Required Document Check List

Dear Applicant,

In order to process your application and get you to work as fast as possible, we need **ALL** of the following documents below signed in all the appropriate places; In addition to any copies of certifications and Personal Identification Papers.

The numbered documents required below can be found at the bottom of our home page: nannysforgrannys.com/employment-information/ Scroll down and click Employment Information. Next you will then scroll down to where you will find a link that reads "Printable Required Mandatory Documents Link" Print and send all originals.

Social Security Number: _____ **Birth date** _____

Employees Pay Rate _____ **Tax Status** _____

Any questions feel free to call us and we will walk you through the process. 631-730-8500

- **Online Application Located at nannysforgrannys.com/employment-information/**
- **(Pgs-2R, 3R, 4R, 5R, 6R) Employee Code of Ethics and Conduct & Agreement**
- **(Pg-12R,13R) Two Reference Request Forms**
- **(Pg-15R,16R) I-9 Form**
- **Photo Copy from list of acceptable documents outlined on page (16A)**

U.S Passport		Native American Tribal Document
Permanent Resident Card with photo	Voters registration Card	Id card issued by federal, state or local government.
Employment Authorization Doc with Photo	U.S Military Card or Draft Record	U.S Coast Guard Merchant Mariner Card
State Driver's License with photograph	ID card issued by federal state or local government	Military Dependents ID card

- **Photo Copy of Social Security Card**
- **(Pg-17R) W-4 Form**
- **(Pg-19R) DOH CHRC Consent for Fingerprint and Criminal History Record Information**
- **(Pg-21R) Drug Test**
- **(Pg-22R) Pre-Employment Physical Assessment Report**
  (PPD, Chest X-ray, Rubella, Rubeola, Drug Screen, Flu Shot)
- **(Pg-23R) Test Positive PPD**
- **(Pg-24R) Hepatitis B Vaccination Dose Tracking**
- **(Pg-28R) Declination of Influenza Vaccination**
- **(Pg-29R) Influenza Vaccination Policy Acknowledgement of receipt**
- **(Pg-62R) Authorization For Release of Confidential HIV Related Information**
- **(Pg-63R) HIV Confidentiality Statement and Acknowledgement**
- **(Pg-165R) Home Health Aide Job Description**
- **(Pg-168R) Personal Care Aide Job Description**
- **(Pg-171R) Caregiver/Homemaker Job Description**
- **(Pg-188R) HHA & PCA Skills Assessment Answer Sheet**
- **(Pg-190R) Acknowledgement of Orientation**
- **(Pg-191R) Habituation Statement**
- **Copy of any Certifications (HHA, PCA's)**
- **Signed Pay Rate Form with Original Signature (No Photocopy)**

Nannys for Grannys
Employee Code of Ethics and Conduct Agreement
Agency Copy

***All employees are expected to be professional and respectful at all times when dealing with clients, family members and co-workers, remembering at all times that they are the representatives and employees of Nanny's for Granny's

Companions-HHA-PCA's and LPN's

- Are expected to follow the care plan as outlined.
- Always are expected to function within the scope of your job description.
- Abide by all HIPPA policies and procedures set forth by the agency
- If any changes in the home or client you are to notify the office immediately. **Initial**_____

Dress Code

- All employees are expected to dress according to agency/facility dress code at caregivers own expense
- If any client/facility requests a change in dress code, aide must inform agency of change request.
- Purchase of uniforms and/or cleaning is the sole expense of employee.
- **NO** jewelry, heavy makeup, big hair styles, heavy scented perfume
- **NO** chemical hair processing: Which includes but not limited to hair dressing of client or caregiver Whatsoever is expressly prohibited.
- **NO** provocative or inappropriate clothing. Ex: pajama pants, sweat pants, ripped clothing, low cut Blouses or shorts. Please dress professional! **Initial**_____

Agency ID Badge

- You are always expected to wear your agency ID badge at all times while on duty.
- ID badge must be returned to agency upon termination of employment. **Initial**_____

Inappropriate Behavior

- **ABSOLOUTELY NO drinking, smoking, use of drugs or controlled substances while on duty at any time**
- **ABSOLOUTELY NO use of slang or foul language while on duty at clients home**
- **ABSOLUTELY NO family, friends, acquaintances or pets of caregiver are ever allowed on premise while on duty.** **Initial**_____

Being On Time

- All aides are expected to arrive to all scheduled assignments on time. Please take travel time into Consideration during foul weather and or holiday schedules.
- If you cannot make it to a case due to *an* emergency, foul weather or if you expect to be late, you are required to notify the office immediately at **631-730-8500 during** regular business hours. On or after those times, you are required to leave a message on the answering machine at the number above.
- **PLEASE DO NOT EVER CALL THE CLIENT OR FAMILY DIRECT- CALL THE OFFICE IMMEDIATELY.**
- **LATENESS** or **NO SHOW** to a case or interview without properly notifying the office at least 3hrs in Advance will result in suspension, termination or having your name permanently removed from our roster. If after hours, leave message on the emergency line 631-730-8500
- Excessive absences or lateness will result in termination. **Initial**_____

2R

Time Off and Overtime

- Live in aides are required to devote no less than 13 hours of care to a client per 24 hour period, and are expected to have no less than 8 hours of sleep, (5 uninterrupted) and 3 hours personal calm time (downtime). If any of these requirements are not met it is the sole responsibility of caregiver to notify the agency immediately to rectify the situation and/or recommend changes to the care plan. Failure to do so will not make us liable. **Initial_____**
- "Live Out" or "hourly" caregivers as per DOL, mandates overtime at 1 1/2 times the regular rate of pay for all hours worked over 40.
- "Live In" caregivers as per DOL, mandates overtime at 11/2 times the regular rate of pay for all hours worked over 40.
- A "Time off Request Form" available from our website is required for all vacations or time off.
- Directions to Website> Nannysforgrannys.com> Scroll down to bottom of home page to Employment Information> Time off request form> Once completed> Submit. An "Auto Reply" will be sent as a confirmation to your email if completed correctly. No verbal times will be accepted **Initial_____**

