
213 Court Street, 8th floor
Middletown, CT 06457

FAX: 860-638-5302

RECOVERY ASSISTANCE MENTAL HEALTH WAIVER APPLICATION

Name:	
Address:	
Mailing Address (if different)	
Telephone:	Cell Phone:
Social Security Number:	Email Address:
CT Driver's License #:	

AVAILABILITY: Please check the days and times which you are available to work

	Morning 6am -12	Afternoon 12-5pm	Evening 5-12am	Overnight 12-6am
Sunday				
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				

ARE YOU WILLING TO PROVIDE BACK UP COVERAGE WHEN CALLED (CHECK ONE): YES NO

What Service Areas are you willing to work?

BRIDGEPORT	MANCHESTER	NEW LONDON	WATERBURY
BRISTOL	MERIDEN	NORWALK	WILLIMANTIC
DANBURY	MIDDLETOWN	NORWICH	WINDHAM
GROTON	NEW BRITAIN	STAMFORD	
HARTFORD	NEW HAVEN	TORRINGTON	

SPECIFIC TOWN _____

PRIOR WORK EXPERIENCE: Please attach resume

Company Name	Address City, State	Supervisor	Position	Duties performed

Have you ever provided services for any DSS or DDS Waivers? Yes No

If yes, which one: _____ Dates of Employment? _____

REFERENCES: Please list two professional and one personal

Type	Name	Address	Phone Number
Professional			
Professional			
Personal			

PLEASE LIST BELOW ANY SPECIAL TRAINING, SKILLS, OR CERTIFICATIONS YOU HOLD THAT PERTAIN TO THE POSITION FOR WHICH YOU ARE APPLYING:

Have you ever been convicted of a felony involving forgery, robbery, larceny, fraud, cruelty to persons, sexual assault, assault, assault of an elderly, blind, disabled, pregnant or mentally retarded person or abuse of the elderly, blind, disabled or mentally retarded person in the United States and/or its territories?

Yes No

Have you ever been convicted of a crime? Yes No

If yes please detail: _____

LANGUAGES SPOKEN (CHECK THOSE THAT APPLY):

ENGLISH SPANISH OTHER (LIST): _____

Please indicate your choice(s) for being included in the Directory below by checking the applicable boxes.

Yes, I wish to be included on the Directory No, I do not wish to be included on the Directory

I attest that all information provided herein is true and correct.

Signature: _____ Date signed: _____

By signing and dating below, I understand that a Criminal Background check will be performed prior to being hired by an individual on the Mental Health Waiver Program or at the request of my potential employer. I also authorize full release of information from my listed employers and references.

Signature: _____ Date signed: _____

Mental Health Waiver
RECOVERY ASSISTANT AGREEMENT

This agreement is between _____(Employer) and
_____(Recovery Assistant) and describes the
Recovery Assistant's responsibilities.

1. All of the statements made by me on my Recovery Assistant application are true and correct.
2. I acknowledge that I meet the qualification and am able to perform all duties of a Recovery Assistant as described on the position description.
3. I will immediately notify ABH of any changes in the information provided by me on the Recovery Assistant application.
4. I will provide services in accordance with the terms of the Participant's Recovery plan.
5. I acknowledge and accept that the payment rate of \$11.83 (prior to withholding taxes) per hour is considered payment in full for the authorized services.
6. I will maintain and submit records that fully describe the services rendered to the employer. These records will be made available to authorized representatives of the Mental Health Waiver program upon request.
7. I agree to not use or disclose Protected Health Information (PHI) other than as permitted or as required by law and to use appropriate safeguards to prevent improper use or disclosure of PHI.
8. I acknowledge that I may be suspended or terminated as Recovery Assistant from the Mental Health Waiver program at the employer's discretion or if I have been found to have engaged in fraudulent or abusive practices.
9. I acknowledge that I am subject to prosecution for fraud to the fullest extent of the law. I acknowledge that altering timesheets, hours, or reporting of false hours is considered fraud.
10. I understand that my employer does not provide Worker's Compensation Coverage.
11. I understand that I am NOT employed by Advanced Behavioral Health, Inc.
12. I understand that ABH is performing payroll services on behalf of the employer.

13. I understand that I may only work the amount of hours that are authorized by the Recovery plan.

14. I have read and accept the terms of this Recovery Assistant Agreement as stated to me above.

15. I also understand that employment may be contingent upon the results of the Criminal Background Check.

16. I understand that I can choose to be included on the Recovery Assistant Directory.

By signing this agreement, I consent to have a Criminal Background Check performed PRIOR to employment by any prospective Employer or his/her authorized designated representative.

