Employee from Another Agency – EFF Hire Packet Forms and Policies

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

PLEASE PRINT ALL INFORMATION CLEARLY TO ENSURE PROMPT PAYMENT

EFF Name _____

Location _____ RFD/VFD _____

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

Sent to Payroll By: _____

(Contact Person) *(Date)*

Return this coversheet with documents checked to Payroll.

Required Forms #1-7 (Unless otherwise noted)		
1.		EFF Hiring Packet Checklist
2.		Emergency Fire Fighter Employment Form
3.		Decedent Warrant
4.		Social Security SSA-1945 (not covered by state)
6.		Ethics Acknowledgement Form
7.		Confirmation of Receipt of DNRC Policies by Emergency Firefighters (EFF's)
Optional - Include only as needed		
8.		Fuel Card Use Form
9.		RMTD Vehicle Use Acknowledgement Form
Reference & Information		
10.		EFF Information Sheet
11.		EFF Employment Conditions Acknowledgement
12.		State Fund 1st Report Instructions
13.		State Payroll Calendar
14.		Travel Voucher Instructions
15.		*Any Additional Documents:*

Home Agency Name: _____

Home Agency Payroll Contact: _____

Employee ID: _____

DNRC Area/Unit Office Personnel Only (57690024)

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

Signature Print Name & Position Date

Questions – Please Contact DNRC Payroll at 444-5735 Revised 2/3/2020

EMERGENCY FIREFIGHTER EMPLOYMENT FORM

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

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

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

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

Employee Contact Information below MUST be filled out.

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

Mailing Address	**Physical Address**

Cell Phone:	Home Phone:	Work/Other:

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

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

Emergency Contact Information:

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

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

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

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

Signature: _____ Date: _____

Revised 1/2020

LEGAL DESIGNATION OF PERSON AUTHORIZED TO RECEIVE DECEDENT'S WARRANTS

Instructions for Employee

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

Beneficiary Designation For Decedent's Final Warrants

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

All information is **required**.

Name of Designee _____
First Middle Last

Mailing Address _____
Street or PO Box City State Zip Code

Social Security Number _____ Date of Birth _____

My signature on this document indicates:

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

Employee Name _____ _____
First Middle Last Social Security Number

_____ _____
Employee Signature Date

Instructions to Employer

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

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

_____ _____ _____
Date of Death Certifying Officer Signature Date

FOR USE BY DEPARTMENT OF ADMINISTRATION - WARRANT WRITING

Agency Contact _____
Agency Phone # _____

Employee Name _____
Beneficiary Name _____
Vendor # _____

Voucher # _____
Done By _____
Approved by _____
Date _____ Date

Replacement # _____
Journal # _____
Approved By _____
Date Date Date

Social Security Administration

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

Employee Name _____ Employee ID # _____

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

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

Windfall Elimination Provision

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

Government Pension Offset Provision

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

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

For More Information

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

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

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

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

Employers must:

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

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

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

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

Signature of Employee _____ **Date** _____

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

The Montana Department of Natural Resources & Conservation

Ethics Policy Acknowledgement

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

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

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

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

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

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

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

Employee Name: _____
(Please print legibly)

_____ _____
(Employee signature) (Date signed)

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

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

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

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

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

_____ _____

Print Name Date