Being Relieved

- If for any reason there is an incident or accident on the job, Call 911 if necessary, followed by a phone call to the office 631-730-8500.
- If you are to be relieved by someone else, it is understood that you are to NEVER LEAVE CLIENT UNATTENDED FOR ANY REASON" until relief aid has arrived. Additional compensation will be provided. Leaving a clients home or unattended is considered "Abandonment" and grounds for immediate termination.
- When a shift replacement arrives for relief, it is the caregiver that is being relieved to review plan of care with relief aide to discuss client's present condition, well being, changes in clients general behavior and or physical condition, duties performed and relay any modifications or changes that need to be addressed for the well being and safety of client. **Initial_____**

Change of hours

- If the client or family requests that you stay longer than outlined in your assignment, or there is change in plan of care, or the need to leave earlier due to a personal emergency, it is mandatory to notify Nanny's for Granny's 631-730-8500 forimmediately for approval and replacement. **Initial_____**

Outline of Services

- Outline of services to be performed by caregiver are outlined as follows and are to be provided for the client exclusively unless otherwise specified in care plan. Companionship, conversation, prepare grocery lists, clip coupons, plan, prepare, cook and clean up after meals, plan outings, trips, visit neighbors and friends within walking distance, monitor diet and eating, check food expirations, assist with morning wake up and preparation if needed, assist with evening tuck in preparation if needed. Arrange appointments and provide reminders, provide medication reminders, double check amounts but "NOT" administer medications, assist with walking, assist with getting in and out of shower or bathroom, answer the door, telephone, assist with clothing selection, care for houseplants, participate in craft projects, play games, cards etc, over see home deliveries, escorting to appointments, accompany to luncheons, dinners, escort for shopping, religious services. Provide light housekeeping ex: dusting, washing dishes, light vacuuming, taking out the garbage, making beds, changing sheets, laundry, and ironing. (Not to exceed 20% of the caregivers daily hours worked) **Initial_____**

Medications

- As an employee of Nannys for Grannys, you herby acknowledge that you WILL NOT UNDER ANY CIRCUMSTANCE DISPENSE OR ADMINISTER ANY MEDICATION AT ANYTIME, you are only approved for medication reminders **Initial_____**

Accepting Money or Gifts

- UNDER NO CIRCUMSTANCE are you to ask for, or accept any money from your client or take home property that belongs to the client, even if the client's family says it's a gift. **Initial**_____

Confidentiality

- UNDER NO CIRCUMSTANCE is there to be any involvement with the client's financial affairs i.e., check writing, banking, signing credit cards, signing of receipts or any other financial transactions.
- You are expected to honor the confidentiality of any client's information which is obtained during the regular course of your employment **Initial**_____

Cell Phones-Personal Computers

- **NO** cell phone use or texting upon entering clients home. All cell phones, tablets or computers must be turned off when entering client's home or facility while on duty.
- Always use or provide the agency's telephone number for your family to contact you if in the event of an emergency. **Initial**_____

Consumer Payment and Benefits

- There should be no discussion what so ever regarding pay and or benefits with client/guardian or any relief aids while employed by the agency.
- It is expressly understood, that there is to be absolutely "NO" contact for any reason, with any client, (active or not) guardian or family member after your association with such case has ended. Failure to comply in these terms may result in suspension, termination and or incur penalty and or court costs as outlined below in this agreement.
- Any questions in regard to pay and or benefits, are to be addressed "off time" (not in the clients Home, preferably) and with the proper office personal employed by Nannys for Grannys.
- As an employee of Nanny's for Granny's, you are strictly prohibited to accept or solicit on behalf of yourself or any other persons, direct employment, compensation from the client or clients family without the express consent from an authorized representative in writing from Nannys for Grannys.
- If you are requested to do so, please notify us immediately or have the client or family contact us.
- Any violation of this will result in a penalty imposed of $5000. Plus any court fees to Nanny's for Granny's **Initial**_____

Privacy

- Take into consideration, and respect your client's right to privacy and dignity while under your care or supervision. Knock on doors before entering home, bedrooms and or bathrooms. Drape client during personal care. **Initial**_____

Unannounced Office Visits

- Employees are to never come to office unless they have an appointment.
- Any employee that shows up to the office uninvited or without an appointment will be turned away.
- The only time an employee should come to this office, would be for updating paperwork or in service education, in either instance, an appointment is required. **Initial**_____

Telephony/Time Slips/Direct Deposit

- "Telephony" is the most convenient and efficient method of confirming hours worked for the quickest compensation. For those not familiar with this method, directions will be provided.
- If the "Telephony" option is not available for that client, a time sheet can be found and printed from our website. All time sheets can be dropped off or mailed, must include an accurate description of duties performed with clients initials confirming dates and times. Any days or times not confirmed by client will be with held until confirmation of such hours or days in question prior to payment being issued and sent using the US Postal Service. **Initial** _____

- All checks are sent out on Fridays. Any delays in receiving your check utilizing the United States Postal Service will **NOT** be our responsibility. It is further accepted that there is a 10 business day grace period before any checks can be reissued from the day the check was dated. Any checks that need to be re-issued in less than the 10 business day grace period will incur a $35.00 stop payment fee which be deducted from any monies due.
- Direct deposit is the most efficient method of payment for services rendered. If this service is not acceptable, a written check will can be sent using USPS first class mail as the preferred carrier. Any other methods not outlined above, such as "Certified Mail" will incur additional charges which will be borne solely by the employee.

