EFF Hiring Packet - Forms and Policies

RETURN TO HELENA-PAYROLL

PLEASE PRINT ALL INFORMATION CLEARLY TO ENSURE PROMPT PAYMENT

EFF Name _____

Location _____ RFD/VFD _____

(Land Office and/or Unit Name) *(if applicable)*

Sent to Payroll By: _____

(Contact Person) *(Date)*

Return this coversheet with documents checked off below.

		Required Forms #1-14 (Unless otherwise noted)
1.		EFF Hiring Packet Checklist
2.		Emergency Fire Fighter Employment Form
3.		EFF Employment Conditions Acknowledgement
4.		W-4 (2020)
5.		Decedent Warrant
6.		I-9 Employment Verification (Federal form I-9, Section 1, should be completed, signed and dated by the EFF and turned into the DNRC hiring office with appropriate documentation. Once reviewed and verified, Section 2 is completed, signed and dated by DNRC representative. First Day of Employment will not be filled in until the EFF is mobilized.)
7.		PERS Information Memo Acknowledge
8.		PERS Optional Membership Election Form
9.		PERS Designation of Beneficiary Form *(only if electing to enroll in PERS)*
10.		Social Security SSA-1945 (not covered by state)
11.		Confirmation of Receipt of DNRC Policies by Emergency Firefighters (EFF's)
12.		Direct Deposit Sign-up Form
13.		RMTD Vehicle Use Acknowledgement Form
14.		Ethics Acknowledgement Form
		Optional - Include only as needed
15.		Fuel Card Use Employee Agreement Form
		Reference & Information
16.		EFF Information Sheet
17.		State Fund 1st Report Instructions
18.		State Payroll Calendar
19.		Travel Voucher Instructions
		Payroll Section
		Selective Service verification
		I-9 Documentation
		PERS Forms (Completed & signed)

PLEASE Note - Public Employees' Retirement System (PERS):

- Everyone must read and sign the PERS Information Memo Acknowledgement, even if declining enrollment.
- Everyone must complete the PERS Optional Membership Election form, even if declining enrollment.
- Only complete a PERS Designation of Beneficiary form if you have elected to enroll in PERS.

DNRC Area/Unit Office Personnel Only (57690024)

Activate DNRC e-mail account: Yes___ No___ Approval: _____ _____ _____

Signature Print Name & Position Date

Questions – Please Contact DNRC Payroll at 444-5735 Revised 1/2020

EMERGENCY FIREFIGHTER EMPLOYMENT FORM

Paycheck and W-2 will be mailed to the address listed below.

See 2020 Payroll Calendar for the State Payday Schedule. Please note that ***ORIGINAL*** EFF Time sheets must be turned in to your **local land office** by the **Pay Period Ending Date** or you may not meet the pay cycle causing your check to be delayed.

Once Payroll has received your time sheet, it will be processed in compliance with the state wide payroll system of a bi- weekly payroll cycle. ***Emergency Fire Fighters are short term workers and do not received benefits. They will be terminated at the end of their assignment.***

Date:		**Name:**
Land Office or Unit		*Please Print Full Name (as it appears on your social security card)*

Employee Contact Information below MUST be filled out.

If your mailing address is different from your physical address please list both of your addresses.

Mailing Address	**Physical Address**

Cell Phone:	Home Phone:	Work/Other:

Social Security Number:	**Date of Birth:**

Marital Status:	(circle one)	Single	Married
Gender:	(circle one)	Male	Female

Emergency Contact Information:

Name:		Relationship:
Cell Phone:	Home Phone:	Work Phone:
Home Address:		

Retiree Info	**(circle one)**	
Are you a retiree from the Public Employees' Retirement System?	YES	NO

Current State of Montana Employee	**(circle one)**	
Are you a current state employee working for another state agency?	YES	NO

If yes, name of state agency:	Name of your State Payroll Contact (please print):
	Phone:

Signature: _____ Date: _____

Revised 1/2020

EMERGENCY FIRE FIGHTER EMPLOYMENT CONDITIONS ACKNOWLEDGEMENT

By signing this form, you agree and acknowledge receipt of it, and understand and agree that employment with the Montana Department of Natural Resources and Conservation (DNRC) as an Emergency Fire Fighter (EFF) includes the following conditions:

1. You are being hired by DNRC as an EFF. An EFF is a short-term worker under the Montana Code Annotated, which are laws that apply to DNRC. Although you may fill out forms ahead of time to be ready to work, your date of initial hire as an EFF is the first date that you are dispatched or called into work by the DNRC.

2. As an EFF, you are not hired under a competitive process.

3. Your EFF period of potential employment will terminate eleven months from the date of initial hire.

4. The DNRC has a one-year probationary period for permanent employees. As an EFF, you cannot complete the probationary period to attain status as a permanent DNRC employee. Subsequent employment as an EFF does not count toward the probationary period or longevity (years of service with the State). Each hire as an EFF begins a new period of employment.

5. Subject to emergencies under 76-13-104, MCA, an EFF short-term worker is a person who:
   (a) is hired by DNRC for an hourly wage established by DNRC;
   (b) may not work for DNRC for more than 90 working days from the date of hire in a continuous 11-month period;
   (c) is not eligible for permanent status;
   (d) may not be hired into another position by DNRC without a competitive selection process; and
   (e) is not eligible to earn leave or holiday benefits and is not eligible to earn group health benefits.

6. The term “working day” means a day, of any number of hours (not to exceed 24 hours), on which you are dispatched and assigned by DNRC to report to a worksite. Each working day, no matter its number of hours, counts toward the 90-day total.

7. You will only be asked to work hours on an as-needed basis by the DNRC. Because you will work only on an “as-needed” basis, DNRC does not guarantee that you will work any number of days and, it is possible that you may not be hired to work any days. DNRC retains the discretion to assign as many or as few hours as it chooses based on its business needs, and makes no promise that full-time hours will be available.

8. You will be paid only for the hours you work.

9. Employment as an EFF does not guarantee that you will be hired again, in any capacity or at any time, by DNRC.

10. DNRC may, in its sole discretion, issue you a cell phone and/or a credit card for use as an EFF. Any cell phone or credit card issued to you by DNRC will be used for DNRC work-related purposes. Within five (5) calendar days of the end of your employment, you will return to DNRC any cell phone or credit card issued to you by DNRC.

11. Federal form I-9, Section 1, should be completed, signed and dated by you, the EFF, and turned into the DNRC hiring office with appropriate documentation. Once reviewed and verified by the DNRC representative, Section 2 is completed, signed and dated. You will then be placed in a “Ready Pool” status and you may or may not be mobilized or activated for the fire season. If you are mobilized or activated, then your first day of employment will be entered on the I-9.