Recovery Assistant Signature: _____ Date: _____

Recovery Assistant Name: _____

Employer Signature: _____ Date : _____

Employer Name : _____

Recovery Assistant Training

Anyone wishing to become a Recovery Assistant as part of the MFP/Mental Health Waiver Program must complete the two day DMHAS Recovery Assistant Training and pass(80%) the exam. The Training is given by Advanced Behavioral Health, Inc on regular basis.

Training schedules can be found on the Website at www.Abhct.com click RESOURCES then
WISE
or by calling Kristie Scott, Program Manager at 860-704-6211

RECOVERY ASSISTANT TRAINING CURRICULUM

Day One

Long Term Care and Rebalancing
Overview of MH Waiver and MFP
Role of Recovery Assistant
Video “Inside Outside”
Myths and Realities of Mental Illness
Providing Support

Day Two

Recovery Assistant Documentation
Working as a Recovery Assistant
Client Rights
Ethics and Boundaries
Review
EXAM

Attendees must participate in both days for the entire day and pass the exam with a passing score of at least 80%. A certificate will be mailed to those who passed the exam by the Department of Mental Health and Addiction Services.

Position Description

Mental Health Waiver SELF DIRECTED RECOVERY ASSISTANT

Reports to: Waiver Participant (Employer)

Hours: Varied- according to Recovery Plan, not to exceed 25.72 hour per week

Qualifications:

- Be at least 18 yrs old;
- Possess at least a high school diploma or GED;
- Possess a valid Connecticut driver's license; and
- Be registered with the Department of Mental Health and Addiction Services (DMHAS) as having completed an approved Recovery Assistant training program and meet any continuing education and/or training requirements set by DMHAS.

Duties:

Recovery Assistant services of at least 15-minutes duration provided to the participant in his/her home and in other community settings. These services include:

Recovery Assistant services of at least 15-minutes duration provided to the participant in his/her home and in other community settings. These services include:

1. Performing the following tasks if the participant (by reason of physical or psychiatric disability) is unable to perform them, or assisting, or cueing the participant to perform them:
 - a. Meal planning and preparation, shopping, housekeeping (e.g., changing linens, washing dishes, vacuuming/dusting, laundry, mending clothing repairs), basic household tasks (e.g., regulating home temperature, storing food appropriately, resolving issues about bill paying).
 - b. Dressing, personal grooming and hygiene (e.g., bathing, dressing, and oral care).
 - c. Appropriate use of emergency medical services.
2. Assisting or cueing the participant to perform or become engaged in:
 - a. Family, social, and recreational activities.
 - b. Appropriate use of natural community supports (e.g., social clubs, faith-based supports).
 - c. Appropriate use of routine medical/dental services.
 - d. Use of medications as prescribed, including self administration of medications.
 - e. Healthy habits (e.g., healthy diet, exercise, and behaviors designed to alleviate stress).
 - f. Fulfillment of personal commitments, and adherence to scheduled appointments/meetings (e.g., clinical, vocational, educational, and judicial/court).
3. Assisting or cueing the participant to avoid:
 - a. Risky behaviors (e.g., unprotected sex, smoking/excessive use of tobacco products, unsafe driving/driving without seatbelt, unsafe relationships, criminal activities).
 - b. Substance abuse.
 - c. Overspending.

- d. Unnecessary conflicts.
- 4. Supportive and problem solving-oriented discussions with the participant.
- 5. Establishing and maintaining a helpful, supportive, companionship relationship with the participant that involves such activities as:
 - a. Escorting the participant to necessary medical, dental, or personal business appointments;
 - b. Reading to or for the participant;
 - c. Engaging in or discussing recreational, hobby, or sport-related activities;
- 6. Other activities directed at reducing disability, restoring participant functioning and achieving independent participation in social, interpersonal, family, or community activities and full community re-integration and independence;
- 7. Participation in waiver Recovery Plan development and quarterly Recovery Plan update meetings, if requested by the DMHAS Support Coordinator; and
- 8. Travel with a participant when the Recovery Assistant is also engaged in a qualifying waiver service activity.