Initial_____

Holiday Pay

- For **PRIVATE CASES ONLY**. The following holidays are paid one and a half time your regular hourly pay as long as you are expected to work on that day.
- Christmas Day, New Years Day, Memorial Day, Thanksgiving Day, Fourth of July, Dr. Martin Luther King Day, Labor Day, or substitution of caregivers own personal holiday.
- For All **INSURANCE CASES** including, but not limited to, Managed Long Term Care Insurance, (MLTC's) Medicare, Medicaid, etc. Holiday pay is NOT included.
- After providing "1 year" of continuous employment without interruption (52 weeks) you are entitled to three paid days of rest which can be in taken in the form of monetary compensation at the regular rate of pay outlined in your DOL rate form or paid time off whichever is desired.
- If your work schedule is intermittent or irregular and not performed on a regular basis, you are Considered employed on a "casual basis" and therefore the 3 days of rest do Not apply.
- Live In Holiday Pay pertains to working hours ONLY and NOT sleeping hours. Start of shift needs to be on the working holiday day in order to earn holiday pay. If shift starts day prior and sleeping falls onto holiday, you do not earn holiday pay for sleeping hours.
- If shift is hourly, the above rule does not apply and holiday pay will be paid for all working hours

Initial_____

Situations to Avoid

Discussing religion, politics, personal issues with the client and/or others while in the care setting.
Engaging the consumer in sexual conduct or in a conduct that a reasonable person may interpret as Sexual in nature even if the conduct is consensual.
Consuming the consumer's food or drink, or using the consumers personal property without his or hers consent is forbidden
NO CALL, NO SHOW, NO MESSAGE, IS GROUNDS FOR IMMEDITATE TERMINATION!

Initial_____

Vaccinations

- All necessary vaccinations requirements must be met as per Dept of Health (DOH). PPD, Rubella, Rubeola, Hepatitis 8 and as of 11-1-13 an Influenza shot (Flu Shot) is required. If the influenza vaccination is not an acceptable option, a surgical mask must be worn at all times while on duty. **Initial_____**

Employment Arbitration Policy

- It is accepted that in the event there is any deviation to the guidelines outlined in this agreement and or clients care plan, it is the caregivers sole responsibility to notify the agency of any changes immediately in writing, text or E-mail and allow a reasonable amount of time (72 hours after notification) for agency to react and rectify the situation with family, physician or forego any claims or liabilities against agency, nurses, employees (past or present), administrators, clients and or family members and or any coordinators, case managers, representatives or principles of Nannys for Grannys for an indefinite period of time.

Initial_____

This Agreement is not, and does not create any contract of employment, express or implied. I acknowledge that if I am employed by Nannys for Grannys, my employment is "at-will," that is, Nannys for Grannys or I may terminate my employment at any time and for any reason, either with or without cause, and that my "at-will" status may be modified only in a writing signed by the President of Nannys for Grannys.

Internal Grievance Procedure: I understand that all grievances must be presented to Nannys for Grannys in writing or other means of legal/dated documentation and allow a reasonable time (72 hours after notification) for corrective action. Failing to notify Nannys for Grannys, you agree to waive all rights to a civil court action regarding your employment with Nannys for Grannys indefinitely.

Initial_____

- It is Understood, Agreed & Accepted that my signature on this document acknowledges that I understand and accept the above Arbitration Policy and agree to abide by its conditions. I further understand that if any disputes cannot be resolved in a peaceful like manner internally, legal arbitration will be the sole means of resolving such disputes. I further accept all cost related too, but not limited too, cost of arbitrator, court reporters etc and that I cannot seek punitive nor emotional stress compensation and that all case must be heard in the jurisdiction of the main office of Nannys for Grannys.

Initial_____

Show up with a Smile

- If by chance I happen to have not mentioned something. Please use your best judgment as a professional. You are hired to take care of a senior because in most case they are not able to do so themselves. Do it to the best of your ability, you are representing us as well as being judged by your client. Consider the clients interests. Many senior have had extremely interesting pasts. Get to know them, talk about grandchildren, did they serve in the military, where have they traveled or lived, are they sports fans, what hobbies do they like. Be alert to topics they like to talk about and you will have a happy client. Last but not least, Show up with a smile!! Many seniors are not able to see their loved ones often or in many cases they have outlived their closest friends. Be happy to see them and they will be happy to see you.

Initial_____

Violation of Policy

- Any violation of the agency policies and procedures will result in the immediate dismissal and penalty charge of $5000 plus any court fees related too and incurred by Nanny's for Granny's. As an employee of Nannies for Grannies Inc, a Home Health Care Agency, I accept and will explicitly follow these policies, procedures, guidelines and standards of work conduct carefully. I understand that failure to comply with agency policies set forth may jeopardize my employment, present and future, and in many instances, may be grounds for immediate suspension or termination.

Employee Signature_____**Dated**_____

RT 12/22/17

6R

Nannys For Grannys
Reference Request Form

Name of Applicant:_____

Position Applied For:_____

Name: _____ Company: _____ Title:_____

Phone Number: _____ Fax Number: _____

Address: _____

Release of information: I hearby release from all liability the company, institution or person named above and authorize them to release all information regarding my employment with them.

Signature of Applicant: _____ Date: _____

The person identifed above has applied for a positon at Nannys for Grannys, Inc. Would you kindly complete the reference information below and return the reference information. This information will be kept confidential. Thank you.

