



# 90 Day Short Term Worker Hire Packet Forms and Policies

**\*\*\*RETURN TO HELENA-PAYROLL\*\*\***

Name \_\_\_\_\_

Location \_\_\_\_\_

*(Land Office, Unit or Regional Water Office Name)*

Sent to Payroll By: \_\_\_\_\_

*(Contact Person)*

*(Date)*

**Return this coversheet with documents checked off below.**

Required Forms		
1.		90 Day STW Hire Packet Checklist
2.		EEO and Emergency Information
3.		<a href="#">Federal W-4</a>
4.		Decedent Warrant
5.		<a href="#">Federal I-9</a> Employment Verification
6.		PERS Information Memo Acknowledge
7.		PERS Optional Membership Election Form
8.		PERS Designation of Beneficiary Form <i>(only if electing to enroll in PERS)</i>
9.		Statement of Selective Service
10.		90 Day STW Confirmation of Receipt of DNRC Policies
11.		Direct Deposit Sign Up Form
Optional Forms		
13.		Fuel Card Use Employee Agreement
14.		State Vehicle Use Employee Agreement
15.		Incident Behavior
16.		Cell Phone Purchase & Activation (Appendix A&B)
17.		State Employee ID Form (electronic picture to be sent by email)
18.		ProCard Forms & Manual
19.		MT State Fund First Report Instructions
20.		Payroll Calendar
21.		Travel Voucher Instructions
Onboarding, Reference & Information		
		<a href="#">Personnel Action Form</a>
		<a href="#">Employee Change Request Form</a>
		DNRC Bi-Weekly Time Sheet
		<i>Any Additional Documents:</i>

**Questions – Please Contact DNRC Payroll at 444-5735**

Revised  
1/2012

# EEO AND EMERGENCY INFORMATION FORM

## Personal Data and Identification Data Components

Name as it appears on your Social Security card:

Prefix \_\_\_\_\_ Employee Name \_\_\_\_\_  
Mr., Mrs., Ms. **First** **Middle Name or Initial** **Last**

Suffix \_\_\_\_\_ (Fourth, Junior, Second, Senior, Third)

**BIRTH DATE: (Required)** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

**GENDER/SEX: (Required)**

Female  Male

**HIGHEST EDUCATION LEVEL**

- |  |   |
|--|---|
| <input type="checkbox"/> Not Indicated             | <input type="checkbox"/> Bachelor's Level Degree  |
| <input type="checkbox"/> Less Than HS Graduate     | <input type="checkbox"/> Some Graduate School     |
| <input type="checkbox"/> HS Graduate or Equivalent | <input type="checkbox"/> Master's Level Degree    |
| <input type="checkbox"/> Some College              | <input type="checkbox"/> Doctorate (Academic)     |
| <input type="checkbox"/> Technical School          | <input type="checkbox"/> Doctorate (Professional) |
| <input type="checkbox"/> 2-Year College Degree     | <input type="checkbox"/> Post -Doctorate          |

**SOCIAL SECURITY NUMBER (Required)**

**Home Address** \_\_\_\_\_  
Street or PO Box City County State Zip Code

**Mailing Address** \_\_\_\_\_  
Street or PO Box City County State Zip Code

**Home Phone** \_\_\_\_\_ Other Phone No. (such as cellular, business, alternate) Indicate **type** of phone

Type \_\_\_\_\_ **Phone No.** \_\_\_\_\_ Type \_\_\_\_\_ Phone No. \_\_\_\_\_  
Main  Preferred  Main  Preferred

E-mail -Indicate type (such as home) \_\_\_\_\_ E-mail \_\_\_\_\_ Type \_\_\_\_\_  
Is this your preferred e-mail? Yes  No  Is this your preferred e-mail? Yes  No

**RACE/ETHNIC IDENTIFICATION - PLEASE CHECK ALL THAT APPLY**

**Are you of Hispanic or Latino origin?** Yes  No  (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

**Select one or more of the following racial categories:**

- American Indian or Alaska Native** (A person having origins in any of the original peoples of North or South America, including Central America, and who maintains tribal affiliations or community attachment.)
- Asian** (A person having origin in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)
- Black or African American** (A person having origins in any of the black racial groups of Africa.)
- Native Hawaiian or other Pacific Islander** (A person having origins in the original peoples of Hawaii, Guam, Samoa, or other Pacific islands.)
- White** (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

**MILITARY STATUS -** Please check the one box that best describes your military status.

- Active Reserve  Armed Forces Service Medal Veteran  Inactive Reserve  No Military Service  Other Protected Veteran  
 Retired Military  Veteran (VA Ineligible)  Veteran of the Vietnam Era  Vietnam & Other Protected Vet

**Military Leave Eligibility:**

Are you an active member of Air or Army National Guard or active member of the reserve corps of armed forces?  Yes  No

**EMPLOYMENT ELIGIBILITY PROOF -** An employee must produce within three days of hire, documentation that he/she is authorized to work in the United States. Examples include a birth certificate or social security card along with a driver's license or other picture ID, a U.S. passport or a green card. Please indicate the documentation you are providing:

1. \_\_\_\_\_ 2. \_\_\_\_\_

**DISABILITY STATUS:**  Disabled person (non-veteran with disability)  Disabled Veteran

# EEO AND EMERGENCY INFORMATION FORM

## Emergency Contact Component

**PRIMARY CONTACT – Please indicate who is your primary emergency contact (only one person).**

**EMERGENCY CONTACT NAME:** \_\_\_\_\_  
First Middle Name or Initial Last

**RELATIONSHIP TO EMPLOYEE:**  Adult Child  Child  Domestic Partner  Employee  Ex Spouse  Friend  
 Grandchild  Grandparent  Great Grandchild  Great Grandparent  In-law  Neighbor  Other Relative  
 Other  Parent  Parent In-law  Roommate  Sibling  Spouse  Step Child  Step Parent

**CONTACT'S HOME ADDRESS AND TELEPHONE:**  Same Address as Employee  
 Same Phone Number as Employee

If different from employee's, please complete information below.

Home Address \_\_\_\_\_  
Street or PO Box City County State Zip Code

Main Phone Number \_\_\_\_\_

Contact's Other Types of Phone Numbers (such as **work** cellular, pager or fax) – Indicate **type** of phone

Type \_\_\_\_\_ Phone No. \_\_\_\_\_ Type \_\_\_\_\_ Phone No. \_\_\_\_\_

**SECONDARY CONTACT – If you have one, please indicate who is your second emergency contact.**

**EMERGENCY CONTACT NAME:** \_\_\_\_\_  
First Middle Name or Initial Last

**RELATIONSHIP TO EMPLOYEE:**  Adult Child  Child  Domestic Partner  Employee  Ex Spouse  Friend  
 Grandchild  Grandparent  Great Grandchild  Great Grandparent  In-law  Neighbor  Other Relative  
 Other  Parent  Parent In-law  Roommate  Sibling  Spouse  Step Child  Step Parent

**CONTACT'S HOME ADDRESS AND TELEPHONE:**  Same Address as Employee  
 Same Phone Number as Employee

If different from employee's, please complete information below.