Your signature is your acknowledgment that you have read, understand, and agree to the above conditions of employment as an EFF short-term worker**.**

_____	_____	_____
Employee’s Signature	Print Employee’s Name	Date

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

2020

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 widow(er))
☐ **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, when to use the online estimator, 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) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **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 accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ▶ ☐

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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 Dependents

If your 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 and 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

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.

Exemption from withholding. You may claim exemption from withholding for 2020 if you meet both of the following conditions: you had no federal income tax liability in 2019 **and** you expect to have no federal income tax liability in 2020. You had no federal income tax liability in 2019 if (1) your total tax on line 16 on your 2019 Form 1040 or 1040-SR is zero (or less than the sum of lines 18a, 18b, and 18c), 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 2020 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 16, 2021.

Your privacy. If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: 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). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

1. Expect to work only part of the year;

2. Have dividend or capital gain income, or are subject to additional taxes, such as the additional Medicare tax;

3. Have self-employment income (see below); or

4. Prefer the most accurate withholding for multiple job situations.

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

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

Specific Instructions

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

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

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

If you (and your spouse) have a total of only two jobs, you may instead 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.

CAUTION ***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. Step 3 of Form W-4 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. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. 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 2020 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.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 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 2020 itemized deductions (from Schedule A (Form 1040 or 1040-SR)). 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:
- $24,800 if you're married filing jointly or qualifying widow(er)
- $18,650 if you're head of household
- $12,400 if you're single or married filing separately

. . . . . **2** $ _____

3 If line 1 is greater than line 2, subtract line 2 from line 1. 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 or 1040-SR)). 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 possessions 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 Widow(er)

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	$220	$850	$900	$1,020	$1,020	$1,020	$1,020	$1,020	$1,210	$1,870	$1,870
$10,000 - 19,999	220	1,220	1,900	2,100	2,220	2,220	2,220	2,220	2,410	3,410	4,070	4,070
$20,000 - 29,999	850	1,900	2,730	2,930	3,050	3,050	3,050	3,240	4,240	5,240	5,900	5,900
$30,000 - 39,999	900	2,100	2,930	3,130	3,250	3,250	3,440	4,440	5,440	6,440	7,100	7,100
$40,000 - 49,999	1,020	2,220	3,050	3,250	3,370	3,570	4,570	5,570	6,570	7,570	8,220	8,220
$50,000 - 59,999	1,020	2,220	3,050	3,250	3,570	4,570	5,570	6,570	7,570	8,570	9,220	9,220
$60,000 - 69,999	1,020	2,220	3,050	3,440	4,570	5,570	6,570	7,570	8,570	9,570	10,220	10,220
$70,000 - 79,999	1,020	2,220	3,240	4,440	5,570	6,570	7,570	8,570	9,570	10,570	11,220	11,240
$80,000 - 99,999	1,060	3,260	5,090	6,290	7,420	8,420	9,420	10,420	11,420	12,420	13,260	13,460
$100,000 - 149,999	1,870	4,070	5,900	7,100	8,220	9,320	10,520	11,720	12,920	14,120	14,980	15,180
$150,000 - 239,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,190	16,050	16,250
$240,000 - 259,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,520	17,170	18,170
$260,000 - 279,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	13,120	15,120	17,120	18,770	19,770
$280,000 - 299,999	2,040	4,440	6,470	7,870	9,190	10,720	12,720	14,720	16,720	18,720	20,370	21,370
$300,000 - 319,999	2,040	4,440	6,470	8,200	10,320	12,320	14,320	16,320	18,320	20,320	21,970	22,970
$320,000 - 364,999	2,720	5,920	8,750	10,950	13,070	15,070	17,070	19,070	21,290	23,590	25,540	26,840
$365,000 - 524,999	2,970	6,470	9,600	12,100	14,530	16,830	19,130	21,430	23,730	26,030	27,980	29,280
$525,000 and over	3,140	6,840	10,170	12,870	15,500	18,000	20,500	23,000	25,500	28,000	30,150	31,650

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	$460	$940	$1,020	$1,020	$1,470	$1,870	$1,870	$1,870	$1,870	$2,040	$2,040	$2,040
$10,000 - 19,999	940	1,530	1,610	2,060	3,060	3,460	3,460	3,460	3,640	3,830	3,830	3,830
$20,000 - 29,999	1,020	1,610	2,130	3,130	4,130	4,540	4,540	4,720	4,920	5,110	5,110	5,110
$30,000 - 39,999	1,020	2,060	3,130	4,130	5,130	5,540	5,720	5,920	6,120	6,310	6,310	6,310
$40,000 - 59,999	1,870	3,460	4,540	5,540	6,690	7,290	7,490	7,690	7,890	8,080	8,080	8,080
$60,000 - 79,999	1,870	3,460	4,690	5,890	7,090	7,690	7,890	8,090	8,290	8,480	9,260	10,060
$80,000 - 99,999	2,020	3,810	5,090	6,290	7,490	8,090	8,290	8,490	9,470	10,460	11,260	12,060
$100,000 - 124,999	2,040	3,830	5,110	6,310	7,510	8,430	9,430	10,430	11,430	12,420	13,520	14,620
$125,000 - 149,999	2,040	3,830	5,110	7,030	9,030	10,430	11,430	12,580	13,880	15,170	16,270	17,370
$150,000 - 174,999	2,360	4,950	7,030	9,030	11,030	12,730	14,030	15,330	16,630	17,920	19,020	20,120
$175,000 - 199,999	2,720	5,310	7,540	9,840	12,140	13,840	15,140	16,440	17,740	19,030	20,130	21,230
$200,000 - 249,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
$250,000 - 399,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
$400,000 - 449,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,450	19,940	21,240	22,540
$450,000 and over	3,140	6,230	8,810	11,310	13,810	15,710	17,210	18,710	20,210	21,700	23,000	24,300