Position held at your organization: _____

References relationship to applicant: _____

Dates employed from: _____-_____ To: _____

Reason for Leaving: _____

Would you re-employ?_____ If No, then why? _____

Applicants Work Record	Satisfactory	Unsatisfactory	Unable to Evaluate
Quality of Work			
Productivity			
Attendance			
Punctuality			
Initiative			
Cooperation			
Dependability			
Accepts Constructive Critisim			
Appearance			

Any Additional Comments: _____

References Signature: _____ Date: _____

Reference Validation: _____ Title: _____ Date:_____

12R

Nannys For Grannys
Reference Request Form

Name of Applicant:_____

Position Applied For:_____

Name: _____ Company: _____ Title:_____

Phone Number: _____ Fax Number: _____

Address: _____

Release of information: I hearby release from all liability the company, institution or person named above and authorize them to release all information regarding my employment with them.

Signature of Applicant: _____ Date: _____

The person identifed above has applied for a positon at Nannys for Grannys, Inc. Would you kindly complete the reference information below and return the reference information. This information will be kept confidential. Thank you.

Position held at your organization: _____

References relationship to applicant: _____

Dates employed from: _____-_____ To: _____

Reason for Leaving: _____

Would you re-employ?_____ If No, then why? _____

Applicants Work Record	Satisfactory	Unsatisfactory	Unable to Evaluate
Quality of Work			
Productivity			
Attendance			
Punctuality			
Initiative			
Cooperation			
Dependability			
Accepts Constructive Critisim			
Appearance			

Any Additional Comments: _____

References Signature: _____ Date: _____

Reference Validation: _____ Title: _____ Date:_____

13R

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See Instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

15R

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			B. Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

16R

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
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				

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

Refer to the instructions for more information about acceptable receipts.

16A

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

▶ **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
▶ **Give Form W-4 to your employer.**
▶ **Your withholding is subject to review by the IRS.**

OMB No. 1545-0074

2020

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		▶ **Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single or Married filing separately**
☐ **Married filing jointly** (or Qualifying widow(er))
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the online estimator, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ▶ ☐

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

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents

If your income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 ▶ $ _____

Multiply the number of other dependents by $500 . . . . ▶ $ _____

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

▶ _____ **Employee's signature** (This form is not valid unless you sign it.) ▶ _____ **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

17R

General Instructions

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505.

Exemption from withholding. You may claim exemption from withholding for 2020 if you meet both of the following conditions: you had no federal income tax liability in 2019 **and** you expect to have no federal income tax liability in 2020. You had no federal income tax liability in 2019 if (1) your total tax on line 16 on your 2019 Form 1040 or 1040-SR is zero (or less than the sum of lines 18a, 18b, and 18c), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2020 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2021.

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

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

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

1. Expect to work only part of the year;

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

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

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

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

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

Specific Instructions

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

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

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

If you (and your spouse) have a total of only two jobs, you may instead check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

CAUTION ***Multiple jobs.*** *Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.*

Step 3. Step 3 of Form W-4 provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2020 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

18A

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

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

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . 1 $

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . 2a $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . 2b $

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . 2c $

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. 3

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . 4 $

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1 Enter an estimate of your 2020 itemized deductions (from Schedule A (Form 1040 or 1040-SR)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . 1 $

2 Enter:
- $24,800 if you're married filing jointly or qualifying widow(er)
- $18,650 if you're head of household
- $12,400 if you're single or married filing separately

. . . . . 2 $

3 If line 1 is greater than line 2, subtract line 2 from line 1. If line 2 is greater than line 1, enter "-0-" . . 3 $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040 or 1040-SR)). See Pub. 505 for more information 4 $

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . 5 $

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

18B

Married Filing Jointly or Qualifying Widow(er)

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$220	$850	$900	$1,020	$1,020	$1,020	$1,020	$1,020	$1,210	$1,870	$1,870
$10,000 - 19,999	220	1,220	1,900	2,100	2,220	2,220	2,220	2,220	2,410	3,410	4,070	4,070
$20,000 - 29,999	850	1,900	2,730	2,930	3,050	3,050	3,050	3,240	4,240	5,240	5,900	5,900
$30,000 - 39,999	900	2,100	2,930	3,130	3,250	3,250	3,440	4,440	5,440	6,440	7,100	7,100
$40,000 - 49,999	1,020	2,220	3,050	3,250	3,370	3,570	4,570	5,570	6,570	7,570	8,220	8,220
$50,000 - 59,999	1,020	2,220	3,050	3,250	3,570	4,570	5,570	6,570	7,570	8,570	9,220	9,220
$60,000 - 69,999	1,020	2,220	3,050	3,440	4,570	5,570	6,570	7,570	8,570	9,570	10,220	10,220
$70,000 - 79,999	1,020	2,220	3,240	4,440	5,570	6,570	7,570	8,570	9,570	10,570	11,220	11,240
$80,000 - 99,999	1,060	3,260	5,090	6,290	7,420	8,420	9,420	10,420	11,420	12,420	13,260	13,460
$100,000 - 149,999	1,870	4,070	5,900	7,100	8,220	9,320	10,520	11,720	12,920	14,120	14,980	15,180
$150,000 - 239,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,190	16,050	16,250
$240,000 - 259,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,520	17,170	18,170
$260,000 - 279,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	13,120	15,120	17,120	18,770	19,770
$280,000 - 299,999	2,040	4,440	6,470	7,870	9,190	10,720	12,720	14,720	16,720	18,720	20,370	21,370
$300,000 - 319,999	2,040	4,440	6,470	8,200	10,320	12,320	14,320	16,320	18,320	20,320	21,970	22,970
$320,000 - 364,999	2,720	5,920	8,750	10,950	13,070	15,070	17,070	19,070	21,290	23,590	25,540	26,840
$365,000 - 524,999	2,970	6,470	9,600	12,100	14,530	16,830	19,130	21,430	23,730	26,030	27,980	29,280
$525,000 and over	3,140	6,840	10,170	12,870	15,500	18,000	20,500	23,000	25,500	28,000	30,150	31,650