Home Address \_\_\_\_\_  
Street or PO Box City County State Zip Code

Main Phone Number \_\_\_\_\_

Contact's Other Types of Phone Numbers (such as **work** cellular, pager or fax) – Indicate **type** of phone

Type \_\_\_\_\_ Phone No. \_\_\_\_\_ Type \_\_\_\_\_ Phone No. \_\_\_\_\_

**X** **Employee Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

# Form W-4 (2019)

**Future developments.** For the latest information about any future developments related to Form W-4, such as legislation enacted after it was published, go to [www.irs.gov/FormW4](http://www.irs.gov/FormW4).

**Purpose.** Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

**Exemption from withholding.** You may claim exemption from withholding for 2019 if **both** of the following apply.

- For 2018 you had a right to a refund of all federal income tax withheld because you had **no tax liability, and**
- For 2019 you expect a refund of all federal income tax withheld because you expect to have **no tax liability.**

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2019 expires February 17, 2020. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

## General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2019 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at [www.irs.gov/W4App](http://www.irs.gov/W4App) to determine your tax withholding more accurately. Consider

using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income not subject to withholding outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2019. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

**Filers with multiple jobs or working spouses.** If you have more than one job at a time, or if you're married filing jointly and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

**Nonwage income.** If you have a large amount of nonwage income not subject to withholding, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Additional Income Worksheet on page 3 or the calculator at [www.irs.gov/W4App](http://www.irs.gov/W4App) to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at [www.irs.gov/W4App](http://www.irs.gov/W4App) to find out if you should adjust your withholding on Form W-4 or W-4P.

**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

### Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

**Line C. Head of household please note:** Generally, you may claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

**Line E. Child tax credit.** When you file your tax return, you may be eligible to claim a child tax credit for each of your eligible children. To qualify, the child must be under age 17 as of December 31, must be your dependent who lives with you for more than half the year, and must have a valid social security number. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

**Line F. Credit for other dependents.** When you file your tax return, you may be eligible to claim a credit for other dependents for whom a child tax credit can't be claimed, such as a qualifying child who doesn't meet the age or social security number requirement for the child tax credit, or a qualifying relative. To learn more about this credit, see Pub. 972. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total

----- Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records. -----

<b>Form W-4</b> Department of the Treasury Internal Revenue Service		<b>Employee's Withholding Allowance Certificate</b>		OMB No. 1545-0074 <span style="font-size: 2em; font-weight: bold;">2019</span>	
▶ Whether you're entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.					
1 Your first name and middle initial		Last name		2 Your social security number	
Home address (number and street or rural route)			3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note: If married filing separately, check "Married, but withhold at higher Single rate."		
City or town, state, and ZIP code			4 If your last name differs from that shown on your social security card, check here. You must call 800-772-1213 for a replacement card. ▶ <input type="checkbox"/>		
5 Total number of allowances you're claiming (from the applicable worksheet on the following pages) . . . . .				5	
6 Additional amount, if any, you want withheld from each paycheck . . . . .				6 \$	
7 I claim exemption from withholding for 2019, and I certify that I meet <b>both</b> of the following conditions for exemption.					
<ul style="list-style-type: none"> <li>• Last year I had a right to a refund of all federal income tax withheld because I had <b>no tax liability, and</b></li> <li>• This year I expect a refund of all federal income tax withheld because I expect to have <b>no tax liability.</b></li> </ul>					
If you meet both conditions, write "Exempt" here . . . . . ▶ 7					
Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.					
Employee's signature (This form is not valid unless you sign it.) ▶				Date ▶	
8 Employer's name and address (Employer: Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)			9 First date of employment		10 Employer identification number (EIN)

income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

**Line G. Other credits.** You may be able to reduce the tax withheld from your paycheck if you expect to claim other tax credits, such as tax credits for education (see Pub. 970). If you do so, your paycheck will be larger, but the amount of any refund that you receive when you file your tax return will be smaller. Follow the instructions for Worksheet 1-6 in Pub. 505 if you want to reduce your withholding to take these credits into account. Enter “-0-” on lines E and F if you use Worksheet 1-6.

### Deductions, Adjustments, and Additional Income Worksheet

Complete this worksheet to determine if you're able to reduce the tax withheld from your paycheck to account for your itemized deductions and other adjustments to income, such as IRA contributions. If you do so, your refund at the end of the year will be smaller, but your paycheck will be larger. You're not required to complete this worksheet or reduce your withholding if you don't wish to do so.

You can also use this worksheet to figure out how much to increase the tax withheld from your paycheck if you have a large amount of nonwage income not subject to withholding, such as interest or dividends.

Another option is to take these items into account and make your withholding more accurate by using the calculator at [www.irs.gov/W4App](http://www.irs.gov/W4App). If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

### Two-Earners/Multiple Jobs Worksheet

Complete this worksheet if you have more than one job at a time or are married filing jointly and have a working spouse. If you

don't complete this worksheet, you might have too little tax withheld. If so, you will owe tax when you file your tax return and might be subject to a penalty.

Figure the total number of allowances you're entitled to claim and any additional amount of tax to withhold on all jobs using worksheets from only one Form W-4. Claim all allowances on the W-4 that you or your spouse file for the highest paying job in your family and claim zero allowances on Forms W-4 filed for all other jobs. For example, if you earn \$60,000 per year and your spouse earns \$20,000, you should complete the worksheets to determine what to enter on lines 5 and 6 of your Form W-4, and your spouse should enter zero (“-0-”) on lines 5 and 6 of his or her Form W-4. See Pub. 505 for details.

Another option is to use the calculator at [www.irs.gov/W4App](http://www.irs.gov/W4App) to make your withholding more accurate.

**Tip:** If you have a working spouse and your incomes are similar, you can check the “Married, but withhold at higher Single rate” box instead of using this worksheet. If you choose this option, then each spouse should fill out the Personal Allowances Worksheet and check the “Married, but withhold at higher Single rate” box on Form W-4, but only one spouse should claim any allowances for credits or fill out the Deductions, Adjustments, and Additional Income Worksheet.

### Instructions for Employer

**Employees, do not complete box 8, 9, or 10. Your employer will complete these boxes if necessary.**

**New hire reporting.** Employers are required by law to report new employees to a designated State Directory of New Hires. Employers may use Form W-4, boxes 8, 9,

and 10 to comply with the new hire reporting requirement for a newly hired employee. A newly hired employee is an employee who hasn't previously been employed by the employer, or who was previously employed by the employer but has been separated from such prior employment for at least 60 consecutive days. Employers should contact the appropriate State Directory of New Hires to find out how to submit a copy of the completed Form W-4. For information and links to each designated State Directory of New Hires (including for U.S. territories), go to [www.acf.hhs.gov/css/employers](http://www.acf.hhs.gov/css/employers).

If an employer is sending a copy of Form W-4 to a designated State Directory of New Hires to comply with the new hire reporting requirement for a newly hired employee, complete boxes 8, 9, and 10 as follows.

**Box 8.** Enter the employer's name and address. If the employer is sending a copy of this form to a State Directory of New Hires, enter the address where child support agencies should send income withholding orders.