Limitations

- 1. Coverage of Recovery Assistant services shall be subject to the following limitations:
- 2. Recovery Assistant services are subject to service volume (number of ¼ hours service units per day and/or week) and duration (number of months or specified service end date) limits established in the waiver Recovery Plan approved by DMHAS and DSS. The departments or their designee will enact these limits;
- 3. Recovery Assistant services shall be based on the waiver Recovery Plan;
- 4. A claim for reimbursement may be submitted for the qualifying waiver services activities of only one Recovery Assistant for services to a participant during a specific time period (i.e., billable unit of time);
- 5. Individuals receiving residential rehabilitation services paid for by Medicaid in a group home are excluded from Recovery Assistant services, except during a brief transition phase to a lower level of care (not to exceed 30 days);
- 6. The department shall not pay for:
 - a. Time spent by the provider solely for the purpose of transporting participants;
 - b. Programs, services or components of services that are of an unproven, experimental, cosmetic or research nature;
 - c. Programs, services or components of services that do not relate to the participant’s diagnosis, symptoms, functional limitations or medical history;
 - d. Programs, services or components of services that are not included in the fee established by the department;
 - e. Services or components of services provided solely for educational or vocational purposes;
 - f. Waiver services provided by a relative of the participant; and
 - g. Costs associated with room and board for participants.

Non-billable Activities

The following activities are not billable, but have been factored into payment rates:

- 1. Day-to-day monitoring regarding the participants health and welfare and problem solving to address concerns;

2. Communication and coordination with the DMHAS Support Coordinator, and with other service providers to relay information germane to the participant's needs and continued recovery;
3. Telephone contact with the participant;
4. Telephone contact with the department or its designated agent for the purpose of requesting or reviewing authorization of services;
5. Completion of progress notes or billing documentation;
6. Individual or group supervision, routine case reviews and rounds, ad hoc consultation with supervisors and discussion or consultation among recovery team members, including for the purpose of treatment planning;
7. No shows, missed or cancelled appointments, and visits to the participant when the participant is unavailable;
8. Recovery Assistant services of less than fifteen minutes duration for recovery procedures whose billing codes are defined in 15-minute increments; and
9. Time spent engaged in activities required by a credentialing, certification or oversight entity such as gathering and submitting care plan, service data or other information.

**ADVANCED BEHAVIORAL HEALTH
RSI**

VOLUNTARY WRITTEN DISCLOSURE AND CONSENT TO REQUEST CONSUMER REPORT
INFORMATION

**SELF DIRECTED RECOVERY ASSISTANT
MFP/MENTAL HEALTH WAIVER**

***This form will be kept in a confidential file separate from the
application for employment***

APPLICANT NAME: _____

I understand that Advanced Behavioral Health, Inc. will utilize the services of a consumer reporting agency as part of the procedure for processing my application for employment as a Self Directed Recovery Assistant for the MFP/Mental Health Waiver Program on behalf as the Employer.

I understand a consumer reporting agency's investigation may include obtaining information covering up to the last seven years, regarding my credit background, driving history, references, character, past employment, job performance, work habits, education, general reputation, personal characteristics, mode of living, civil judgments, and liens. I further understand that information will be requested from various Federal, State, and other agencies, which may include records concerning my past activities relating to my driving, criminal conduct, civil court and other experiences

I understand such information may be obtained by direct or indirect contact with former employers, schools, financial institutions, landlords and public agencies or other persons who may have such knowledge.

I also understand that before I am denied employment based, in whole or part, on information obtained in the report, I will be provided a copy of the report and a description in writing of my rights under the Fair Credit Reporting Act.

I understand if I disagree with the accuracy of any information in the report, I must notify Advanced Behavioral Health, Inc. five business days of my receipt of the report. If I notify Advanced Behavioral Health, Inc. within five business days of the receipt of the report that I am challenging information in the report, Advanced Behavioral Health, Inc. will not make a final decision on my employment status until after I have had a reasonable opportunity to address the information contained in the report.

I further understand that, to aid in the proper identification of my file or records, I am providing the following information, as well as any other information that may be required at a later date

PAGE - 2 - VOLUNTARY WRITTEN DISCLOSURE /CONSENT TO REQUEST CONSUMER REPORT INFORMATION, CONT.

RECORD OF CONVICTION:

Please read carefully the entire paragraph before answering the question.

Have you ever been convicted of a violation of any federal, state county or municipal law, regulation or ordinance? Yes No

Include any convictions as the result of court martial while in the military service. Do not include arrests without convictions or motor vehicle violations for which the only penalty imposed was a fine of \$50.00 or less. Note: You are not required to disclose the existence of any arrest, criminal charge or conviction, the records of which have been erased Connecticut General Statutes Sections 46b-146, 54-76o or 54-142a. Criminal records subject to erasure pursuant to Connecticut General Statutes Sections 46b-146, 54-76o or 54-142a are records related to (a) determinations of "delinquency" or that, as a child, you were a member of a family with service needs, (b) a ruling you are a "youthful offender", (c) a finding you are not guilty for a criminal charge, or (d) a conviction for which you have received an "absolute pardon". Any person whose criminal records have been erased pursuant to Connecticut General Statutes Sections 46b-146, 54-76o or 54-142a shall be deemed to never have been arrested within the meaning of the general statutes with respect to the proceedings so erased and may so swear under oath.