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$460	$940	$1,020	$1,020	$1,470	$1,870	$1,870	$1,870	$1,870	$2,040	$2,040	$2,040
$10,000 - 19,999	940	1,530	1,610	2,060	3,060	3,460	3,460	3,460	3,640	3,830	3,830	3,830
$20,000 - 29,999	1,020	1,610	2,130	3,130	4,130	4,540	4,540	4,720	4,920	5,110	5,110	5,110
$30,000 - 39,999	1,020	2,060	3,130	4,130	5,130	5,540	5,720	5,920	6,120	6,310	6,310	6,310
$40,000 - 59,999	1,870	3,460	4,540	5,540	6,690	7,290	7,490	7,690	7,890	8,080	8,080	8,080
$60,000 - 79,999	1,870	3,460	4,690	5,890	7,090	7,690	7,890	8,090	8,290	8,480	9,260	10,060
$80,000 - 99,999	2,020	3,810	5,090	6,290	7,490	8,090	8,290	8,490	9,470	10,460	11,260	12,060
$100,000 - 124,999	2,040	3,830	5,110	6,310	7,510	8,430	9,430	10,430	11,430	12,420	13,520	14,620
$125,000 - 149,999	2,040	3,830	5,110	7,030	9,030	10,430	11,430	12,580	13,880	15,170	16,270	17,370
$150,000 - 174,999	2,360	4,950	7,030	9,030	11,030	12,730	14,030	15,330	16,630	17,920	19,020	20,120
$175,000 - 199,999	2,720	5,310	7,540	9,840	12,140	13,840	15,140	16,440	17,740	19,030	20,130	21,230
$200,000 - 249,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
$250,000 - 399,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
$400,000 - 449,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,450	19,940	21,240	22,540
$450,000 and over	3,140	6,230	8,810	11,310	13,810	15,710	17,210	18,710	20,210	21,700	23,000	24,300

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$830	$930	$1,020	$1,020	$1,020	$1,480	$1,870	$1,870	$1,930	$2,040	$2,040
$10,000 - 19,999	830	1,920	2,130	2,220	2,220	2,680	3,680	4,070	4,130	4,330	4,440	4,440
$20,000 - 29,999	930	2,130	2,350	2,430	2,900	3,900	4,900	5,340	5,540	5,740	5,850	5,850
$30,000 - 39,999	1,020	2,220	2,430	2,980	3,980	4,980	6,040	6,630	6,830	7,030	7,140	7,140
$40,000 - 59,999	1,020	2,530	3,750	4,830	5,860	7,060	8,260	8,850	9,050	9,250	9,360	9,360
$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,780	10,980	11,180	11,580	12,380
$80,000 - 99,999	1,900	4,300	5,710	7,000	8,200	9,400	10,600	11,180	11,670	12,670	13,580	14,380
$100,000 - 124,999	2,040	4,440	5,850	7,140	8,340	9,540	11,360	12,750	13,750	14,750	15,770	16,870
$125,000 - 149,999	2,040	4,440	5,850	7,360	9,360	11,360	13,360	14,750	16,010	17,310	18,520	19,620
$150,000 - 174,999	2,040	5,060	7,280	9,360	11,360	13,480	15,780	17,460	18,760	20,060	21,270	22,370
$175,000 - 199,999	2,720	5,920	8,130	10,480	12,780	15,080	17,380	19,070	20,370	21,670	22,880	23,980
$200,000 - 249,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
$250,000 - 349,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
$350,000 - 449,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	[illegible]	[illegible]	25,200
$450,000 and over	3,140	6,840	9,560	12,140	14,640	17,140	19,640	21,530	23,030	[illegible]	25,940	27,240

DOH CHRC form 102: Acknowledgement and Consent for Fingerprinting and Disclosure of Criminal History Record Information

NYS Department of Health, Criminal History Record Check Unit

chrc@health.state.ny.us

The purpose of this form is to obtain consent from the subject individual for fingerprints and criminal history record information pursuant to Article 28-E of the Public Health Law and Section 845-b of the Executive Law.