**Box 9.** If the employer is sending a copy of this form to a State Directory of New Hires, enter the employee's first date of employment, which is the date services for payment were first performed by the employee. If the employer rehired the employee after the employee had been separated from the employer's service for at least 60 days, enter the rehire date.

**Box 10.** Enter the employer's employer identification number (EIN).

**Personal Allowances Worksheet (Keep for your records.)**

- A** Enter "1" for yourself . . . . . **A** \_\_\_\_\_
- B** Enter "1" if you will file as married filing jointly . . . . . **B** \_\_\_\_\_
- C** Enter "1" if you will file as head of household . . . . . **C** \_\_\_\_\_
- D** Enter "1" if: {
  - You're single, or married filing separately, and have only one job; or
  - You're married filing jointly, have only one job, and your spouse doesn't work; or
  - Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.
 } **D** \_\_\_\_\_
- E** **Child tax credit.** See Pub. 972, Child Tax Credit, for more information.
  - If your total income will be less than \$71,201 (\$103,351 if married filing jointly), enter "4" for each eligible child.
  - If your total income will be from \$71,201 to \$179,050 (\$103,351 to \$345,850 if married filing jointly), enter "2" for each eligible child.
  - If your total income will be from \$179,051 to \$200,000 (\$345,851 to \$400,000 if married filing jointly), enter "1" for each eligible child.
  - If your total income will be higher than \$200,000 (\$400,000 if married filing jointly), enter "-0-" . . . . . **E** \_\_\_\_\_
- F** **Credit for other dependents.** See Pub. 972, Child Tax Credit, for more information.
  - If your total income will be less than \$71,201 (\$103,351 if married filing jointly), enter "1" for each eligible dependent.
  - If your total income will be from \$71,201 to \$179,050 (\$103,351 to \$345,850 if married filing jointly), enter "1" for every two dependents (for example, "-0-" for one dependent, "1" if you have two or three dependents, and "2" if you have four dependents).
  - If your total income will be higher than \$179,050 (\$345,850 if married filing jointly), enter "-0-" . . . . . **F** \_\_\_\_\_
- G** **Other credits.** If you have other credits, see Worksheet 1-6 of Pub. 505 and enter the amount from that worksheet here. If you use Worksheet 1-6, enter "-0-" on lines E and F . . . . . **G** \_\_\_\_\_
- H** Add lines A through G and enter the total here . . . . . **H** \_\_\_\_\_

For accuracy, complete all worksheets that apply.

- If you plan to itemize or claim adjustments to income and want to reduce your withholding, or if you have a large amount of nonwage income not subject to withholding and want to increase your withholding, see the **Deductions, Adjustments, and Additional Income Worksheet** below.
- If you have more than one job at a time or are married filing jointly and you and your spouse both work, and the combined earnings from all jobs exceed \$53,000 (\$24,450 if married filing jointly), see the **Two-Earners/Multiple Jobs Worksheet** on page 4 to avoid having too little tax withheld.
- If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 above.

**Deductions, Adjustments, and Additional Income Worksheet**

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

- 1** Enter an estimate of your 2019 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 10% of your income. See Pub. 505 for details . . . . . **1** \$ \_\_\_\_\_
- 2** Enter: {
  - \$24,400 if you're married filing jointly or qualifying widow(er)
  - \$18,350 if you're head of household
  - \$12,200 if you're single or married filing separately
 } . . . . . **2** \$ \_\_\_\_\_
- 3** Subtract line 2 from line 1. If zero or less, enter "-0-" . . . . . **3** \$ \_\_\_\_\_
- 4** Enter an estimate of your 2019 adjustments to income, qualified business income deduction, and any additional standard deduction for age or blindness (see Pub. 505 for information about these items) . . . . . **4** \$ \_\_\_\_\_
- 5** Add lines 3 and 4 and enter the total . . . . . **5** \$ \_\_\_\_\_
- 6** Enter an estimate of your 2019 nonwage income not subject to withholding (such as dividends or interest) . . . . . **6** \$ \_\_\_\_\_
- 7** Subtract line 6 from line 5. If zero, enter "-0-". If less than zero, enter the amount in parentheses . . . . . **7** \$ \_\_\_\_\_
- 8** Divide the amount on line 7 by \$4,200 and enter the result here. If a negative amount, enter in parentheses. Drop any fraction . . . . . **8** \_\_\_\_\_
- 9** Enter the number from the **Personal Allowances Worksheet**, line H, above . . . . . **9** \_\_\_\_\_
- 10** Add lines 8 and 9 and enter the total here. If zero or less, enter "-0-". If you plan to use the **Two-Earners/Multiple Jobs Worksheet**, also enter this total on line 1 of that worksheet on page 4. Otherwise, stop here and enter this total on Form W-4, line 5, page 1 . . . . . **10** \_\_\_\_\_

### Two-Earners/Multiple Jobs Worksheet

**Note:** Use this worksheet *only* if the instructions under line H from the **Personal Allowances Worksheet** direct you here.

- 1 Enter the number from the **Personal Allowances Worksheet**, line H, page 3 (or, if you used the **Deductions, Adjustments, and Additional Income Worksheet** on page 3, the number from line 10 of that worksheet) . . . . . **1** \_\_\_\_\_
  - 2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However**, if you're married filing jointly and wages from the highest paying job are \$75,000 or less and the combined wages for you and your spouse are \$107,000 or less, don't enter more than "3" . . . . . **2** \_\_\_\_\_
  - 3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet . . . . . **3** \_\_\_\_\_
- Note:** If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.
- 4 Enter the number from line 2 of this worksheet . . . . . **4** \_\_\_\_\_
  - 5 Enter the number from line 1 of this worksheet . . . . . **5** \_\_\_\_\_
  - 6 **Subtract** line 5 from line 4 . . . . . **6** \_\_\_\_\_
  - 7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . . . **7** \$ \_\_\_\_\_
  - 8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . . . . **8** \$ \_\_\_\_\_
  - 9 **Divide** line 8 by the number of pay periods remaining in 2019. For example, divide by 18 if you're paid every 2 weeks and you complete this form on a date in late April when there are 18 pay periods remaining in 2019. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck . . . . . **9** \$ \_\_\_\_\_

Table 1				Table 2			
Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from <b>LOWEST</b> paying job are—	Enter on line 2 above	If wages from <b>LOWEST</b> paying job are—	Enter on line 2 above	If wages from <b>HIGHEST</b> paying job are—	Enter on line 7 above	If wages from <b>HIGHEST</b> paying job are—	Enter on line 7 above
\$0 - \$5,000	0	\$0 - \$7,000	0	\$0 - \$24,900	\$420	\$0 - \$7,200	\$420
5,001 - 9,500	1	7,001 - 13,000	1	24,901 - 84,450	500	7,201 - 36,975	500
9,501 - 19,500	2	13,001 - 27,500	2	84,451 - 173,900	910	36,976 - 81,700	910
19,501 - 35,000	3	27,501 - 32,000	3	173,901 - 326,950	1,000	81,701 - 158,225	1,000
35,001 - 40,000	4	32,001 - 40,000	4	326,951 - 413,700	1,330	158,226 - 201,600	1,330
40,001 - 46,000	5	40,001 - 60,000	5	413,701 - 617,850	1,450	201,601 - 507,800	1,450
46,001 - 55,000	6	60,001 - 75,000	6	617,851 and over	1,540	507,801 and over	1,540
55,001 - 60,000	7	75,001 - 85,000	7				
60,001 - 70,000	8	85,001 - 95,000	8				
70,001 - 75,000	9	95,001 - 100,000	9				
75,001 - 85,000	10	100,001 - 110,000	10				
85,001 - 95,000	11	110,001 - 115,000	11				
95,001 - 125,000	12	115,001 - 125,000	12				
125,001 - 155,000	13	125,001 - 135,000	13				
155,001 - 165,000	14	135,001 - 145,000	14				
165,001 - 175,000	15	145,001 - 160,000	15				
175,001 - 180,000	16	160,001 - 180,000	16				
180,001 - 195,000	17	180,001 and over	17				
195,001 - 205,000	18						
205,001 and over	19						

**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 who claims no withholding allowances; 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 aren't required to provide the information requested on a form that's 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.