If "YES", IN WHAT STATE? _____ Year _____.

Print Name: _____

List ALL other first & last names ever used:

Social Security #: _____ Date of Birth: _____

Driver's License #: _____

Current Address: _____

City: _____ State _____ ZIP _____ how long at address? _____

Previous Address: _____

City: _____ State _____ ZIP _____ how long at address? _____

I hereby consent to this investigation, without reservation, and authorize Advanced Behavioral Health, Inc. to procure a report on my background as stated above from a consumer reporting agency.

Applicant's Signature: _____

For Employer Use Only:

Requested by: _____ Phone: _____ Fax: _____

Criminal Report: CT _____ Other(s) _____ Driver History: _____

Phone 860-678-0066

Fax 860-678-0077 or 860-678-0099

Fraud and Compliance Statement



Payroll fraud is a crime!

Fraud is defined as a [deception](#) made for personal gain. Fraud is a [crime](#), and is also a [civil law](#) violation.

Examples of Fraud

- Recording hours not actually worked on a timecard
- Forging the signature of Employer
- Altering a timesheet after it has been signed by a Employer
- Exaggerating hours on a timesheet

Any suspicion of payroll fraud will be investigated. ABH is obligated to inform the Department of Social Services and Department of Mental Health and Addiction Services of any fraud. ABH will notify the proper authorities of any suspected fraud.

If you suspect fraud and would like to speak to someone about it please call the Directory of Quality Assurance at 1-860-704-6445.

Or submit written information to:

ABH, Inc
213 Court Street
Middletown, CT 06457.

FRAUD is a crime that is punishable with jail



Instructions

Please read all instructions carefully before completing this form.

Anti-Discrimination Notice. It is illegal to discriminate against any individual (other than an alien not authorized to work in the U.S.) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work eligible individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents presented have a future expiration date may also constitute illegal discrimination.

What Is the Purpose of This Form?

The purpose of this form is to document that each new employee (both citizen and non-citizen) hired after November 6, 1986 is authorized to work in the United States.

When Should the Form I-9 Be Used?

All employees, citizens and noncitizens, hired after November 6, 1986 and working in the United States must complete a Form I-9.

Filling Out the Form I-9

Section 1, Employee: This part of the form must be completed at the time of hire, which is the actual beginning of employment. Providing the Social Security number is voluntary, except for employees hired by employers participating in the USCIS Electronic Employment Eligibility Verification Program (E-Verify). **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

Preparer/Translator Certification. The Preparer/Translator Certification must be completed if **Section 1** is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete **Section 1** on his/her own. However, the employee must still sign **Section 1** personally.

Section 2, Employer: For the purpose of completing this form, the term "employer" means all employers including those recruiters and referrers for a fee who are agricultural associations, agricultural employers or farm labor contractors.

Employers must complete **Section 2** by examining evidence of identity and employment eligibility within three (3) business days of the date employment begins. If employees are authorized to work, but are unable to present the required

document(s) within three business days, they must present a receipt for the application of the document(s) within three business days and the actual document(s) within ninety (90) days. However, if employers hire individuals for a duration of less than three business days, **Section 2** must be completed at the time employment begins. **Employers must record:**

1. Document title;
2. Issuing authority;
3. Document number;
4. Expiration date, if any; and
5. The date employment begins.

Employers must sign and date the certification. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. These photocopies may only be used for the verification process and must be retained with the Form I-9. **However, employers are still responsible for completing and retaining the Form I-9.**

Section 3, Updating and Reverification: Employers must complete **Section 3** when updating and/or reverifying the Form I-9. Employers must reverify employment eligibility of their employees on or before the expiration date recorded in **Section 1**. Employers **CANNOT** specify which document(s) they will accept from an employee.

- A. If an employee's name has changed at the time this form is being updated/reverified, complete Block A.
- B. If an employee is rehired within three (3) years of the date this form was originally completed and the employee is still eligible to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.
- C. If an employee is rehired within three (3) years of the date this form was originally completed and the employee's work authorization has expired or if a current employee's work authorization is about to expire (reverification), complete Block B and:
 1. Examine any document that reflects that the employee is authorized to work in the U.S. (see List A or C);
 2. Record the document title, document number and expiration date (if any) in Block C, and
 3. Complete the signature block.

What Is the Filing Fee?

There is no associated filing fee for completing the Form I-9. This form is not filed with USCIS or any government agency. The Form I-9 must be retained by the employer and made available for inspection by U.S. Government officials as specified in the Privacy Act Notice below.