SECTION 1 – SUBJECT INDIVIDUAL INFORMATION

Last Name	First Name	Middle Initial	Maiden Name

Date of Birth (mm/dd/yyyy)	Alias/AKA	Mother's Maiden Name

Mailing Address (street)	City	State	ZIP Code

SECTION 2 - ATTESTATION

1. I have applied to an agency to provide direct care or supervision to residents or patients. I understand that as part of the application process, the Public Health Law (PHL) Article 28-E requires that the New York State Department of Health perform a criminal history check on me with the New York State Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI).
2. I acknowledge and consent to having my fingerprints taken for the purpose of a criminal history record check by the DCJS and the FBI.
3. I have been advised that DOH is authorized by law to receive the results of the criminal history record check from DCJS and the FBI for the purpose of developing a criminal history record summary. In accordance with applicable laws, DOH will furnish appropriate summary information to the agency to which I applied for a position to provide direct care or supervision to residents or patients. I have been advised that the criminal history record summary will indicate whether I have a criminal history, including convictions of a crime (felony or misdemeanor) or criminal charges which do not reflect a disposition. The criminal history record summary prepared by DOH and sent to the agency will contain the results of the criminal history record check performed by DCJS. I have been advised that the information shall be confidential pursuant to applicable federal and state laws, rules and regulations and shall only be disclosed to persons authorized by law. I have been informed that upon receiving notification from DCJS that there is a subsequent pending criminal action or proceeding or conviction, the DOH shall promptly notify an authorized person(s) of a provider of the additional allegation or new conviction.
4. I hereby consent to DOH sharing with any DCJS agency to which I applied for a position to provide direct care or supervision, any criminal history record check information provided to DOH by the FBI, including the specific crime(s) for which I was convicted or charged, the date of the arrest for such charge, and/or date of conviction, and the jurisdiction in which the arrest or conviction took place.
5. I have been informed of the procedures and my rights to obtain, review and seek correction of my criminal history information pursuant to regulations and procedures established by the DCJS and the FBI. If I believe an error has been made by DCJS for any New York State conviction/charge or the FBI for any non-New York State conviction/charge, I understand that I should notify DCJS and/or the FBI to report and request correction of this error to the addresses below.

NYS Division of Criminal Justice Services
Criminal History Bureau
Record Review Unit-5th Floor
4 Tower Place
Albany, NY 12203
(518) 485-7675

Federal Bureau of Investigation
Criminal Justice Information Services
(CJIS) Division
1000 Custer Hollow Road
Clarksburg, WV 26306

6. I understand that I have the right to withdraw my application for employment, without prejudice, any time before employment is offered or declined, regardless of whether an agency, DOH or I have reviewed my criminal history information.
7. I certify to the best of my knowledge and belief that I (check as appropriate):
   - ☐ **Have** ☐ **Have not been convicted of a crime in New York State or any other jurisdiction**
   - ☐ **Do** ☐ **Do not have a final finding of patient or resident abuse**

   If you checked either "Have" and/or "Do", please provide a brief explanation. (Optional)

   _____
8. My current mailing or home address is indicated in Section 1 of this form.
9. I have read this form and hereby consent to the request by the agency to use my fingerprints to obtain my criminal history record, if any, from the DCJS and the FBI. I hereby consent to the re-disclosure of any convictions or open charges on my criminal history record, received by DOH from DCJS, to the requesting agency in accordance with applicable laws. I declare and affirm that the information I have provided on this consent form is true, complete and accurate and that the fingerprints to be submitted are my own.

Applicant Signature: _____ Date: ____/____/_____

Name and Signature of Parent or Legal Guardian: _____ Date: ____/____/_____
(if subject individual is under 18 years of age)

SECTION 3 – AGENCY AUTHORIZED PERSON INFORMATION

Agency Name:	Operating License Number (PFI):
Print Name of Authorized Person:	Title:
Signature of Authorized Person:	Date:

This form is to be retained by the agency. Do not forward to the DOH CHRC Unit.

19R 07/2016

There are two types of drug tests:

Pre-employment testing

• Applicants for employment at **NANNIES FOR GRANNIES, INC.** are drug-tested after receiving a final offer of employment and prior to beginning work. Applicants are notified at the time of application that testing for drugs is a requirement for employment process. Offers of employment are contingent upon successfully passing a drug test.

Testing for Reasonable Suspicion:

• A drug screen may be ordered by the Director of Clinical Services, in consultation with the

Administrator, when a reasonable suspicion of working under influence exists. Refusal to submit to the testing may result in disciplinary action, up to and including termination.

• A positive drug screen means the verified presence of alcohol or other controlled substances. All positive test results are maintained in a separate, confidential, need-to-know access file.

• Every employee, as a condition of continued employment, is required to immediately notify the Administrator, if they are convicted under federal or state criminal statue whether the act causing the conviction occurred on or off work time.

• The company will report information concerning possession distribution or use of any illegal drug to law enforcement officials.

*** I HAVE READ AND UNDERSTAND THE ABOVE AND WILL COMPLY WITH THIS AGREEMENT.**

_____ _____

Employee Signature *Date*

NANNIES FOR GRANNIES, INC. EMPLOYEE PHYSICAL EXAMINATION REPORT

☐Pre-Employment Physical Assessment ☐Annual Assessment ☐Return to work/LOA ☐Other:

Name:	Marital Status: ☐M ☐S ☐W ☐D	Sex:☐M ☐F
Address	SS #:	Title:

PHYSICAL EXAMINATION

HEAD/ENT:

EYES:

NECK:

BREASTS:

LUNGS:

CARDIOVASCULAR:

MUSCULOSKELETAL:

ABDOMEN:

GENITOURINARY:

CENTRAL NERVOUS SYSTEM:

COMMENTS:

HT:	WT:	B/P:	PULSE:	RESP:	TEMP:

LABORATORY TEST RESULTS

TEST	DATE	RESULTS		
RUBELLA TITER		☐NON-IMMUNE ☐IMMUNE	**LAB VALUE:**	
MEASLES TITER		☐NON-IMMUNE ☐IMMUNE	**LAB VALUE:**	
PPD (ANNUALLY)	1. DATE IMPLANTED	1. DATE READ:	RESULTS (mmxmm):	
	2. DATE IMPLANTED	2. DATE READ:	RESULTS (mmxmm):	
CHEST X-RAY (+PPD)	Date:	Results:		

IMMUNIZATIONS:	DATE	DATE	DATE
RUBELLA	1.		
RUBEOLA/MEASLES	1.	2.	
HEPATITIS B VACCINE	1.	2.	3.
OTHER:			

☐This individual is free from a health impairment which is of potential risk to the patient or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other substances that may alter his/her behavior.