**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):

<input type="checkbox"/> 1. A citizen of the United States	
<input type="checkbox"/> 2. A noncitizen national of the United States ( <i>See instructions</i> )	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 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. ( <i>See instructions</i> )	
<p><i>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.</i></p> <p>1. Alien Registration Number/USCIS Number: _____  <b>OR</b>          2. Form I-94 Admission Number: _____  <b>OR</b>          3. Foreign Passport Number: _____          Country of Issuance: _____</p>	
<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;">           QR Code - Section 1            Do Not Write In This Space         </div>	

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



*Employer Completes Next Page*





**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.")*

<b>Employee Info from Section 1</b>	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
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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		Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space
Issuing Authority				
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.)*

<b>A. New Name (if applicable)</b>			<b>B. Date of Rehire (if applicable)</b>
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)
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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
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## 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
<ol style="list-style-type: none"> <li>1. U.S. Passport or U.S. Passport Card</li> <li>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</li> <li>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</li> <li>4. Employment Authorization Document that contains a photograph (Form I-766)</li> <li>5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status:                             <ol style="list-style-type: none"> <li>a. Foreign passport; and</li> <li>b. Form I-94 or Form I-94A that has the following:                                     <ol style="list-style-type: none"> <li>(1) The same name as the passport; and</li> <li>(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.</li> </ol> </li> </ol> </li> <li>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</li> </ol>	OR	<ol style="list-style-type: none"> <li>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</li> <li>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</li> <li>3. School ID card with a photograph</li> <li>4. Voter's registration card</li> <li>5. U.S. Military card or draft record</li> <li>6. Military dependent's ID card</li> <li>7. U.S. Coast Guard Merchant Mariner Card</li> <li>8. Native American tribal document</li> <li>9. Driver's license issued by a Canadian government authority</li> <li style="text-align: center;"><b>For persons under age 18 who are unable to present a document listed above:</b></li> <li>10. School record or report card</li> <li>11. Clinic, doctor, or hospital record</li> <li>12. Day-care or nursery school record</li> </ol>	AND	<ol style="list-style-type: none"> <li>1. A Social Security Account Number card, unless the card includes one of the following restrictions:                             <ol style="list-style-type: none"> <li>(1) NOT VALID FOR EMPLOYMENT</li> <li>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</li> <li>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</li> </ol> </li> <li>2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)</li> <li>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</li> <li>4. Native American tribal document</li> <li>5. U.S. Citizen ID Card (Form I-197)</li> <li>6. Identification Card for Use of Resident Citizen in the United States (Form I-179)</li> <li>7. Employment authorization document issued by the Department of Homeland Security</li> </ol>

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  
ACKNOWLEDGEMENT**

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



## PUBLIC EMPLOYEES' RETIREMENT SYSTEM (PERS) OPTIONAL MEMBERSHIP ELECTION

**(Do not give this form to PERS retirees.)**

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
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### EMPLOYER INFORMATION – to be completed by employer

Employee's Hire Date	Employing Agency <p style="text-align: center;">DNRC</p>	Employer Number <p style="text-align: center;">576</p>
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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 <p style="text-align: center;">Tammy Stineback</p>	Title <p style="text-align: center;">Payroll Supervisor</p>	Phone Number ( 406 ) 444-5735
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Signature	Date
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**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



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

MEMBER INFORMATION				
Last Name		First Name, MI		Social Security Number*
Date of Birth / /	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Employing Agency		MPERA Assigned Employer Number
Member's Mailing Address				
City		State	Zip Code	
Daytime Phone Number ( )		Email Address		
PRIMARY AND/OR CONTINGENT BENEFICIARY DESIGNATION				
<input type="checkbox"/> I wish to retain the PERS beneficiary designation currently on file with MPERA.				
<p><b>Completion of this section revokes all prior beneficiary designations.</b> 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 (for the benefit of a natural person only), a charitable organization or your estate as a primary or contingent beneficiary, you will also need to complete the "Other designation" section.</p>				
<p><b>Primary Beneficiary</b> - attach additional list if necessary.</p>				
Full Name	Relationship	Birth Date	SSN	Allocation
				%
				%
				%
<p><b>Contingent Beneficiary (optional)</b> - attach additional list if necessary.</p>				
Full Name	Relationship	Birth Date	SSN	Allocation
				%
				%
				%
<b>Other designation</b>				
Name of Trust, Charity or Estate		Trustee/Contact Name		Address
REQUIRED SIGNATURES				
Member Signature			Date	
Witness Name printed (not a beneficiary)		Signature		Date

## Statement of Selective Service Registration Status

If you are a male born on or after January 1, 1960, and are at least 18 years of age, the Montana Compliance with Military Selective Service Act requires that you register with the Selective Service System unless you meet certain exemptions under Selective Service law. If you are required to register, but fail to do so, you are not eligible for employment with the state of Montana

### Certification of Registration Status

Check one:

- I certify I am registered with the Selective Service System.
- I certify I am exempt from the registration requirements of Selective Service.
- I certify I have not registered with the Selective Service System.
- I certify I have not reached my 18<sup>th</sup> birthday and understand I am required to register at that time.

### Non-registered Men Under Age 26

If you have reached your 18<sup>th</sup> birthday, are under age 26, and have not registered, you should register promptly. State of Montana agencies are prohibited from hiring you unless you are registered.

### Non-registered Men Age 26 or Over

If you were born on January 1, 1960 or later, and were required to register but did not do so, you can no longer register under Selective Service law. State of Montana agencies are prohibited from hiring you unless you can prove that your failure to register was neither knowing nor willful. You may request that an agency make a decision regarding your failure to register. Return this certification statement to the agency along with a written statement that requests a review and explains the reasons for your failure to register. You also should submit other documentation that proves your failure to register was neither knowing nor willful.

### False Statement Notification

A false statement may be grounds for not hiring you, or for dismissing you if you have already begun work. Also, you may be punished by fine or imprisonment.