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	$830	$930	$1,020	$1,020	$1,020	$1,480	$1,870	$1,870	$1,930	$2,040	$2,040
$10,000 - 19,999	830	1,920	2,130	2,220	2,220	2,680	3,680	4,070	4,130	4,330	4,440	4,440
$20,000 - 29,999	930	2,130	2,350	2,430	2,900	3,900	4,900	5,340	5,540	5,740	5,850	5,850
$30,000 - 39,999	1,020	2,220	2,430	2,980	3,980	4,980	6,040	6,630	6,830	7,030	7,140	7,140
$40,000 - 59,999	1,020	2,530	3,750	4,830	5,860	7,060	8,260	8,850	9,050	9,250	9,360	9,360
$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,780	10,980	11,180	11,580	12,380
$80,000 - 99,999	1,900	4,300	5,710	7,000	8,200	9,400	10,600	11,180	11,670	12,670	13,580	14,380
$100,000 - 124,999	2,040	4,440	5,850	7,140	8,340	9,540	11,360	12,750	13,750	14,750	15,770	16,870
$125,000 - 149,999	2,040	4,440	5,850	7,360	9,360	11,360	13,360	14,750	16,010	17,310	18,520	19,620
$150,000 - 174,999	2,040	5,060	7,280	9,360	11,360	13,480	15,780	17,460	18,760	20,060	21,270	22,370
$175,000 - 199,999	2,720	5,920	8,130	10,480	12,780	15,080	17,380	19,070	20,370	21,670	22,880	23,980
$200,000 - 249,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
$250,000 - 349,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
$350,000 - 449,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,900	25,200
$450,000 and over	3,140	6,840	9,560	12,140	14,640	17,140	19,640	21,530	23,030	24,530	25,940	27,240

LEGAL DESIGNATION OF PERSON AUTHORIZED TO RECEIVE DECEDENT'S WARRANTS

Instructions for Employee

1. Complete the Beneficiary Designation portion of this form. This form must be typed or printed legibly in ink.
2. Provide designee's full legal name (example "Mary Lynn Smith" or "To the Estate of Jane Smith"). The designee name cannot be "Mrs. John E. Smith".
3. No erasures or corrections in the designee's name can be accepted. If an error is made, complete a new form.
4. Inform your HR/payroll personnel when designee's address changes.
5. Sign this form in ink and submit to your agency HR/payroll personnel.
6. Designee may be changed at any time by completing another form and submitting to your agency HR/payroll personnel. You are requested to update your designee every calendar year.

Beneficiary Designation For Decedent's Final Warrants

Pursuant to §2-18-412, MCA, I hereby designate the following person who, notwithstanding any other provision of law, shall be entitled upon my death to receive all state warrants, excluding payment of death benefits and refund of employee retirement contributions, payable to me as a result of my employment with the State of Montana had I survived.

All information is **required**.

Name of Designee _____
First Middle Last

Mailing Address _____
Street or PO Box City State Zip Code

Social Security Number _____ Date of Birth_____

My signature on this document indicates:

1. I understand this is a legally binding document.
2. I hereby revoke any previous designation filed by me.
3. If the above named designee cannot be contacted within sixty days after the date of my death, this designation shall be void and the warrant will be reissued to my estate.
4. This designation will remain in full force and effect until revoked by me in writing.

Employee Name _____ _____
First Middle Last Social Security Number

_____ _____
Employee Signature Date

Instructions to Employer

Review above information for proper completion by employee and reaffirm to employee, this is a **legally binding document**. Place document in employee's file. Have your employees periodically review their designation.

1. Upon death of employee, complete the information below. The Certifying Officer should be the agency head or personnel officer. ***Carefully follow the checklist for Deceased Employee available on the MINE website.***
2. Send two copies of this form to the SHRD Human Resources Information Services Bureau and retain original in employee's file.
3. If death occurs after the warrant has been issued but before it has been negotiated, recover the warrant (if possible) and submit to the SHRD Human Resources Information Services Bureau.

_____ _____ _____
Date of Death Certifying Officer Signature Date

FOR USE BY DEPARTMENT OF ADMINISTRATION - WARRANT WRITING

Agency Contact

Agency Phone #

Employee Name

Beneficiary Name

Vendor #

Voucher #

Done By

Date

Approved by

Date

Replacement #

Date

Journal #

Date

Approved By

Date

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

▶ **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

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

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		Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

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		
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		**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		

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

MONTANA DEPARTMENT OF NATURAL RESOURCES & CONSERVATION

FINANCIAL SERVICES OFFICE

TO: DNRC New and Re-Hires

FROM: Financial Services Office-Payroll

DATE: December 7, 2018

SUBJECT: **PERS OPTIONAL MEMBERSHIP ELECTION (Form 1016) INFORMATION ACKNOWLDGEMENT**

When completing the Public Employees' Retirement System (PERS) Optional Membership Election form 1016, please note the following important facts:

- You are **required** to select "I elect PERS membership" if you are currently a member of PERS. Your membership can be either **ACTIVE** or **INACTIVE**. Your membership may be from another government entity (i.e. county employment).
- If you select "I decline PERS" and DNRC Payroll staff determines that you are a member of PERS, DNRC is required to re-enroll you as a PERS member.
- Even if you are not a member of PERS and you select "I decline PERS membership", you will automatically become a member of PERS when you post more than 960 hours on your timesheet.
- You are required to pay the Employee portion of PERS as soon as you work more than 960 hours. DNRC encourages employees to track their own hours and to monitor their payroll information to assure that the employee portion of the PERS contribution is being deducted from their earnings.
- PERS calculates the 960 hours on a state fiscal year basis using the date paid. For example, the first pay date in FY15 was July 9, 2014 (Pay Period Ended June 27, 2014). Therefore, the start date for hours counted toward 960 in FY15 is June 14, 2014. The end date for FY15 is June 12, 2015. Once you work over 960 hours between those dates, DNRC Payroll will enroll you as a PERS member. (The 960 hours are not only those hours worked for DNRC but any hours worked in a PERS covered position.)
- The following hours are included in the 960 calculation:
  - Regular Time
  - Over-Time
  - Holiday
  - Vacation
  - Sick Leave
  - Exempt Comp Time Taken
  - Non-Exempt Comp Time Taken
  - Payouts of Leave Balances
- The following hours are not included in the 960 calculation:
  - Exempt Comp Earned
  - Non-Exempt Comp Earned
  - Leave without Pay

If you have any questions, or would like more information, please contact DNRC Payroll in Helena at (406) 444-5735.

Your signature below is your acknowledgment that you have read and understand the above information:

_____	_____	_____
Employee's Signature	Print Employee's Name	Date

Montana Public Employee Retirement Administration
PO Box 200131 • Helena MT 59620-0131
(406) 444-3154 • Toll Free (877) 275-7372

PUBLIC EMPLOYEES' RETIREMENT SYSTEM (PERS)
OPTIONAL MEMBERSHIP ELECTION

This election must be completed by both employee and employer and received by MPERA within **90 days** of the employee's hire date or the employee waives membership. If any information in this form conflicts with statute or rule, the statute or rule will apply. If you have any questions about optional membership, please contact our office.