USCIS Forms and Information

To order USCIS forms, call our toll-free number at 1-800-870-3676. Individuals can also get USCIS forms and information on immigration laws, regulations and procedures by telephoning our National Customer Service Center at 1-800-375-5283 or visiting our internet website at www.uscis.gov.

Photocopying and Retaining the Form I-9

A blank Form I-9 may be reproduced, provided both sides are copied. The Instructions must be available to all employees completing this form. Employers must retain completed Forms I-9 for three (3) years after the date of hire or one (1) year after the date employment ends, whichever is later.

The Form I-9 may be signed and retained electronically, as authorized in Department of Homeland Security regulations at 8 CFR § 274a.2.

Privacy Act Notice

The authority for collecting this information is the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 USC 1324a).

This information is for employers to verify the eligibility of individuals for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The form will be kept by the employer and made available for inspection by officials of U.S. Immigration and Customs Enforcement, Department of Labor and Office of Special Counsel for Immigration Related Unfair Employment Practices.

Submission of the information required in this form is voluntary. However, an individual may not begin employment unless this form is completed, since employers are subject to civil or criminal penalties if they do not comply with the Immigration Reform and Control Act of 1986.

Paperwork Reduction Act

We try to create forms and instructions that are accurate, can be easily understood and which impose the least possible burden on you to provide us with information. Often this is difficult because some immigration laws are very complex. Accordingly, the reporting burden for this collection of information is computed as follows: 1) learning about this form, and completing the form, 9 minutes; 2) assembling and filing (recordkeeping) the form, 3 minutes, for an average of 12 minutes per response. If you have comments regarding the accuracy of this burden estimate, or suggestions for making this form simpler, you can write to: U.S. Citizenship and Immigration Services, Regulatory Management Division, 111 Massachusetts Avenue, N.W., 3rd Floor, Suite 3008, Washington, DC 20529. OMB No. 1615-0047.

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

**Form I-9, Employment
Eligibility Verification**

Please read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification. To be completed and signed by employee at the time employment begins.

Print Name: Last	First	Middle Initial	Maiden Name
Address (Street Name and Number)		Apt. #	Date of Birth (month/day/year)
City	State	Zip Code	Social Security #

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):

A citizen or national of the United States

A lawful permanent resident (Alien #) A _____

An alien authorized to work until _____
(Alien # or Admission #)

Employee's Signature _____ Date (month/day/year) _____

Preparer and/or Translator Certification. (To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Preparer's/Translator's Signature _____	Print Name _____
Address (Street Name and Number, City, State, Zip Code) _____	Date (month/day/year) _____

Section 2. Employer Review and Verification. To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number and expiration date, if any, of the document(s).

List A	OR	List B	AND	List C
Document title: _____		_____		_____
Issuing authority: _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____

CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) _____ and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment.)

Signature of Employer or Authorized Representative _____	Print Name _____	Title _____
Business or Organization Name and Address (Street Name and Number, City, State, Zip Code) _____		Date (month/day/year) _____

Section 3. Updating and Reverification. To be completed and signed by employer.

A. New Name (if applicable) _____	B. Date of Rehire (month/day/year) (if applicable) _____
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C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.

Document Title: _____	Document #: _____	Expiration Date (if any): _____
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I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible 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 _____	Date (month/day/year) _____
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LISTS OF ACCEPTABLE DOCUMENTS

LIST A Documents that Establish Both Identity and Employment Eligibility	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Eligibility
1. U.S. Passport (unexpired or expired)		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. U.S. Social Security card issued by the Social Security Administration <i>(other than a card stating it is not valid for employment)</i>
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 Birth Abroad issued by the Department of State <i>(Form FS-545 or Form DS-1350)</i>
3. An unexpired foreign passport with a temporary I-551 stamp		3. School ID card with a photograph		3. Original or certified copy of a birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official seal
4. An unexpired Employment Authorization Document that contains a photograph (Form I-766, I-688, I-688A, I-688B)		4. Voter's registration card		4. Native American tribal document
		5. U.S. Military card or draft record		5. U.S. Citizen ID Card <i>(Form I-197)</i>
5. An unexpired foreign passport with an unexpired Arrival-Departure Record, Form I-94, bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, if that status authorizes the alien to work for the employer		6. Military dependent's ID card		6. ID Card for use of Resident Citizen in the United States <i>(Form I-179)</i>
		7. U.S. Coast Guard Merchant Mariner Card		7. Unexpired employment authorization document issued by DHS <i>(other than those listed under List A)</i>
		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		

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274)