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Legal signature of individual

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Date signed

## Confirmation of Receipt of DNRC Policies by 90-Day Short Term Employee

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:

	Policy Name	Number	Date	Initials
1.	Drug Free Workplace Policy	P-DNC-HR-022	06/25/02	
2.	Drug & Alcohol Testing Policy	P-DNRC-HR-006	10/03/95	
3.	Drug & Alcohol Testing Addendum	P-DNRC-HR-006A	11/01/96	
4.	Electronic Mail Policy	P-DNRC-IT-006 (DOA)	06/03/11	
5.	Family & Medical Leave Act Policy	P-DNRC-HR-001 (DOA)	09/20/13	
6.	Fuel Card Policy	P-DNRC-OP-10	01/31/13	
7.	Employee Use of Information Technology	P-DNRC-IT-001 (DOA)	10/01/12	
8.	Model Rules of Conduct	P-DNRC-HR-041	11/18/07	
9.	Overtime & Non-Exempt Comp Time	P-DNRC-HR-008 (DOA)	09/21/12	
10.	Probationary Requirements Policy	P-DNRC-HR-048 (DOA)	09/21/12	
11.	Public Information Policy	P-DNRC-OP-004	09/10/12	
12.	Seat Belt Policy	P-DNRC-OP-008	12/21/01	
13.	Sexual Harassment Policy	P-DNRC-HR-004	09/05/95	
14.	EEO & Non-Discrimination	P-DNRC-HR-017 (DOA)	03/18/13	
15.	Employee's Guide: Standards of Conduct	G-DNRC-HR-007 (DOA)	03/01/11	
16.	Substance Abuse/Use Policy	P-DNRC-HR-010	11/21/95	
17.	Telecommunication Policy	P-DNRC-IT-002	09/05/12	
18.	Travel Policy	P-DNRC-OP-022	12/23/04	
19.	State Vehicle Use (Tort Defense) ARM	P-DNRC-HR-037	03/08/13	
	Additional Policies:			
	Additional Policies:			
	Additional Policies:			

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

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

# **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

<b>A NAME OF EMPLOYEE</b> <i>(last, first, middle initial)</i>			<b>D DEPOSITOR ACCOUNT NUMBER</b>																																		
ADDRESS <i>(street, route, P.O. Box, APO/FPO)</i>			<table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>																																		
CITY	STATE	ZIP CODE	<b>E DEPOSITOR ROUTING NUMBER</b>																																		
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<b>B TYPE OF DEPOSITOR ACCOUNT</b> <input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS			<b>PAYEE/JOINT PAYEE CERTIFICATION</b>																																		
<b>C THIS BOX FOR ALLOTMENT OF PAYMENT ONLY (if applicable)</b>			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.																																		
TYPE	AMOUNT																																				

## SECTION 2 ATTACHED A VOIDED CHECK

Attach a voided copy of your check here.

<b>SIGNATURE</b>	<b>DATE</b>

**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**

**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.

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Employee Signature

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Authorizing Official's Signature

---

Employee Printed Name

---

Authorizing Official Printed Name

---

Date

---

Date

**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.**

# Incident Behavior

## Common Responsibilities Volunteers and Single Resource Casual Hires

### Inappropriate Behavior:

It is extremely important that inappropriate behavior be recognized and dealt with promptly. Inappropriate behavior is all forms of harassment including sexual and racial harassment.

**Harassment in any form will not be tolerated.** When you observe or hear of inappropriate behavior you should:

- Inform and educate subordinates of their rights and responsibilities.
  - Tell the harasser to stop the offensive conduct.
- Provide support to the victim.
- Report the incident to your supervisor and the individuals' supervisor, if the behavior continues. Disciplinary action may be necessary.
- Develop appropriate corrective measures.
- Document inappropriate behavior and report it to the appropriate incident manager or agency official.
- While working in and around private property, recognize and respect all private property.

### Drugs and Alcohol:

- Non-prescription unlawful drugs and alcohol are not permitted at the incident.
- Use of medical marijuana on incidents is prohibited.
- Possession or use of these substances will result in disciplinary action.
- During off-incident rest periods, personnel are responsible for proper conduct and maintenance of fitness for duty. Drug or alcohol abuse resulting in unfitness for duty will result in disciplinary action.
- Be a positive role model. Do not be involved with drug or alcohol abuse.
- Report any observed drug or alcohol abuse to your supervisor.

I have read and I understand the above described incident behavior responsibilities:

---

Signature

---

Date

**DNRC Telecommunication Policy - Appendix A  
Device Activation/Change/Inactivation Form**

Requester: \_\_\_\_\_ Request Date: \_\_\_\_\_

**Type of Submission (check all that apply):**

- New Account Activation       Inactivate Account       Change Assigned/Shared User  
 New Device Activation       Inactivate Device       Change Device or Carrier

**Type of Device:**

- Simple Cellular Phone     \*Smart Phone     \*Tablet     \*Air Card     \*Other \_\_\_\_\_

**Job Responsibilities that Justify Issuing a Cellular or Mobile Device:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

1. All employees using these devices are responsible for reading the Telecommunication Policy and signing below.
2. Employees who will use a mobile device (such as a PDA, smart phone, tablet, or air card), are responsible for also reading the DNRC Mobile Device Procedures and signing below.

***I have read the DNRC Telecommunications Policy and agree with the terms and conditions.***

\*If for a mobile device:

***I have also read the DNRC Mobile Device Procedures and agree with the terms and conditions.***

**Employee name (print):** \_\_\_\_\_ **Signature:** \_\_\_\_\_

*Assigned User*

**Employee name (print):** \_\_\_\_\_ **Signature:** \_\_\_\_\_

*Shared User*

**Employee name (print):** \_\_\_\_\_ **Signature:** \_\_\_\_\_

*Shared User*

*Names and signatures of additional shared users can be written on the back or attached.*

Please document related details below.

Device Details	New Device	Existing Device
Phone Number		
Service Provider		
Make / Model		
Purchase Date		
Division/Bureau/Section		
Org Number		
<b>Only for Mobile Device</b>		
<b>Operating System</b>	<input type="checkbox"/> iOS (Apple) <input type="checkbox"/> Android	

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
 Div. Administrator/Designee

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
 OIT Review

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
 Direct Supervisor

*Please attach any additional information to this document  
and send submissions to DNRC Office of Information Technology.*

**DNRC Telecommunication Policy - Appendix B**  
**DNRC Personal Device Use and**  
**Request for Personal Mobile Service Package Reimbursement**

Requester: \_\_\_\_\_ Request Date: \_\_\_\_\_

User Info	
Name	
Employee ID	
Division	
Bureau/Office/Unit	
Device Info	
Device Service Provider	
Account #	
Device Phone Number	
Device Make / Model	
Device Operating System	<input type="checkbox"/> iOS (Apple) <input type="checkbox"/> Android
If Requesting Reimbursement	
Org Number (for billing)	
Actual Monthly Data Package Cost	\$ _____

If for reimbursement: Detail job responsibilities that justify the necessity for reimbursement for data package. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

***I have read the DNRC Telecommunications Policy and DNRC Mobile Device Procedures and agree with the terms and conditions of each.***

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

<b>Direct Supervisor</b>	<input type="checkbox"/> Approve	<input type="checkbox"/> *Deny
Signature: _____	Date: _____	
<b>Division Administrator/Designee</b>	<input type="checkbox"/> Approve	<input type="checkbox"/> *Deny
Signature: _____	Date: _____	
<b>OIT</b>	<input type="checkbox"/> Approve	<input type="checkbox"/> *Deny
Signature: _____	Date: _____	

\*If denied, please explain reason for denial to employee

- For reimbursement: Attach copy of mobile phone statement with **employee name** and **mobile service package cost specifically associated with the cell phone being used for state business** highlighted.
- Submit document(s) to the DNRC Office of Information Technology for processing.

**GENERAL SERVICES DIVISION  
DEPARTMENT OF ADMINISTRATION  
444-3060**

**EMPLOYEE IDENTIFICATION OR BUILDING ACCESS CARD AUTHORIZATION  
FOR STATE EMPLOYEES ONLY**

Name: \_\_\_\_\_

(Please Type or Print Clearly)

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

(Out of Town Requests Only)

Department: \_\_\_\_\_

- Division: \_\_\_\_\_ Director's Office  
 \_\_\_\_\_ Board of Oil & Gas Conservation Division  
 \_\_\_\_\_ Conservation & Resource Development Division  
 \_\_\_\_\_ Water Resources Division  
 \_\_\_\_\_ Forestry Division  
 \_\_\_\_\_ Trust Land Management Division

Employee #: \_\_\_\_\_

Badge # (if assigned by your agency; otherwise GSD will assign this number): \_\_\_\_\_

What building does this employee need access to? \_\_\_\_\_

Access Level Requested: Please select one choice.

Identification Card Only Requires No Access Card \$10.00 per card  	<b>Low Level Access</b> 5:00 A.M. – 11:00 P.M. Monday thru Friday  	<b>Mid Level Access</b> 5:00 A.M. to 11:00 P.M. 7 days  	<b>High Level Access*</b> 24 hours - 7 days a week  
--	--	--	--

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Official Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
**Please Print** Authorized Official Name

**Must have original signatures – photocopies WILL NOT be accepted.**  
**Note:** The first access card is issued at no cost to the agency if access is to a facility serviced by the Department of Administration. Access cards issued to agencies for buildings not under the DOA umbrella will be charged \$10.00 per access card. Replacement cards are issued to the agencies at the cost of \$10.00 per card.  
 Contact General Services at 444-3060 if you do not know whom, in your agency, is authorized to sign this form.

**GENERAL SERVICES DIVISION  
DEPARTMENT OF ADMINISTRATION  
444-3060**

**EMPLOYEE IDENTIFICATION OR BUILDING ACCESS CARD  
AUTHORIZATION  
FOR STATE EMPLOYEES/INTERN ONLY**

Name: \_\_\_\_\_ Department: DNRC \_\_\_\_\_  
(Please Type or Print Clearly)

Division: \_\_\_\_\_ Employee #: \_\_\_\_\_

**(Out of Helena Requests Only)**

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Badge # (if assigned by your agency; otherwise General Services Division will assign this number):

\_\_\_\_\_

What building does this employee need access to? \_\_\_\_\_

Access Level Requested: Please select one choice(s) necessary to do assigned duties.

Check Below	Approved Access Level	Type of Access
	General Access	General
	Central Storage Access	Elevated
	Human Resource Access	Elevated
	OIT Access	Elevated
	I.D. Card (No Access)	None
	Intern I.D. Card (General Access)	General

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Official Signature

\_\_\_\_\_  
Date

Check name of Authorized Official who signed above:

- Christy Stapley, Human Resource Manager
- Kelly Bishop, Human Resource Specialist
- Paige Tabor, Safety Specialist
- Kerry S. Davant, Chief of Staff

Must have original signatures – photocopies **WILL NOT** be accepted.

Note: The first access card is issued at no cost to the agency if access is to a facility serviced by the Department of Administration. Access cards issued to agencies for buildings not under the DOA umbrella will be charged \$10.00 per access card. Replacement cards are issued to the agencies at the cost of \$10.00 per card.

Contact General Services at 444-3060 if you do not know whom, in your agency, is authorized to sign this form.



**State of Montana**

**Employee Agreement to Accept the U.S. Bank Visa® Purchasing Card**

The U.S. Bank Visa® Purchasing Card represents the State's trust in you. You are empowered as a responsible agent to safeguard the State's assets. Your signature below is verification that you have read the Policies and Procedures and agree to comply with it as well as the following responsibilities. It also acknowledges that you have received the U.S. Bank Visa® Purchasing Card

1. I understand the card is for State-approved purchases only, and I agree not to charge personal purchases.
2. I will follow the established procedures for using the Purchasing Card. Improper use of this card can be considered misappropriation of State funds. This may result in disciplinary actions, including termination of employment, criminal action or civil liability.
3. If the card is lost or stolen, I will immediately notify U.S. Bank by telephone. I will confirm the telephone call by mail or facsimile with a copy of the notification to the Program Administrator.
4. I agree to surrender the card immediately upon termination of employment, whether for retirement, voluntary or involuntary reasons.
5. The card is issued in my name. I will not allow any other person to use the card. I am considered responsible for any and all charges against the card.
6. All charges will be billed directly to and paid directly by the State. The bank cannot accept any monies from me directly; therefore any personal charges billed to the State could be considered misappropriation of State funds.
7. As the card is State property, I understand that I may be periodically required to comply with internal control procedures designed to protect State assets. This may include being asked to produce the card to validate its existence and account number. I may also be asked to produce receipts and statements to audit its use.
8. I will receive a Monthly Statement, which will report all activity during the statement period. Since I am responsible for all charges (but not for payment) on the card, I will resolve any discrepancies by either contacting the supplier or the bank.
9. I understand the U.S. Bank Purchasing Card is not necessarily provided to all employees. Assignment is based on my need to purchase materials for the business. My card may be revoked based on change of assignment or location. I understand that the card is not an entitlement nor reflective of title or position.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Supervisor Signature

\_\_\_\_\_  
Employee Printed Name

\_\_\_\_\_  
Supervisor Printed Name

Date: \_\_\_\_\_

Date: \_\_\_\_\_



**STATE OF MONTANA**  
**Department of Natural Resources**  
**and Conservation**

# **PROCARD HOLDER MANUAL**

*“As employees involved in the expenditure of public funds, we are called upon to avoid even the appearance of impropriety and to conduct our business in a manner above reproach in every respect.”*

# **USING THE STATE'S PROCARD PROGRAM**

## **USER'S MANUAL**

The ProCard Program was established by the Department of Administration (DOA) to provide state employees with a method of paying for and managing purchases.

In order to receive your ProCard, please read this manual, complete the attached application and Cardholder Agreement and give them to your supervisor. Keep this manual, and any future revisions for your use.

### **CARDHOLDER RESPONSIBILITIES:**

1. Comply with departmental procurement and expenditure policies.
2. Ensure that the ProCard is used whenever legal and possible.
3. Attach all itemized sales slips/register receipts to monthly ProCard statements and submit to Financial Services Office (FSO) in Helena (submit statement to FSO even if the balance is \$0).
4. Report lost or stolen cards to US Bank immediately (24 hours a day). Report the loss or theft to your supervisor and ProCard Department Coordinator at the first opportunity during business hours.

### **PROCARD CANNOT BE USED FOR THE FOLLOWING:**

1. Personal purchases or entertainment;
2. Cash advances;
3. Charges which exceed allowable lodging amounts for business purposes;
4. Health and medical services; with the exception of DOT physical exams;
5. Standard Merchant Category exclusions (e.g., liquor stores, cigar stores, grizzlies tickets etc.);
6. Entertainment;
7. Individual meals (multiple meals may be purchased for fire crews during active fire duty only);
8. Split charges in order to avoid exceeding the individual transaction limit;
9. The ProCard cannot be used by anyone other than the cardholder whose name is embossed on the card; or
10. Fuel and related state vehicle purchases unless you are unable to use the State's Vehicle Purchasing Fleet Card. If the ProCard is used for fuel instead of the Fleet Card, we will not automatically receive the \$0.18 per gallon tax rebate (we have to request the rebate later).

### **PENALTY FOR CARD MISUSE**

Employees who misuse the ProCard are subject to the DNRC discipline handling policy.

### **KEY CONTACTS**

The following resources are available to answer any questions you may have, or help solve problems that may arise:

- a. **To report your ProCard lost or stolen please call:**  
US Bank (24 hours/day)  
Lost/Stolen Card Service:  
1-800-344-5696  
AND  
Cathlien Butler (during normal business hours)

[cbutler@mt.gov](mailto:cbutler@mt.gov)

Accounting Technician  
DNRC Financial Services Office  
(406) 444-4260

**b. ProCard Customer Service (10 a.m. - 8 p.m. Eastern Time):**

US Bank  
Purchasing Card Customer Service 1-800-344-5696

**c. DNRC ProCard Coordinator-Questions, Answers and Payments:**

Name: Cathlien Butler  
[cbutler@mt.gov](mailto:cbutler@mt.gov)  
Accounting Technician  
DNRC Financial Services Office  
Phone: (406) 444-4260  
FAX: (406) 444-2684  
PO Box 201601  
Helena, MT 59620-1601

**d. ProCard Program Administrator:**

Name: Rick Dorvall  
[rickdorvall@mt.gov](mailto:rickdorvall@mt.gov)  
Department of Administration  
State Procurement Bureau  
Phone: (406) 444-3366  
FAX: (406) 444-2529  
Room 165 Mitchell Building  
Helena, MT 59620-0135

## TO APPLY FOR A PROCARD

You can print the card application and agreement from the DNRC Intranet under Director's Office > Financial Services Office > ProCard. Open the "ProCard New Acct Info Form.pdf" and the "ProCard Employee Agreement Form.pdf". Fill out the application, have both the employee and supervisor sign the application and send it along with the signed agreement to the Helena FSO.

## GUIDELINES FOR CARD USE

### 1. Card Activation

When you receive your ProCard you will be instructed to call US Bank. In order to activate your ProCard they will ask you to enter your card account number and your social security number. When they ask for your social security number, you should enter the last four digits of your **employee number** rather than your social security number. When asked to enter your zip code, enter your city zip code+four. After this call, your ProCard is ready for use.

### 2. Card Use

The Visa based ProCard can be used by any vendor or merchant who accepts Visa and is in a Merchant Category group that was approved for your card. Your ProCard has also been given specific spending limits. The Merchant Categories and spending limits were determined by state guidelines and DNRC. Your DNRC ProCard Coordinator can tell you the Merchant

Categories and limits that were set for your ProCard.

If you experience denials when trying to use your ProCard, contact US Bank Customer Service with the date, dollar amount and approximate time of the attempted purchase, along with the merchant's name. They will be able to investigate to see if your Merchant Category or spending limits caused the denial.

### 3. Transaction Procedure

- a. When you make a ProCard transaction via the internet, the phone or through the mail, follow the procedures below:
  - I. Tell the supplier that you will be paying with your State ProCard. If it is a phone or mail order, give the merchant the ProCard number and the expiration date.
  - II. Retain all itemized receipts, invoices and ProCard slips.
  - III. Follow departmental procedures for approval and payment of your charges.
- b. When you make a transaction using the ProCard, the following procedures shall be followed:
  - I. Each ProCard is set up with a default organization number and a default account number (e.g. 50602 SW Fire Suppression and 62886-Procurement Card Default). The correct Org (if different from the default) and account number must be input into the SABHRS ProCard module on or before the 26<sup>th</sup> of each month by your proxy. If that does not occur, a journal voucher will be required the next month. It is imperative that the ProCard user notifies the proxy so they can make any necessary change prior to the 26<sup>th</sup> of each month.
- c. Upon request, SABHRS proxy access will be assigned to administrative/accounting staff in the local office. This will assist in the monitoring and administering of ProCard transactions.
- d. On or before the 28<sup>th</sup> of the month the statement with attached itemized receipts will be forwarded to the DNRC ProCard Coordinator. Otherwise the card transactions will record to the default center and account, which will result in financial reports being inaccurate. These reports will serve as an audit trail for ProCard transactions.
- e. When the card is used to make a purchase, the vendor transmits the charge information to US Bank, the administrator for the cards. The vendor will receive payment for the purchase within 48 to 72 hours. US Bank posts the data from card transactions to the Online Access system nightly. Every day, the previous day's ProCard transactions are loaded into the SABHRS system. Agency personnel are responsible for reviewing and approving the transactions prior to the end of the billing cycle, when the accounting entries and journals are generated. On the second to the last day of each month, transactions are posted to the state accounting system using the accounting information reflected for those transactions at that time. Purchases via the internet are to be made on secure websites whenever possible. Closely monitor your web browser security settings and security warnings.
- f. When making phone and mail orders, the cardholder should instruct the vendor to:
  - refrain from writing the credit card number on the shipping slip.
  - note on the shipping slip that the package is a credit card purchase.
  - note on the shipping slip that the package is to the attention of the card holder.
  - include the credit card slip inside the package.

## CHANGES TO CARD INFORMATION AND LIMITS

**General Card information-** phone number or mailing address changes to your ProCard account must be submitted (E-mail is sufficient) by your supervisor to the DNRC ProCard Coordinator. Name changes must be submitted directly to US Bank with proof of change (i.e. marriage license). See Key Contacts section above for US Bank contact information.

- 1. Change to Authorized \$ Limits-** The maximum monthly dollar amount established for most cards is \$5,000.00. In some cases (such as fire procurements or a one-time purchase of supplies or services pre-approved through Procurement and Contracting Bureau) the maximum amount may be changed. Additionally, the maximum charge amount can be set lower and we can limit the types of businesses where a card can be used. i.e. A card can be limited to only stores classified as hardware, automotive supply or foods stores, etc.

To request a single transaction dollar amount in excess of \$2,000, the Division Administrator or designee shall e-mail the DNRC ProCard Coordinator with who, why, for how long, how much etc. If the request is > \$15,000/month, the DNRC ProCard Coordinator may make a recommendation and solicit approval from the Division Administrator.

### 2. What If the Supplier Does Not Accept Credit Cards?

You may find suppliers who do not accept credit cards. If this happens, you have several options:

1. Thank the supplier for their time, and find one who will accept the Montana ProCard method of payment.
2. If it is a supplier you regularly use, explain the payment method and ask them if they are interested in obtaining the ability to accept credit cards. Suggest that they contact their commercial bank to obtain credit card services.
3. Contact your ProCard Program Administrator at DOA with the vendor's business name, address, phone and contact person's name.
4. Effective November 24<sup>th</sup>, 2007, virtually all DNRC local procurements should be made with the ProCard.

### 3. Credit Card Security

The ProCard should always be treated with a level of care that will secure the card and account number.

#### a. Storage of the ProCard

Keep your ProCard in an accessible--but secure--location.

#### b. Credit Card Account Number

Guard the ProCard account number carefully. Do not post it at your desk or write it in your day planner. Exercise caution when transmitting and handling receipts that contain account number and expiration dates.

#### c. Lost or Stolen Cards

Just like your personal credit cards, if the ProCard is lost or stolen you must immediately notify the US Bank (24 hours a day). Call US Bank at 1-800-344-5696. Notify your supervisor and DNRC ProCard Coordinator as soon as possible during business hours. If the cardholder is unable to contact US Bank, the DNRC ProCard Coordinator will order a replacement card.

### 4. What If I Leave State Service or No Longer Need My Card?

First, have your supervisor e-mail a request to the DNRC ProCard Coordinator to close your account. Then, cut up or shred your card through the magnetic strip and dispose of it. Your

card should be inactivated and destroyed if: (a) you leave state service; (b) move to a new job in which you will no longer require a ProCard or have to change your default codes; or (c) your account needs to be closed for any other reason.

#### **5. Disputed Items and Billing Errors**

- a. If you have a problem with an item that you purchased with the ProCard, you should first try to reach a resolution with the supplier or merchant who provided the item. In most cases, disputes can be resolved directly between the cardholder and the merchant. If an agreement cannot be reached with the supplier, the next step is to submit a "Customer Statement of Disputed Items" form to US Bank.
- b. If there is a billing error on your Cycle Report, submit a "Customer Statement of Disputed Items" form to US Bank. You should receive the form from US Bank in 1-2 weeks; fill out the form and return to US Bank
- c. Nearly all exceptions can be managed using steps 1 and 2. If you have been unable to obtain an acceptable resolution, call your DNRC ProCard Coordinator.
- d. If a dispute is resolved in your favor, the supplier or US Bank will initiate a credit to your account within 30 days.

#### **6. Credits**

The supplier or merchant shall issue you a credit on your ProCard account for any item returned. This credit will appear on your next statement.

#### **7. Will the ProCard Have Any Impact on the Cardholder's Personal Credit Reference?**

No. The ProCard is a corporate liability card, not a personal liability card. (You do have a responsibility to use the ProCard in a manner approved by the State and DNRC). See your Cardholder Agreement.

**State of Montana**

**Employee Agreement to Accept the U.S. Bank Visa® Purchasing Card**

The U.S. Bank Visa® Purchasing Card represents the State’s trust in you. You are empowered as a responsible agent to safeguard the State’s assets. Your signature below is verification that you have read the Policies and Procedures and agree to comply with it as well as the following responsibilities. It also acknowledges that you have received the U.S. Bank Visa® Purchasing Card

1. I understand the card is for State-approved purchases only, and I agree not to charge personal purchases.
2. I will follow the established procedures for using the Purchasing Card. Improper use of this card can be considered misappropriation of State funds. This may result in disciplinary actions, including termination of employment, criminal action or civil liability.
3. If the card is lost or stolen, I will immediately notify U.S. Bank by telephone (on the back of the card). I will confirm the telephone call by mail, e-mail or fax with a copy of the notification to the Program Administrator.
4. I agree to surrender the card immediately upon termination of employment, whether for retirement, voluntary or involuntary reasons.
5. The card is issued in my name. I will not allow any other person to use the card. I am considered responsible for any and all charges against the card.
6. All charges will be billed directly to and paid directly by the State. The bank cannot accept any monies from me directly; therefore, any personal charges billed to the State could be considered misappropriation of State funds.
7. As the card is State property, I understand that I may be periodically required to comply with internal control procedures designed to protect State assets. This may include being asked to produce the card to validate its existence and account number. I may also be asked to produce receipts and statements to audit its use.
8. I will receive a Monthly Statement, which will report all activity during the statement period. Since I am responsible for all charges (but not for payment) on the card, I will resolve any discrepancies by either contacting the supplier or US Bank.
9. I understand the U.S. Bank Purchasing Card is not necessarily provided to all employees. Assignment is based on my need to purchase materials for the business. My card may be revoked based on change of assignment or location. I understand that the card is not an entitlement nor reflective of title or position.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Supervisor Signature

\_\_\_\_\_  
Employee Printed Name

\_\_\_\_\_  
Supervisor Printed Name

Date: \_\_\_\_\_

Date: \_\_\_\_\_

**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 <input type="checkbox"/> Less Than High School <input type="checkbox"/> GED or High School Diploma <input type="checkbox"/> Beyond High School		Gender <input type="checkbox"/> Male <input type="checkbox"/> Unknown <input type="checkbox"/> Female		Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Not Married <input type="checkbox"/> 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 <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Volunteer			Number of days worked per week:		Wage: <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Other: <input type="checkbox"/> Day <input type="checkbox"/> BI-weekly <input type="checkbox"/> Year					
In addition to gross earnings cited above worker received: <input type="checkbox"/> Board & Room <input type="checkbox"/> Overtime <input type="checkbox"/> Bonus <input type="checkbox"/> Commissions <input type="checkbox"/> Other:					Estimated value if any:			Is sick leave available? Used? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No		
Worked next scheduled shift <input type="checkbox"/> Yes <input type="checkbox"/> No		Off work more than 4 work days <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure		Date Last Worked	Date of Return to work	Full wages paid for date of Injury? <input type="checkbox"/> yes <input type="checkbox"/> No		Salary continued? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Accident address or location: City: State: Postal code: -				
Date employer notified:	Accident reported to:			Safety equipment provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	Safety equipment used? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> No treatment <input type="checkbox"/> Emergency room <input type="checkbox"/> Treatment on-site by employer or medical Staff <input type="checkbox"/> Clinic/Dr. Office <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Employer is a <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company		Injured worker is a <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain fully. Use separate sheet if you need additional space.					Was worker injured while in your employ? <input type="checkbox"/> yes <input type="checkbox"/> 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) <input type="checkbox"/>	
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 CALENDARS

2019

JANUARY

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

FEBRUARY

S	M	T	W	TH	F	S
					1	2
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17	18	19	20	21	22	23
24	25	26	27	28		

MARCH

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17	18	19	20	21	22	23
24	25	26	27	28	29	30

APRIL

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MAY

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JUNE

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JULY

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AUGUST

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SEPTEMBER

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29	30					

OCTOBER

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NOVEMBER

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DECEMBER

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29	30	31				

PAYDAY ○

PAY PERIOD ENDING □

HOLIDAY ◇



## INSTRUCTIONS FOR TRAVEL EXPENSE VOUCHER

**NOTE: If the least-cost method of travel is not used, you MUST attach justification.**

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