EMPLOYEE INFORMATION – to be completed by employee

Last Name	First Name, MI	Social Security Number *
Date of Birth	Email Address	Phone Number ( )

Membership is optional only for certain new employees. (See optional positions below.) If you are currently an active or inactive member of PERS (already have contributions in PERS through this or any other agency), you cannot elect out of PERS. By signing below, I acknowledge that I understand:

- If I have contributions on account at MPERA, I must contribute to PERS;
- **If I decline membership, I cannot later become a member of PERS while still employed with the same employer but in a different optional position;**
- If I decline membership, terminate employment, and become employed in another optional position within 30 days of termination, I may not become a member in the second optional position;
- If I decline membership, terminate employment, and become employed in another optional position 30 days or more after my termination, I am allowed a new election;
- If I decline membership, I will not receive membership service or service credit for employment for which membership was declined; and
- If I subsequently accept employment in a position for which retirement is mandatory, I must become a member regardless of this election.

I am eligible to choose PERS membership due to employment with this agency and I am **not** an active, inactive or retired member of PERS.

ELECTION

☐ **I decline PERS membership** **Are you a working retiree? _____**

☐ **I elect PERS membership (Please complete a PERS Membership Card / Designation of Beneficiary)**

Employee Signature	Date

EMPLOYER INFORMATION – to be completed by employer

Employee's Hire Date	Employing Agency	Employer Number
	DNRC	576

Please verify the above employee is eligible for optional membership. Working retirees, excluded employees and mandatory members are NOT eligible for an optional membership election. § 19-3-401,403 and 412, MCA.

Check the type of optional position (you must check only one):

☐ Employee directly appointed by the Governor

☐ Chief administrative officer of a city or county

☐ Legislative branch employee working 10 months or less to perform work related to the legislative session

☐ New employee of a county hospital or rest home

☐ Employee working 960 hours or less in PERS-covered positions

Printed Name	Title	Phone Number
Tammy Stineback	Payroll Supervisor	(406) 444-5735
Signature		Date

Return completed form to DNRC Payroll within 90 days of hire. Retain a copy for your records.

* For identification and tax purposes. §19-2-403(7) MCA, 26 USC § 6041A and 6109

Montana Public Employee Retirement Administration
PO Box 200131 • Helena MT 59620-0131
(406) 444-3154 • Toll Free (877) 275-7372
http://mpera.mt.gov

PUBLIC EMPLOYEES' RETIREMENT SYSTEM (PERS) MEMBERSHIP/DESIGNATION OF BENEFICIARY FORM

MEMBER INFORMATION

Last Name		First Name, MI	Social Security Number* - -
Date of Birth / /	Gender ☐ M ☐ F	Employing Agency	Employer Number (MPERA use only)
Member's Mailing Address			
City		State	Zip Code
Daytime Phone Number ( )		Email Address	

PRIMARY AND/OR CONTINGENT BENEFICIARY DESIGNATION

Completion of this section revokes all prior beneficiary designations unless you are prohibited from changing your beneficiary by a valid temporary restraining order issued pursuant to § 40-4-121, MCA. You may designate one or more primary or contingent beneficiaries by using a separate line for each person. Contingent beneficiaries receive benefits only if all listed primary beneficiaries are deceased. If you list two or more primary (or two or more contingent beneficiaries) they will be treated on a share and share alike basis. If you prefer a different allocation, please specify. If you designate a trust, a charitable organization or your estate as a primary or contingent beneficiary, you will also need to complete the "Other Designation" section.

Primary Beneficiary - *attach additional list if necessary.*

Full Name	Gender	Relationship	Birth Date	SSN*	Allocation
	☐ M ☐ F				%
	☐ M ☐ F				%
	☐ M ☐ F				%

Contingent Beneficiary (optional) - *attach additional list if necessary.*

Full Name	Gender	Relationship	Birth Date	SSN*	Allocation
	☐ M ☐ F				%
	☐ M ☐ F				%
	☐ M ☐ F				%

Other Designation (NOTE: Any designated trust must already be in existence - this form cannot create a trust. Further, by designating a trust you verify that it is (1) valid under state law; (2) irrevocable on or before your death; and (3) for the benefit of identifiable living person(s).)

Name of Trust, Charity or Estate	Trustee/Contact Name
Address	Tax Identification Number

REQUIRED SIGNATURES

Member Signature		Date
Witness Name printed (not a beneficiary)	Witness Signature	Date

Original signatures are required. MPERA cannot accept faxed or photocopies of this form.

This form must be filed with MPERA before any changes will take effect.

MBS-0044-0121-01-0000000000

* For identification and tax purposes. *§19-2-403(8) MCA, 26 USC § 6109.*

Social Security Administration

Statement Concerning Your Employment in a Job Not Covered by Social Security

Employee Name _____ Employee ID # _____
Employer Name Department of Natural Resources & Conservation Employer ID # 81-0302402

Your earnings from this job are not covered under Social Security. When you retire, or if you become disabled, you may receive a pension based on earnings from this job. If you do, and you are also entitled to a benefit from Social Security based on either your own work or the work of your husband or wife, or former husband or wife, your pension may affect the amount of the Social Security benefit you receive. Your Medicare benefits, however, will not be affected. Under the Social Security law, there are two ways your Social Security benefit amount may be affected.

Windfall Elimination Provision
Under the Windfall Elimination Provision, your Social Security retirement or disability benefit is figured using a modified formula when you are also entitled to a pension from a job where you did not pay Social Security tax. As a result, you will receive a lower Social Security benefit than if you were not entitled to a pension from this job. For example, if you are age 62 in 2013, the maximum monthly reduction in your Social Security benefit as a result of this provision is $395.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit. For additional information, please refer to Social Security Publication, "Windfall Elimination Provision."

Government Pension Offset Provision
Under the Government Pension Offset Provision, any Social Security spouse or widow(er) benefit to which you become entitled will be offset if you also receive a Federal, State or local government pension based on work where you did not pay Social Security tax. The offset reduces the amount of your Social Security spouse or widow(er) benefit by two-thirds of the amount of your pension.

For example, if you get a monthly pension of $600 based on earnings that are not covered under Social Security, two-thirds of that amount, $400, is used to offset your Social Security spouse or widow(er) benefit. If you are eligible for a $500 widow(er) benefit, you will receive $100 per month from Social Security ($500-$400=$100). Even if your pension is high enough to totally offset your spouse or widow(er) Social Security benefit, you are still eligible for Medicare at age 65. For additional information, please refer to Social Security Publication, "Government Pension Offset."

For More Information
Social Security publications and additional information, including information about exceptions to each provision, are available at www.socialsecurity.gov. You may also call toll free 1-800-772-1213, or for the deaf or hard of hearing call the TTY number 1-800-325-0778 or contact your local Social Security office.