☐**This individual is able to work with the following limitations:**

☐**This individual is not physically/mentally able to work.** ***(specify reason):***

Physician Signature: **Lic. No.** **Date:**

22R

Nannys for Grannys

The following individual has a positive PPD and has had an initial negative chest x-ray for tuberculosis. This assessment form must be completed annually for continued employment with Nannys for Grannys.. This self assessment is in place of additional x-rays that it may be harmful to the employee's health.

Name: _____ Date: _____

Please complete:

Do you have any signs or symptoms of the following:

Cough lasting longer than 3 weeks	☐yes	☐ no
Fever lasting longer than 3 weeks	☐yes	☐ no
Night sweats	☐yes	☐ no
Unintentional weight loss	☐yes	☐ no
Malaise/fatigue	☐yes	☐ no

If I have answered yes to two or more of the above symptoms I will check with my physician regarding my condition. To the best of my knowledge as a health care professional, I certify that I do not have any symptoms or conditions which indicate I may have tuberculosis as of this time.

Signature: _____ Date: _____

23R

NANNIES FOR GRANNIES, INC.

HEPATITIS B VACCINE PROGRAM

☐ I do not wish to be given the Hepatitis B Vaccine at this time. I am aware that I may request to be provided the vaccine at a later date during my employment with the agency.

☐ I have already received the Hepatitis B Vaccine series.

Signature: _____ Date: _____

☐ I am requesting to receive the Hepatitis B Vaccine. (complete consent below)

HEPATITIS B VACCINATION CONSENT

I, _____, have been provided with information on the Hepatitis B vaccine and have been evaluated by an agency health professional.

I have had the opportunity to ask questions about the benefits and risks of Hepatitis B Vaccination.

I also understand that there is no guarantee that I will become immune and that there is a possibility that I will experience an adverse side effect from the vaccine.

I am **NOT allergic** to yeast or yeast products.

I am **NOT currently immunosuppressed**, neither by disease or medication.

For women: I have been advised that studies have not been conducted to determine the effect of the vaccine on a developing fetus. Therefore, the safety of the Hepatitis B vaccine relating to the developing fetus is currently unknown.

Employee Signature: _____ Date: _____

Witness Signature: _____ Date: _____

24R

Declination of Influenza Vaccination
For Health Care Personnel

Employee's Name:_____
Employee's ID#:_____

I have been advised that I should receive the influenza vaccine to protect myself and the patients I serve. I have read the Centers for Disease Control and Prevention's (CDC) Vaccine Information Statement explaining the vaccine and the disease it prevents. I have had the opportunity to discuss the statement and have my questions answered by a healthcare provider. I am aware of the following facts:

- Influenza is a serious respiratory disease that kills thousands in the United States each year.

- Influenza vaccination is recommended for me and all other healthcare personnel to protect this facility's patients from influenza, its complications, and death.

- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to patients in this facility.

- If I become infected with influenza, I can spread severe illness to others even when my symptoms are mild or non-existent.

- I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't, my immunity declines over time. This is why vaccination against influenza is recommended each year.

- I understand that I cannot get influenza from the influenza vaccine.

- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including all patients in this healthcare facility, coworkers, my family and my community.

- Because I have refused vaccination against influenza, I will be required to wear surgical or procedure masks in areas where patients or residents may be present during the influenza season.

I acknowledge that I have read this document in its entirety and fully understand it. Despite these facts, I have decided to decline the influenza vaccine by my signature below. I realize that I may re-address this issue at any time and accept vaccination in the future.

Signature:_____
Date:_____

Witness:_____
Date:_____

28R

Employee Influenza Vaccination Policy
Acknowledgement of Receipt

Please print your name and title and then sign and date the form to indicate that you have received a copy of Nannys For Grannys Policy for the Administration of Influenza Vaccine dated September 3, 2013. You are responsible for reading and adhering to the policy.

_____ _____

Print Name **Signature**

_____ _____

Job Title **Date**

29R

New York State Department of Health
AIDS Institute

Authorization for Release of Health Information and Confidential HIV-Related Information*

This form authorizes release of health information including HIV-related information. You may choose to release only your non-HIV health information, only your HIV-related information, or both. Your information may be protected from disclosure by federal privacy law and state law. Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

Under New York State Law HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; persons involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood; or by special court order. Under New York State law, anyone who illegally discloses HIV-related information may be punished by a fine of up to $5,000 and a jail term of up to one year. However, some re-disclosures of health and/or HIV-related information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for more information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019. You may also contact the NYS Division of Human Rights at 1-888-392-3644.

By checking the boxes below and signing this form, health information and/or HIV-related information can be given to the people listed on page two (and on additional sheets if necessary) of the form, for the reason(s) listed. Upon your request, the facility or person disclosing your health information must provide you with a copy of this form.

I consent to disclosure of (please check all that apply):

- ☐ My HIV-related information
- ☐ My non-HIV health information
- ☐ Both (non-HIV health and HIV-related information)

Name and address of facility/person disclosing HIV-related information:

_____

_____

Name of person whose information will be released: _____

Name and address of person signing this form (if other than above):

_____

_____

Relationship to person whose information will be released: _____

_____

Describe information to be released: _____

Reason for release of information: _____

Time Period During Which Release of Information is Authorized: From: _____ To: _____

Exceptions to the right to revoke consent, if any:

_____

_____

Description of the consequences, if any, of failing to consent to disclosure upon treatment, payment, enrollment, or eligibility for benefits
(Note: Federal privacy regulations may restrict some consequences):

_____

_____

Please sign below **only** if you wish to authorize all facilities/persons listed on pages 1,2 (and 3 if used) of this form to share information among and between themselves for the purpose of providing health care and services.