Information about Social Security Form SSA-1945 Statement Concerning Your Employment in a Job Not Covered by Social Security

New legislation [Section 419(c) of Public Law 108-203, the Social Security Protection Act of 2004] requires State and local government employers to provide a statement to employees hired January 1, 2005 or later in a job not covered under Social Security. The statement explains how a pension from that job could affect future Social Security benefits to which they may become entitled.

Form SSA-1945, Statement Concerning Your Employment in a Job Not Covered by Social Security, is the document that employers should use to meet the requirements of the law. The SSA-1945 explains the potential effects of two provisions in the Social Security law for workers who also receive a pension based on their work in a job not covered by Social Security. The Windfall Elimination Provision can affect the amount of a worker's Social Security retirement or disability benefit. The Government Pension Offset Provision can affect a Social Security benefit received as a spouse, surviving spouse, or an ex-spouse.

Employers must:

- Give the statement to the employee prior to the start of employment;
- Get the employee's signature on the form; and
- Submit a copy of the signed form to the pension paying agency.

Social Security will not be setting any additional guidelines for the use of this form.

Copies of the SSA-1945 are available online at the Social Security website: www.socialsecurity.gov/online/ssa-1945.pdf.
Paper copies can be requested by email at: ofsm.oswm.rqct.orders@ssa.gov or by fax at 410-965-2037. The request must include the name, complete address and telephone number of the employer. Forms will not be sent to a post office box. Also, if appropriate, include the name of the person to whom the forms are to be delivered. The forms are available in packages of 25. Please refer to Inventory Control Number (ICN) 276950 when ordering.

I certify that I have received Form SSA-1945 that contains information about the possible effects of the Windfall Elimination Provision and the Government Pension Offset Provision on my potential future Social Security Benefits.

Signature of Employee _____ **Date** _____

Form **SSA-1945** (01-2013)
Destroy Prior Edition

Confirmation of Receipt of DNRC Policies by Emergency Firefighters (EFF's)

By signing below, I agree that as a condition of employment with the State of Montana, Department of Natural Resources and Conservation (DNRC), I will comply with the following listed DNRC policies:

Initials	Required Policies	Number	Date
	Drug Free Workplace Policy	P-DNRC-HR-022	06/25/02
	Model Rules of Conduct Policy	P-DNRC-HR-041	11/18/07
	Public Information Policy	P-DNRC-OP-004	09/10/12
	Sexual Harassment Policy	P-DNRC-HR-4	09/05/95
	Substance Abuse/Use Policy	P-DNRC-HR-010	11/21/95

Optional Policies – Include only as Needed			
	Drug & Alcohol Testing (required for Empl w/CDL)	P-DNRC-HR-006	10/03/95
	Drug & Alcohol Testing Addendum (required for Empl w/CDL)	P-DNRC-HR-006A	11/01/96

I acknowledge that the policies have been made available to me, and declare that, prior to signing this form; I have read and do understand these policies.

_____ _____

Print Name Date

DIRECT DEPOSIT SIGN-UP FORM

To enroll in direct deposit, either complete the below Section 1 or attach a voided check to Section 2.

The Direct Deposit process may take up to 2 payroll cycles before taking effect.

SECTION 1 *TO BE COMPLETED BY EMPLOYEE*

A NAME OF EMPLOYEE *(last, first, middle initial)*	**D DEPOSITOR ACCOUNT NUMBER**
ADDRESS *(street, route, P.O. Box, APO/FPO)*	**E DEPOSITOR ROUTING NUMBER**
CITY **STATE** **ZIP CODE**	
B TYPE OF DEPOSITOR ACCOUNT ☐ **CHECKING** ☐ **SAVINGS**	**PAYEE/JOINT PAYEE CERTIFICATION**
C THIS BOX FOR ALLOTMENT OF PAYMENT ONLY (if applicable) **TYPE** **AMOUNT**	I certify that I am entitled to the payment identified above, and that I have read and understood this form. In signing this form I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.

SECTION 2 *ATTACHED A VOIDED CHECK*

Attach a voided copy of your check here.

SIGNATURE	**DATE**

Your signature authorizes the State of Montana to set up Direct Deposit on your behalf.
If you have any questions, please contact DNRC payroll at (406) 444-6743

DEPARTMENT OF ADMINISTRATION
RMTD VEHICLE USE POLICY
ACKNOWLEDGEMENT FORM

I, _____ am currently employed by _____
understand and agree that my use of the any and all vehicles owned, rented and/or leased by the State, my Department, my Division
or my work unit shall be exclusively related to doing the business of the State of Montana.

I also understand that I am not to use such vehicles for any other reason whatsoever (human life threatening medical emergency excepted).

I agree to operate such vehicles in a safe, prudent, and lawful manner at all times and to comply with the state's motor vehicle laws and policies.

I will wear seat belts at all times and assure that all vehicle occupants do the same when the vehicle is in motion. I will not permit any other person to operate the vehicle, unless such use is made part of this agreement. I will not permit unauthorized passengers to ride in the vehicle without the prior written approval of the Risk Management and Tort Defense Division. I will not carry or consume alcoholic
beverages in a state vehicle or drive a state vehicle out of the State of Montana without prior approval of a state agency.

I truthfully state that I have a valid, non-conditional driver's license and that my license is not currently under suspension. I do truthfully state that I have been convicted in the past 36 months of the following motor vehicle violations (please list):

Type of Conviction_____ Date:_____
Type of Conviction_____ Date:_____
Type of Conviction_____ Date:_____
Type of Conviction_____ Date:_____
Type of Conviction_____ Date:_____

NOTE: If you have listed one or more moving violation convictions during the past 36 months, you must attach your explanation for each conviction or provide a copy of your driver's record along with this signed form.

I understand that, in accordance with the state vehicle use rule ARM 2.6.201 through ARM 2.6.214, if my total conviction points for convictions after 10/12/01 exceed 5 points for a single infraction or an accumulation of 12 points within the past 36 months, I will the report the infraction to supervisor. If my conviction points exceed 15, I understand that I may not be allowed to operate a state vehicle.

I understand that any material false statement or use of the vehicle not permitted by this agreement will require me to assume the full legal and financial consequences of my actions. **Important Notice to Driver: Do not sign below unless you have read and understood this document.**

_____ _____
Driver Signature **Date**

Note: Each state employee must read and understand the provisions of the State Vehicle Use Rule (ARM 2.6.201 through ARM 2.6.214). Supervisors must obtain written documentation of the same by having each employee sign a vehicle use agreement at new employee orientation and periodically thereafter. A copy of the signed agreement must be kept in each employee's personnel file. A sample vehicle use agreement is hereby provided. Agencies may develop their own forms or processes. Please contact the Risk Management & Tort Defense Division with additional questions.

The Montana Department of Natural Resources & Conservation

Ethics Policy Acknowledgement

This policy acknowledgment is for the State Ethics Policy. It is the policy of the Department of Natural Resources & Conservation that its employees will behave in an ethical and respectful manner. The department is committed to following established core behaviors, and standards of conduct, and employees will participate in ethics training as required by state policy. New employees are required to read and sign the *State Ethics Policy*. Employees will disclose any conflicts of interest immediately. The Department of Natural Resources & Conservation, Human Resources Office and/or Management will review all conflict of interest and follow up if necessary.

It is the intent of the Department of Natural Resource & Conservation to adopt the Montana Operations Manual *State Ethics Policy*:

***Montana Operations Manual State Ethics Policy*:**

https://montana.policytech.com/docview/?docid=162&public=true

Employees have a duty to perform diligently, faithfully and with integrity. Employees must carry out all assigned duties and responsibilities and maintain a courteous, productive and otherwise acceptable working relationship with fellow workers and with the general public.

Required Employee Signature for the State Ethics Policy:
I have received the links for the *State Ethics Policy*, which outlines the Code of Ethics found in Title 2 – Chapter 2 MCA, I understand it is my responsibility to familiarize myself with the information contained therein and to use this policy as a reference should it be needed. I further acknowledge I have had an opportunity to ask any questions, I might have regarding the material.

By my signature below, I acknowledge, understand, accept and agree to comply with the above stated policies and Montana state law.

Employee Name: _____
(Please print legibly)

_____ _____
(Employee signature) (Date signed)

EFF Optional/Reference Packet

Please Keep for Your Records

STATE OF MONTANA

FUEL CARD USE EMPLOYEE AGREEMENT

1. I have read, understand, and will comply with the Fuel Card Policy.
2. I understand I am required to use ethanol-blended gasoline when the manufacturer allows and I am prohibited from using premium grade fuel unless required by the vehicle operations manual.
3. I agree to use the card for all fuel purchases unless obtained from a state-owned bulk site with a manual transaction process.
4. I will immediately notify the authorizing official if a card is lost or stolen or if my PIN is compromised.
5. I understand that I am required to comply with internal control procedures.
6. I agree not to share my Personal Identification Number (PIN) with any other person.
7. I understand I can only use the card for fuel and authorized vehicle maintenance purchases for state-owned vehicles.
8. If I misuse the card for personal purchases, I authorize the State to deduct from my salary or from other monies owed me, an amount equal to the total of the personal purchases. I also agree to allow the State to collect any amounts owed by me even if the State no longer employs me.
9. I understand improper use of this card may result in disciplinary actions, including termination of employment and criminal action.
10. I understand the State may terminate my card use privileges at any time for any reason.

Employee Signature	Authorizing Official's Signature
Employee Printed Name	Authorizing Official Printed Name
Date	Date

Montana DNRC Emergency Firefighter (EFF) Information Sheet

HIRING

The State of Montana DNRC hires casuals, or temporary employees, as state EFF's. They are not federal AD's. All hiring paperwork is normally completed and submitted to DNRC payroll in Helena prior to an incident. While EFFs are considered Short Term Workers, they are not held to the 90-working day threshold.

- Workers Compensation Insurance: EFF's are covered under MT Workers Compensation Insurance (MT State Fund: 1-800-332-6102, team 6). See *First Report of Injury* and reporting instructions.
- Taxes & Benefits: State and federal taxes are deducted from EFF gross earnings and state unemployment insurance is paid by the state. (Social Security taxes are not deducted from EFF earnings). EFF's are not entitled to sick or annual leave and are not required to participate in the state retirement plan unless already enrolled or work more than 960 hours per year.
- Entitlements: If incident commissary is available, EFF's are granted commissary privileges on a cash only basis. EFF's earn overtime on greater than 8 hours in a day and greater than 40 hours in a week. Though time is kept on the OF-288, overtime does not need to be computed on an incident; it will be figured when EFF time reports are processed by the DNRC Payroll. EFF's are not entitled to hazard pay or any other pay differentials, unless they are specially trained and are working on the OU3 asbestos area. State employees including EFF's are entitled to one compensated R&R day upon return home from a 14-day assignment; if the IC feels this is warranted, it can be provided by the incident prior to demobilization.
- Pay Rates: EFF pay rates are determined by the nature of the work assigned. See the NRCG supplement to Chapter 10 of the SIIBM at the following website for Montana EFF pay rates. See NRCG supplement to Chapter 50 for additional EFF info. http://dnrc.mt.gov/divisions/forestry/fire-and-aviation/fire-business/forms-and-information

TRAVEL

While in travel status, meals or lodging expenses may occasionally be paid out of pocket. Reimbursement for such expenses will be in accordance with State of Montana travel policies and state per diem rates. Montana travel and per diem meal rates (in state or out of state, as applicable) always apply, regardless of host agency or location of incident. Lodging reimbursement rates are generally at the current federal lodging rate. Lodging receipts must be submitted. Requests for reimbursement of travel expenses must be documented on a DNRC Travel Expense Voucher and submitted to the home unit. Montana travel and per diem policies and forms can be found at the following website: http://dnrc.mt.gov/forestry/fire/business/forms.asp. Higher meal rates may be available in-state for suppression personnel, please contact your hiring office for more information or see Chapter 310 of the DNRC 300-Incident Business Management Manual.

MT Per Diem meal rates (flat rates, receipts not required):

In state:	Breakfast	$7.50	Out of state:	Breakfast	$13.00
	Lunch	$8.50		Lunch:	$14.00
	Dinner	$14.50		Dinner:	$23.00
		$30.50 per day			$50.00 per day

VEHICLE USE

The dispatch office should arrange for travel to and from the incident. Prior authorization is required for use of a personal vehicle. The State of Montana Personal Vehicle Use Authorization Form must be completed and approved by an authorized agency official. If approved to use a personal vehicle, the EFF will be reimbursed for mileage at state rates. This request for reimbursement should be documented on a Travel Expense Voucher. If the vehicle is specifically ordered on a Resource Order for use on the incident, it should be signed up on an EERA at the home unit and paid at a daily and/or mileage rate, as applicable.

PAYMENT DOCUMENTS

ALL PAYMENTS FOR EFF'S AND/OR LOCAL GOVERNMENT FORCES ARE PROCESSED THROUGH THE HOME UNIT (DNRC HIRING OFFICE). The crew representative (or individual) must bring the **original** payment documents back to the home unit for processing. MT DNRC is the only payment agency for EFF's and local government equipment from Montana.

HOME UNIT CONTACT INFORMATION (hiring Land Office or Unit Office)

Address: _____ Phone: _____

_____ Contacts: _____

_____ _____

DNRC hiring official: Attach blank First Report of Injury and reporting instructions to this form; give to each EFF at time of hire.
EFF: Carry this form and a copy with you on incident assignments. Present copy to Finance Section.

Rev. 2/2020

MONTANA STATEFUND
P.O. Box 4759
Helena, MT 59604-4759

First Report

Fax: 406-495-5020
Voice: 800-332-6102
Dept Code: (if applicable)

Claims Examiner Date Stamp

OSHA LOG CASE #

Worker

Last Name	First Name	M.I.	Date of Birth	Social Security Number - -

Home address	City	State	Postal Code -

Phone Number ( ) -	Education ☐ Less Than High School ☐ GED or High School Diploma ☐ Beyond High School	Gender ☐ Male ☐ Unknown ☐ Female	Marital Status ☐ Married ☐ Separated ☐ Not Married ☐ Unknown	Number of Dependents

Wages

Date Hired	Gross earnings for four pay periods preceding the injury.	1 Date / Amount /	2 Date / Amount /	3 Date / Amount /	4 Date / Amount /

Employment Status ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer	Number of days worked per week:	Wage: ☐ Hour ☐ Week ☐ Month ☐ Other: ☐ Day ☐ BI-weekly ☐ Year

In addition to gross earnings cited above worker received: ☐ Board & Room ☐ Overtime ☐ Bonus ☐ Commissions ☐ Other:	Estimated value if any:	Is sick leave available? ☐ Yes ☐ No	Used? ☐ Yes ☐ No

Worked next scheduled shift ☐ Yes ☐ No	Off work more than 4 work days ☐ Yes ☐ No ☐ Not Sure	Date Last Worked	Date of Return to work	Full wages paid for date of Injury? ☐ yes ☐ No	Salary continued? ☐ Yes ☐ No

Accident Description

Description of Accident (continue on separate sheet if necessary)

Cause of Injury	Part of Body	Nature of Injury	Date and Time of Injury /

Date disability began:	Date of Death:	Occupation:	Names of witnesses: 1) 2)

Accident on employer's premises? ☐ Yes ☐ No	Accident address or location: City: State: Postal code: -

Date employer notified:	Accident reported to:	Safety equipment provided? ☐ Yes ☐ No	Safety equipment used? ☐ Yes ☐ No

Medical

Attending Physician's Name	Address	State	Postal Code -	Phone Number ( ) -
Hospital Name	Address	State	Postal Code -	Phone Number ( ) -

Type of initial medical treatment received: ☐ No treatment ☐ Emergency room ☐ Treatment on-site by employer or medical Staff ☐ Clinic/Dr. Office ☐ Hospital

Signature

This is my claim for workers' compensation benefits due to the on-the-job injury, occupational disease or death of the above named worker. **I understand** that signing this claim for compensation authorizes the release of rehabilitation records, Social Security records and health care information (medical records) relevant to this claim to the workers' compensation insurer and the insurer's agents. **I also understand** that if I obtain or exert unauthorized control over workers' compensation benefits, I may be subject to civil and criminal penalties.

Signature of Injured Worker or Beneficiary: Date:

Employer

Employer Name	Doing Business as:	Federal Employer Identification Number (tax I.D.)

Mailing Address	City	State	Postal Code -	Phone Number ( ) -

Location of operation, if different from mailing address:	Nature of Business or SIC Code:	Self-Insured? ☐ Yes ☐ No

Employer is a ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Company	Injured worker is a ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Company ☐ A member of the employer's (sole proprietor or) family living in the employer's household.

Do you have any reason to question this accident? ☐ Yes ☐ No	If yes, please explain fully. Use separate sheet if you need additional space.	Was worker injured while in your employ? ☐ yes ☐ no

Insurance Agent's Name	Insurance Agency	Agent's Telephone Number ( ) -

Prepared by:	Official title:	Date:

Payroll Classification Code under which you report employee's wages:	Authorized Employer's Signature:_____ Date:_____

Insurer Only

Claim Administrator's Claim Number:	Date reported to Claim Administrator:	The above information is correct with the following exceptions: ☐ (Attach extra sheets if box at right is checked)

Third Party Administrator's Name:	Claim Administrator's Address:	Insurer FEIN:

Insurer's Name:	Third Party Administrator's FEIN:

Policy Number:	Policy Effective Date:	Policy Expiration Date:

First Report of Injury

Work-Related Injury & Occupational Disease Reporting

All DNRC personnel, including EFF's, must fill out a First Report of Injury (FROI) form for every on-the-job injury. This form when submitted protects the employee's right to benefits in the event a seemingly minor injury develops into a more serious condition.

Employees – Notify the supervisor of any on-the-job injury **IMMEDIATELY**

Supervisors – Three options for submitting FROI:

1.) Fill out the FROI and fax it to: **(406) 444-1357**, Attn: Paige Tabor **within 24 hours** of the injury. Paige Tabor will check the report to verify completion and forward to Montana State Fund immediately.

2.) Contact **Paige Tabor**, DNRC, Safety Officer **(406) 444-2079** *office*; **(406) 437-2746** *cell;* **(406) 368-2398** *home,* **within 24 hours** of the injury. Inform her of all the details so she may submit the report to Montana State Fund

3.) If you do not have access to a fax machine and cannot reach Paige Tabor to give her the details to file **within 24 hours** of the injury, phone in the report to Montana State Fund directly at **(800) 332-6102, Ext 5337** for Mitzie Saltzman, Team 6.

It is the **supervisor's** responsibility to

- Report the injury to Paige Tabor within 24 hours via fax or phone ***or***
- Submit the report directly to Montana State Fund via phone within 24 hours of the injury ***and*** notify Paige Tabor that a report has been filed *as quickly as possible*.

On fire assignments, the employee's supervisor is his/her immediate supervisor at the incident. If the immediate supervisor is not a DNRC employee, the **injured employee** is then responsible to submit the FROI with the fire supervisor's signature.

Contact the home unit as soon as possible to inform the DNRC supervisor of the injury.

- A hard copy of the FROI may be found in the DNRC Fire & Aviation Management Bureau's 300 Manual or may be obtained from any DNRC area office.
- To print a copy from the MSF website go to: http://www.montanastatefund.com/wps/portal. Go to Reporting an Injury at the bottom left of the screen. Click on First Report of Injury Form. You will not be able to file online. Print the form, fill out, and **fax to Paige Tabor at (406) 444-1357**.

Helpful Hints:

- Fill out all sections, except 'Insurer Only' section, as completely and legibly as possible.
- Employee and supervisor should both sign, if available. Supervisor must sign before submitting. Submit this form within 24 hours even if employee is not available to sign, e.g., hospitalized, etc.
- DNRC's federal tax ID # is **81-0302402.**
- Use payroll classification code **9422** for firefighters.
- For 'Employer mailing address,' use the main Helena DNRC address: P.O. Box 201601, Helena, MT 59620-1601. For phone number, use a number where the supervisor can be reached.
- For 'Location of Operation,' use the employee's home unit address.
- Leave the following boxes blank:

  'Employer is a sole proprietorship, partnership, corporation, limited liability company.'
  'Injured worker is a sole proprietorship, partnership, corporation, limited liability company.'
  'Insurance Agent's name'
  'Insurance Agency'
  'Agent's Telephone Number'

STATE OF MONTANA

Payroll Insurance Deduction Calendar

2020

January

S	M	T	W	TH	F	S
			1	2	JAN 3	4
5	6	7	8	9	10	11
12	13	14	15	16	FREE 17	18
19	20	21	22	23	24	25
26	27	28	29	30	JAN 31	

February

S	M	T	W	TH	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	FEB 14	15
16	17	18	19	20	21	22
23	24	25	26	27	FEB 28	29

March

S	M	T	W	TH	F	S
1	2	3	4	5	6	7
8	9	10	11	12	MAR 13	14
15	16	17	18	19	20	21
22	23	24	25	26	MAR 27	28
29	30	31				

April

S	M	T	W	TH	F	S
			1	2	3	4
5	6	7	8	9	APR 10	11
12	13	14	15	16	17	18
19	20	21	22	23	APR 24	25
26	27	28	29	30		

May

S	M	T	W	TH	F	S
					1	2
3	4	5	6	7	MAY 8	9
10	11	12	13	14	15	16
17	18	19	20	21	MAY 22	23
24	25	26	27	28	29	30
31						

June

S	M	T	W	TH	F	S
	1	2	3	4	JUNE 5	6
7	8	9	10	11	12	13
14	15	16	17	18	JUNE 19	20
21	22	23	24	25	26	27
28	29	30				

July

S	M	T	W	TH	F	S
			1	2	JULY 3	4
5	6	7	8	9	10	11
12	13	14	15	16	FREE 17	18
19	20	21	22	23	24	25
26	27	28	29	30	JULY 31	

August

S	M	T	W	TH	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	AUG 14	15
16	17	18	19	20	21	22
23	24	25	26	27	AUG 28	29
30	31					

September

S	M	T	W	TH	F	S
		1	2	3	4	5
6	7	8	9	10	SEPT 11	12
13	14	15	16	17	18	19
20	21	22	23	24	SEPT 25	26
27	28	29	30			

October

S	M	T	W	TH	F	S
				1	2	3
4	5	6	7	8	OCT 9	10
11	12	13	14	15	16	17
18	19	20	21	22	OCT 23	24
25	26	27	28	29	30	31

November

S	M	T	W	TH	F	S
1	2	3	4	5	NOV 6	7
8	9	10	11	12	13	14
15	16	17	18	19	NOV 20	21
22	23	24	25	26	27	28
29	30					

December

S	M	T	W	TH	F	S
		1	2	3	DEC 4	5
6	7	8	9	10	11	12
13	14	15	16	17	FREE 18	19
20	21	22	23	24	25	26
27	28	29	30	31		

○ PAYDAY

□ PAY PERIOD ENDING

◆ HOLIDAY

FOR ALL RATES AND SPECIFIC RULES SEE TRAVEL REGULATIONS AT
http://doa.mt.gov/doatravel/travelmain.asp

TRAVEL EXPENSE VOUCHER
STATE OF MONTANA

Employee				Non-Employee Travel			
Name				Name			
Date		Employee No		Date		SSN	
Address				Address			
Month/Yr		**Dept**		**Org**			
List meals provided							
Purpose							

Dates	Depart Time	am pm	Arrive Time	am pm	Description/Destination	Mode of Travel	Miles	Rate	Subtotal	Lodging	Meals Per Diem	Other Expense	Total

INSTRUCTIONS FOR TRAVEL EXPENSE VOUCHER

NOTE: If the least-cost method of travel is not used, you <u>MUST</u> attach justification.

1)	**Employee Number**	For a non-employee, a SSN (or tax payer ID) is required.
2)	**Address**	Required for employee and non-employee travel.
3)	**Month/Year**	Month and year of travel.
4)	**Department**	Department where the employee/non-employee works.
5)	**Org**	Input the org if it is different than the department's default org.
6)	**Meals Provided**	List any meals included in the training/meetings.
7)	**Purpose**	Explain reason for the travel: where and why.
8)	**Dates**	Dates of the travel/expense.
9)	**Departure time**	Time of departure from home or the office, not airport departure time.
10)	**Arrival Time**	Time of arrival at final destination (e.g., hotel or office, not airport arrival time).
11)	**Description/Destination**	Destination or a description of the charge listed.
12)	**Mode of Travel**	Method of travel. Examples: CA - Commercial Air (Plane): must include amount of ticket in "Rate" and 1 in "Miles". PA - Personal Aircraft PC - Personal Car (not a motor pool or rental car) SA - State Aircraft SC - State Car (car, truck, mini van, etc.)
13)	**Miles**	For travel in a personal car or aircraft, list the total miles traveled (nearest tenth of a mile). Input "1" for commercial transportation.
14)	**Rate**	Rate received per mile or the cost of the commercial transportation (see travel regulations for current rates, web page link above).
15)	**Lodging**	Amount paid for lodging including tax (movies, phone charges, room service excluded).
16)	**Meals**	Amount of per diem entitled to (not the actual cost); meals provided are not allowable.
17)	**Other Expense**	Allowable expenses that are not listed anywhere else. If any item is $25 or more, a receipt must must be attached, unless the receipt is with the state credit card/invoice claim. Agencies may choose to include registration fees as part of this category.
18)	**Amount Charged on State Credit Card**	This will populate from the itemization below.
19)	**Non-Permanent Travel Advance**	List amount of non-permanent advance received (warrant or payroll).
20)	**Itemization of State CreditCard/Warrant**	List all charges on state credit card or warrant (e.g., registration, lodging, rental car, airline, etc.). For items charged on a state credit card or paid by a warrant, the receipt/invoice should be kept with the credit card/invoice claim.

Example: Travel to Boston on 3/15/05 for training. $100 travel advance was received through payroll. Travel costs were:

airline ticket for $695 paid by state credit card on 1/15/05
shuttle cost of $10 each way (3/15/05, 3/18/05)
$75 dinner paid by state credit card on 3/16/05
lodging (including taxes) of $110 per night (3/15/05, 3/16/05, 3/17/05) paid by state credit card on 3/17/05
room service for $106 (meals per diem) paid by state credit card on 3/17/05
car rental of $150 paid by state credit card on 3/18/05