Signature _____ Date _____

*** This Authorization for Release of Health Information and Confidential HIV-Related Information form is HIPAA compliant. If releasing only non-HIV related health information, you may use this form or another HIPAA-compliant general health release form.**

62R

HIV CONFIDENTIALITY STATEMENT AND ACKNOWLEDGEMENT

" CONFIDENTIAL HIV RELATED INFORMATION MEANS ANY INFORMATION CONCERNNG WHETHER AN INDIVIDUAL HAS BEEN THE SUBJECT OF AN HIV RELATED TEST, OR HAS HIV INFECTION, HIV RELATED ILLNESSES OR AIDS, OR INFORMATION WHICH IDENTIFIES OR REASONABLY COULD IDENTIFY AN INDIVIDUAL AS HAVING ONE OR MORE OF SUCH CONDITIONS, INCLUDING INFORMATION PERTAINING TO SUCH INDIVIDUAL'S CONTACTS"

I HAVE BEEN GIVEN AND UNDERSTAND NANNYS FOR GRANNYS POLICY AND PROCEDURE REGARDING HIV CONFIDENTIALITY LAW AND RELEASE OF HIV INFORMATION

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

63R

property of the Agency. Only authorized personnel will have access to clinical/financial/personnel records.

All agency records, files, documents and Access to confidential employee/patient information files will be limited to agency personnel involved in the care and service of the patient.

Agency staff with access to computer files holds all information in strictest confidence in the processing, storage and discarding of all data. Only authorized personnel will have access to written and computer data information; Authorized personnel will be assigned passwords/access codes to computer files necessary to conduct their responsibilities;

Responsibilities of this job position has clearance for access to the following confidential information:

Patient plans of care and identifying data

I have been oriented to the agency's confidentiality policy. I understand that any Agency employees who do not honor the Confidentiality Policy are subject to termination and possible legal action. I agree to abide by the agency's confidentiality policy.

Employee Signature: _____ Date: _____

Effective:	Signature :	Review:	Signature:

SPECIALIZED SKILLS AND TECHNICAL COMPETENCIES:

1. Knowledge of safe and appropriate method of provid ng personal care.
2. Knowledge of meal preparation and basic nutrition.
3. Knowledge of environmental management and safety.

PHYSICAL DEMANDS: The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform essential functions. Check one physical requirement which applies to this position:

MEDIUM WORK: Exerting up to 50 pounds of force occasionally and/or up to 20 pounds of force frequently and/or up to 10 pounds of force constantly to move objects.

WORK ENVIRONMENT: Patient's home, facilities

Confidentiality Statement:
Agency records are maintained in a safe and secure area with specific access availability to ensure confidentiality. Agency records, files, documents and reports are the exclusive property of the Agency. Only authorized personnel will have access to clinical/financial/personnel records.

All agency records, files, documents and Access to confidential employee/patient information files will be limited to agency personnel involved in the care and service of the patient.

Agency staff with access to computer files holds all information in strictest confidence in the processing, storage and discarding of all data. Only authorized personnel will have access to written and computer data information; Authorized personnel will be assigned passwords/access codes to computer files necessary to conduct their responsibilities;

Responsibilities of this job position has clearance for access to the following confidential information:

Patient plans of care, identifying patient data.

I have been oriented to the agency's confidentiality policy. I understand that any Agency employees who do not honor the Confidentiality Policy are subject to termination and possible legal action. I agree to abide by the agency's confidentiality policy.

Employee Signature: _____ Date: _____

I have been oriented to the agency's confidentiality policy. I understand that any Agency employees who do not honor the Confidentiality Policy are subject to termination and possible legal action. I agree to abide by the agency's confidentiality policy.

Employee Signature: _____ Date: _____

Effective:	Signature :	Review:	Signature:

HHA & PCA SKILLS ASSESSMENT ANSWERS

Name: _____ Date: _____

1. _____
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    b. _____
    c. _____
    d. _____
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49. _____
50. _____

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NANNIES FOR GRANNIES, INC.

ACKNOWLEDGMENT OF ORIENTATION

Name: _____ Social Security # : _____

Title: _____ Date of Employment: _____

I acknowledge that I have received orientation to the following:

Agency's Mission, Philosophy and Goals

Agency's Personnel Policies and Procedures

Continuous Quality Improvement

Agency's Administrative Policy and Procedure Manual

Patient Bill of Rights, Patient Confidentiality, Right to Respect/Privacy/Property/Complaint Process

HIV Confidentiality/HIPAA

Advance Directives/DNR

OSHA Standards:
- Occupational Exposure to Bloodborne/Tuberculosis Program
- Epidemiology and Symptoms
- Modes of Transmission
- Engineering Controls, Work practices and use of Protective equipment
- Hepatitis B Vaccine Program
- Responsibilities and Reporting Mechanism for Exposure incident
- Universal Precautions/Standard Precautions
- Infection Control Practices

Job Description

Time and Activity Reports

Clinical Documentation Requirements

Disaster and Emergency Preparedness / Safety Policy and Procedure/Fire Safety

Policies and Procedures specific to my job responsibilities

Inservice and Continuing Education Requirements

I understand that this information is readily accessible as a resource to me. I have been given the opportunity to ask for clarification as necessary and will seek additional clarification from my supervisor, as necessary.

I have read the above statements and agree to comply with the agency's policies and procedures.

Employee Signature: _____

Date: _____

HABITUATION STATEMENT

_____ is free from any health impairment that is a potential risk to the patient or to other employee or which may interfere with the performance of his/her duties including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs, or substances which may alter the individual's behavior.

Physician Signature:	Stamp and Lic. No.	Date: