

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

Permanent Resident Card with photo

Employment Authorization Doc with Photo

State Driver's License with photograph

Voter's registration Card

U.S Military Card or Draft Record

ID card issued by federal state or local government

Native American Tribal Document

Id card issued by federal, state or local government.

U.S Coast Guard Merchant Mariner Card

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)**
- **Copy of Covid Vaccination Card**
- **Signed Pay Rate Form with Original Signature (No Photocopy)**

Nannys for Grannys
Employee Code of Ethics and Conduct Agreement
*****Employee 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 and ability.
- Abide by all HIPPA policies and procedures set forth by the agency.
- Any noticeable changes in the home or client you are to notify the office immediately.

Initial _____

Dress Code

- All employees are expected to dress appropriately 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 and responsibility 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

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

Initial _____

Being On Time

- All aides are expected to arrive 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 expected to notify the office immediately at **631-730-8500** during regular business hours. If after hours, leave a message on the answering machine we check messages frequently.
- **PLEASE DO NOT EVER CALL THE CLIENT OR FAMILY DIRECT- CALL THE OFFICE.**
- **LATENESS or NO SHOW** without properly notifying the office at least 3hrs in advance can result in suspension, termination or having your name permanently removed from our roster.
- Excessive absences or lateness will result in termination

Initial _____

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. Caregivers are afforded 8 hours of sleep, (5 of which must be uninterrupted) and (3 hours personal downtime). $8+3+13=24$ If any of these requirements are not met it is the responsibility of the caregiver to notify the agency immediately to rectify the situation and/or recommend changes to the care plan. Failure to do so will alleviate us (The Agency) of any liability.
- "Live In" "Live Out" or "Hourly" as per DOL, mandates overtime at 1 1/2 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. To avoid any miscommunication, 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 immediately.
- 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 if needed. Leaving a client at home unattended is considered "Abandonment" and grounds for immediate termination. **DON'T DO IT!**
- 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, wellbeing, any changes in client's general behavior and or physical condition and duties performed and relay any modifications or changes that need to be addressed for the wellbeing 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 immediately 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., oversee 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 hereby acknowledge that you **WILL NOT UNDER ANY CIRCUMSTANCE DISPENSE OR ADMINISTER ANY MEDICATION AT ANYTIME**, you are only approved for medication reminders

Initial _____

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Accepting Money or Gifts

- UNDER NO CIRCUMSTANCE are you to ask for or accept any money from your client or take-home personal 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

- Cell phone use is frowned upon by the agency and the clients while on duty, full attention should be devoted to the client's welfare and companionship and not to your cell phone. All cell phones, tablets or computers are recommended to be in the off position when entering client's home or facility while on duty.

Initial _____

Consumer Payment and Benefits

- There should be no discussion what so ever regarding fees, compensation and or benefits with client/guardian or with any relief aids while employed by the agency or on duty.
- 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 client's 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 any other situations appointment are 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 and must include an accurate description of duties performed with clients' initials confirming dates and times. Any days or times not signed off by client will be withheld until such confirmation can be made.

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 Year's 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 should be avoided.
- 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 client's food or drink, or using the consumers personal property without his or her express consent should be avoided unless offered. Initial_____

Vaccinations

- All necessary vaccinations must be met as per Dept of Health (DOH). PPD, Rubella, Rubeola, Hepatitis 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. In addition, as of Sept 1 2021, proof of covid vaccination is required. For those who choose not vaccinate due to religion, health or personal reasons other accommodations will be made, but an N95 mask must be worn at **ALL** times to protect yourself and the health and safety of the client. 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_____

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- 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 Nanny's for Granny's.
- 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 to cost of arbitrator, court reporters etc. Nor can I seek punitive or 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 seniors 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, 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 to and incurred by Nanny's for Granny's. As an employee of Nannies for Grannies Inc, a Senior Home Health Care Agency, I accept and will explicitly follow these policies and 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 09/03/2021

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**Nannys For Grannys
Reference Request Form**

Name of Applicant: _____

Position Applied For: _____

Name: _____ Company: _____ Title: _____

Phone Number: _____ Fax Number: _____

Address: _____

Release of information: I hereby 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 identified above has applied for a position 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 Criticism			
Appearance			

Any Additional Comments: _____

References Signature: _____ Date: _____

Reference Validation: _____ Title: _____ Date: _____

Nannys For Grannys
Reference Request Form

Name of Applicant: _____

Position Applied For: _____

Name: _____ Company: _____ Title: _____

Phone Number: _____ Fax Number: _____

Address: _____

Release of information: I hereby 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 identified above has applied for a position 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.

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Dates employed from: _____ - _____ To: _____

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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: _____



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):

<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>	
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)
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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

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
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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.)

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)
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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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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	LIST B Documents that Establish Identity	LIST C Documents that Establish Employment Authorization
OF	AND	
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (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. 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 	<ol style="list-style-type: none"> 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 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 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <li style="text-align: center;">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 	<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 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. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security

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

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.

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) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> 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, other details, and privacy.

Step 2: 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.

Multiple Jobs or Spouse Works Do only one of the following.

(a) Reserved for future use.

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; 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 generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate

TIP: If you have self-employment income, see page 2.

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 Dependent and Other Credits	If your total 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 for qualifying children and other dependents. You may add to this the amount of any other credits. 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: Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Sign Here

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

Date

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

General Instructions

Section references are to the Internal Revenue Code.

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, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2023 if you meet both of the following conditions: you had no federal income tax liability in 2022 **and** you expect to have no federal income tax liability in 2023. You had no federal income tax liability in 2022 if (1) your total tax on line 24 on your 2022 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), 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 2023 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 15, 2024.

Your privacy. 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).

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 income and self-employment taxes through withholding from your wages, you should enter the self-employment income on Step 4(a). Then compute your self-employment tax, divide that tax by the number of pay periods remaining in the year, and include that resulting amount per pay period on Step 4(c). You can also add half of the annual amount of self-employment tax to Step 4(b) as a deduction. To calculate self-employment tax, you generally multiply the self-employment income by 14.13% (this rate is a quick way to figure your self-employment tax and equals the sum of the 12.4% social security tax and the 2.9% Medicare tax multiplied by 0.9235). See Pub. 505 for more information, especially if the sum of self-employment income multiplied by 0.9235 and wages exceeds \$160,200 for a given individual.

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.

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



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. This step 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. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. 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 2023 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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



If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

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.

- 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 2023 itemized deductions (from Schedule A (Form 1040)). 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:

}	• \$27,700 if you're married filing jointly or a qualifying surviving spouse
	• \$20,800 if you're head of household
	• \$13,850 if you're single or married filing separately

 **2** \$ _____
- 3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. 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)). 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 territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

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	\$0	\$850	\$850	\$1,000	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,870
\$10,000 - 19,999	0	930	1,850	2,000	2,200	2,220	2,220	2,220	2,220	2,220	3,200	4,070
\$20,000 - 29,999	850	1,850	2,920	3,120	3,320	3,340	3,340	3,340	3,340	4,320	5,320	6,190
\$30,000 - 39,999	850	2,000	3,120	3,320	3,520	3,540	3,540	3,540	4,520	5,520	6,520	7,390
\$40,000 - 49,999	1,000	2,200	3,320	3,520	3,720	3,740	3,740	4,720	5,720	6,720	7,720	8,590
\$50,000 - 59,999	1,020	2,220	3,340	3,540	3,740	3,760	4,750	5,750	6,750	7,750	8,750	9,610
\$60,000 - 69,999	1,020	2,220	3,340	3,540	3,740	4,750	5,750	6,750	7,750	8,750	9,750	10,610
\$70,000 - 79,999	1,020	2,220	3,340	3,540	4,720	5,750	6,750	7,750	8,750	9,750	10,750	11,610
\$80,000 - 99,999	1,020	2,220	4,170	5,370	6,570	7,600	8,600	9,600	10,600	11,600	12,600	13,460
\$100,000 - 149,999	1,870	4,070	6,190	7,390	8,590	9,610	10,610	11,660	12,860	14,060	15,260	16,330
\$150,000 - 239,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
\$240,000 - 259,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
\$260,000 - 279,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	18,140
\$280,000 - 299,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,870	17,870	19,740
\$300,000 - 319,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,470	15,470	17,470	19,470	21,340
\$320,000 - 364,999	2,040	4,440	6,760	8,550	10,750	12,770	14,770	16,770	18,770	20,770	22,770	24,640
\$365,000 - 524,999	2,970	6,470	9,890	12,390	14,890	17,220	19,520	21,820	24,120	26,420	28,720	30,880
\$525,000 and over	3,140	6,840	10,460	13,160	15,860	18,390	20,890	23,390	25,890	28,390	30,890	33,250

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	\$310	\$890	\$1,020	\$1,020	\$1,020	\$1,860	\$1,870	\$1,870	\$1,870	\$1,870	\$2,030	\$2,040
\$10,000 - 19,999	890	1,630	1,750	1,750	2,600	3,600	3,600	3,600	3,600	3,600	3,760	3,970
\$20,000 - 29,999	1,020	1,750	1,880	2,720	3,720	4,720	4,730	4,730	4,890	5,090	5,290	5,300
\$30,000 - 39,999	1,020	1,750	2,720	3,720	4,720	5,720	5,730	5,890	6,090	6,290	6,490	6,500
\$40,000 - 59,999	1,710	3,450	4,570	5,570	6,570	7,700	7,910	8,110	8,310	8,510	8,710	8,720
\$60,000 - 79,999	1,870	3,600	4,730	5,860	7,060	8,260	8,460	8,660	8,860	9,060	9,260	9,280
\$80,000 - 99,999	1,870	3,730	5,060	6,260	7,460	8,660	8,860	9,060	9,260	9,460	10,430	11,240
\$100,000 - 124,999	2,040	3,970	5,300	6,500	7,700	8,900	9,110	9,610	10,610	11,610	12,610	13,430
\$125,000 - 149,999	2,040	3,970	5,300	6,500	7,700	9,610	10,610	11,610	12,610	13,610	14,900	16,020
\$150,000 - 174,999	2,040	3,970	5,610	7,610	9,610	11,610	12,610	13,750	15,050	16,350	17,650	18,770
\$175,000 - 199,999	2,720	5,450	7,580	9,580	11,580	13,870	15,180	16,480	17,780	19,080	20,380	21,490
\$200,000 - 249,999	2,900	5,930	8,360	10,660	12,960	15,260	16,570	17,870	19,170	20,470	21,770	22,880
\$250,000 - 399,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
\$400,000 - 449,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
\$450,000 and over	3,140	6,380	9,010	11,510	14,010	16,510	18,010	19,510	21,010	22,510	24,010	25,330

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	\$620	\$860	\$1,020	\$1,020	\$1,020	\$1,020	\$1,650	\$1,870	\$1,870	\$1,890	\$2,040
\$10,000 - 19,999	620	1,630	2,060	2,220	2,220	2,220	2,850	3,850	4,070	4,090	4,290	4,440
\$20,000 - 29,999	860	2,060	2,490	2,650	2,650	3,280	4,280	5,280	5,520	5,720	5,920	6,070
\$30,000 - 39,999	1,020	2,220	2,650	2,810	3,440	4,440	5,440	6,460	6,880	7,080	7,280	7,430
\$40,000 - 59,999	1,020	2,220	3,130	4,290	5,290	6,290	7,480	8,680	9,100	9,300	9,500	9,650
\$60,000 - 79,999	1,500	3,700	5,130	6,290	7,480	8,680	9,880	11,080	11,500	11,700	11,900	12,050
\$80,000 - 99,999	1,870	4,070	5,690	7,050	8,250	9,450	10,650	11,850	12,260	12,460	12,870	13,820
\$100,000 - 124,999	2,040	4,440	6,070	7,430	8,630	9,830	11,030	12,230	13,190	14,190	15,190	16,150
\$125,000 - 149,999	2,040	4,440	6,070	7,430	8,630	9,980	11,980	13,980	15,190	16,190	17,270	18,530
\$150,000 - 174,999	2,040	4,440	6,070	7,980	9,980	11,980	13,980	15,980	17,420	18,720	20,020	21,280
\$175,000 - 199,999	2,190	5,390	7,820	9,980	11,980	14,060	16,360	18,660	20,170	21,470	22,770	24,030
\$200,000 - 249,999	2,720	6,190	8,920	11,380	13,680	15,980	18,280	20,580	22,090	23,390	24,690	25,950
\$250,000 - 449,999	2,970	6,470	9,200	11,660	13,960	16,260	18,560	20,860	22,380	23,680	24,980	26,230
\$450,000 and over	3,140	6,840	9,770	12,430	14,930	17,430	19,930	22,430	24,150	25,650	27,150	28,600



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

- 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).
- I acknowledge and consent to having my fingerprints taken for the purpose of a criminal history record check by the DCJS and the FBI.
- 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.
- 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.
- 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

- 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.
- 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)

- My current mailing or home address is indicated in Section 1 of this form.
- 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 statute 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

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

Name:	Marital Status: <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> W <input type="checkbox"/> D	Sex: <input type="checkbox"/> M <input type="checkbox"/> 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:
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LABORATORY TEST RESULTS

TEST	DATE	RESULTS	
RUBELLA TITER		<input type="checkbox"/> NON-IMMUNE <input type="checkbox"/> IMMUNE	LAB VALUE:
MEASLES TITER		<input type="checkbox"/> NON-IMMUNE <input type="checkbox"/> 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



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 | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Fever lasting longer than 3 weeks | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Night sweats | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Unintentional weight loss | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Malaise/fatigue | <input type="checkbox"/> yes | <input type="checkbox"/> 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: _____

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: _____

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: _____

**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

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.



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: _____

NANNIES FOR GRANNIES, INC.
POLICY AND PROCEDURE MANUAL

SPECIFIC DUTIES AND RESPONSIBILITIES: In order to comply with the Americans with Disabilities Act (ADA), each essential duty should be indicated with an "x" in the ADA box. A duty is essential if: (1) the position exists to perform that duty; (2) it requires specialized skills and/or expertise; (3) it can only be performed by a limited number of available employees.

ADA	DUTIES / RESPONSIBILITIES
X	Preparing and serving normal/therapeutic diets. Assisting patient with eating, monitors intake.
X	Assisting with bathing of patient - in bed, tub and shower
X	Assisting with grooming, care of hair, including shampoo, shaving with electric razor only, and ordinary care of nails - this means soaking and filing nails.
X	Assisting with care of teeth and mouth.
X	Assisting patient on and off bedpan, commode and toilet.
X	Assisting patient in transferring from bed to chair, to wheelchair and in walking with or without devices.
X	Assisting patient with dressing
X	Assisting patient with self-administered, oral medications that have been ordered by the medical practitioner.
X	Taking temperature, pulse and respiration as directed
X	Use of special equipment i.e. hoier lift.
X	Assisting, as instructed with a home exercise program including passive range of motion, turning and positioning.
X	Reporting any change in patient's mental and physical condition or home situation to the nurse.
X	Making and changing bed/linens
X	Dusting and vacuuming the rooms the patient uses.
X	Tidying kitchen, dishwashing
X	Tidying bedroom
X	Tidying bathroom
X	Patient's personal laundry; this may include necessary ironing and mending.
X	Provides a supportive environment and ongoing reality orientation to confused patients using appropriate interpersonal behavioral techniques.
X	Assists with self-administered medications.
X	Take and record temperature, pulse, respiration.
X	Measure and record Intake and Output
X	Reinforce sterile dressing.
X	Empty urinary or ostomy bag
X	Cleanse catheter insertion site.
X	Administer special skin care as directed
X	Collect stool, sputum and urine specimens using appropriate techniques
X	FUNCTIONS PERMISSIBLE FOR HOME HEALTH AIDES UNDER SPECIAL CIRCUMSTANCES: If no family member is present or capable of providing care for a specific patient, the nurse may with the approval of the physician, teach and closely supervise the Aide in the following procedures: FUNCTIONS PERMISSIBLE UNDER SPECIAL CIRCUMSTANCES: (continued)
X	Assist with changes of colostomy bag
X	Reinforce dressing and change simple non-sterile dressing.
X	Assist with the use of devices geared to disability to aid in daily living
X	Assist patient with prescribed exercises which the Home Health Aide has been taught by appropriate professional personnel.
X	Apply prescribed ice cap or ice collar.
X	Perform simple urine test for sugar, acetone or albumen and record results
X	Perform functions allowable as per : NYS DOH Approved Scope of Practice

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THE HOME HEALTH AIDE WILL NOT PERFORM THESE FUNCTIONS UNDER ANY CIRCUMSTANCES:

1. Foley catheter irrigation.
2. Apply a sterile dressing.
3. Give enemas or remove impactions.
4. Perform gastric lavage or gavage.
5. Applications of heat in any form.

CUSTOMER SERVICE/INTERPERSONAL SKILL

1. Assists other employees where needed;
2. Is responsible and cooperative with patients/families, supervisors, fellow employees;
3. Maintains friendly working atmosphere;
4. Maintains appropriate attitude;
5. Maintains appropriate appearance;
6. Accepts constructive criticism as evidenced by appropriate changes in behavior;
7. Utilizes established channels of communication.
8. Recognizes, accepts and respects people as individuals;
9. Recognizes limitations and seeks assistance appropriately.

SPECIALIZED SKILLS AND TECHNICAL COMPETENCIES:

1. Ability to apply prosthetic devices;
2. Ability to take and record TPR and measure I&O;
3. Ability to reinforce sterile dressing and change non-sterile dressing;
4. Ability to follow the instructions related to exercise and positioning;
5. Ability to safely use the hoier lift;
6. Ability to care for urinary, ostomy and foley catheters;
7. Ability to apply warm or cold compress, ace bandage and elastic stockings.

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

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

NANNIES FOR GRANNIES, INC.
POLICY AND PROCEDURE MANUAL

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:
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NANNIES FOR GRANNIES, INC.
POLICY AND PROCEDURE MANUAL

POSITION DESCRIPTION

POSITION: Personal Care Aide

REPORTS TO: Nurse

POSITION SUMMARY:

A Personal Care Aide is a person who provides nutritional support, assistance with personal hygiene and the environmental maintenance necessary for an individual to remain in his/her own home. The Personal Care Aide is under direct supervision of the licensed nurse. The PCA provides services in accordance with Level I and Level II Personal Care Aide Functions and Tasks Scope of Practice.

QUALIFICATIONS:

Successful completion of a New York State Department of Health/Department of Social Services approved Personal Care Aide training program as demonstrated by a valid Personal Care Aide Certificate.

- Ability to speak, read and write in English sufficiently to understand and interpret the HHA Plan of Care, document care provided on the HHA Time and Activity report and able to call agency to report change and/or issues related to the patient and/or 911 in case of an emergency.
- Ability to add and subtract two digit numbers and to multiply and divide with 10's and 100's. Ability to perform these operations using units of American money and weight measurement, volume and distance.
- Holds a valid Personal Care Aide Certificate.
- Ability to apply common sense understanding to carry out simple one or two step instructions. Ability to deal with standardized situations with only occasional or no variables.

CONTACT:

Most frequent contact:

Nature or Purpose:

Patients/Patient families;
agency staff (coordinator, nurse)

Provide care and service
Receive supervision, development of POC.

EQUIPMENT OPERATION:

Walker, Cane, Crutches, Wheelchair, Commode, Hospital Bed, Hoyer Lift, Household appliances (i.e. vacuum, refrigerator, stove, blender, toaster, etc.)

SPECIFIC DUTIES AND RESPONSIBILITIES: In order to comply with the Americans with Disabilities Act (ADA), each essential duty should be indicated with an "x" in the ADA box. A duty is essential if: (1) the position exists to perform that duty; (2) it requires specialized skills and/or expertise; (3) it can only be performed by a limited number of available employees.

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POLICY AND PROCEDURE MANUAL

ADA	DUTIES / RESPONSIBILITIES
X	Preparing and serving normal diets. Assisting patient with eating, monitors intake.
X	Assisting with bathing of patient - in bed, tub and shower
X	Assisting with grooming, care of hair, including shampoo, shaving with electric razor only, and ordinary care of nails - this means soaking and filing nails.
X	Assisting with care of teeth and mouth.
X	Assisting patient on and off bedpan, commode and toilet.
X	Assisting patient in transferring from bed to chair, to wheelchair and in walking with or without devices.
X	Assisting patient with dressing
X	Assisting patient with self-administered, oral medications that have been ordered by the medical practitioner.
X	Use of special equipment i.e. hooyer lift.
X	Passive range of motion, turning and positioning.
X	Reporting any change in patient's mental and physical condition or home situation to the nurse.
X	Making and changing bed/linens
X	Dusting and vacuuming the rooms the patient uses.
X	Tidying kitchen, Dishwashing.
X	Tidying bedroom
X	Tidying bathroom
X	Patient's personal laundry; this may include necessary ironing and mending.
X	Provides a supportive environment and ongoing reality orientation to confused patients using appropriate interpersonal behavioral techniques.
X	Assists with self-administered medications.
X	Administer special skin care as directed
X	Collect stool, sputum and urine specimens using appropriate techniques

THE PERSONAL CARE AIDE WILL NOT PERFORM THESE FUNCTIONS UNDER ANY CIRCUMSTANCES:

1. Foley catheter irrigation.
2. Apply a sterile dressing.
3. Give enemas or remove impactions.
4. Perform gastric lavage gavage.
5. Applications of heat in any form.

CUSTOMER SERVICE/INTERPERSONAL SKILL

1. Assists other employees where needed;
2. Is responsible and cooperative with patients/families, supervisors, fellow employees;
3. Maintains friendly working atmosphere;
4. Maintains appropriate attitude;
5. Maintains appropriate appearance;
6. Accepts constructive criticism as evidenced by appropriate changes in behavior.
7. Utilizes established channels of communication.
8. Recognizes, accepts and respects people as individuals;
9. Recognizes limitations and seeks assistance appropriately.

NANNIES FOR GRANNIES, INC.
POLICY AND PROCEDURE MANUAL

SPECIALIZED SKILLS AND TECHNICAL COMPETENCIES:

1. Knowledge of safe and appropriate method of providing 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: _____

Eff. Date:

Signature :

Review Date:

Signature:

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NANNIES FOR GRANNIES, INC.
POLICY AND PROCEDURE MANUAL

POSITION: Homemaker

REPORTS TO: Nurse

POSITION SUMMARY:

The Homemaker is accountable for performing household activities to maintain an environment which is safe, clean, and promotes the physical and emotional well-being of the patient. The HM provides services in accordance with Level Personal Care Aide Functions and Tasks Scope of Practice.

QUALIFICATIONS:

Successful completion of New York State Department of Health/Department of Social Services approved Personal Care Aide training and/or Home Health Aide training program as demonstrated by a valid Person Care Aide/Home Health Aide Certificate.

Ability to speak, read and write in English sufficiently to understand and interpret the HHA Plan of Care, document care provided on the HHA Time and Activity report and able to call agency to report change and/or issues related to the patient and/or 911 in case of an emergency.

Ability to perform these operations using units of American money and weight measurement, volume and distance.

EQUIPMENT OPERATION:

Household appliances (i.e. vacuum, refrigerator, stove, blender, toaster, etc.)

SPECIFIC DUTIES AND RESPONSIBILITIES: In order to comply with the Americans with Disabilities Act (ADA), each essential duty should be indicated with an "x" in the ADA box. A duty is essential if: (1) the position exists to perform that duty; (2) it requires specialized skills and/or expertise; (3) it can only be performed by a limited number of available employees.

ADA	RESPONSIBILITIES
X	Follows care/service plan developed by the Registered Nurse
X	Maintains patient privacy and treats patients with dignity and respect
X	Performs duties, as assigned, in accordance with Agency policies
X	Maintains confidentiality of all patient related information
X	Maintains a safe and clean environment
X	Assures patient safety
X	Assists with personal laundry
X	Prepares, serves meals
X	Cleans kitchen/bathroom
X	Grocery Shopping
X	Escorts patient to appointments
X	Household management
X	Care of children as supervised and directed by patient
X	Documents services provided on activity records in a timely manner
X	Reports pertinent observations to supervisor
X	Participates in inservice program and meetings as requested by the DCS
X	Utilizes Standard Precautions and infection control techniques as necessary
X	Refusal to participate in aspects of care are appropriately justified, based on cultural or religious beliefs

NANNIES FOR GRANNIES, INC.
POLICY AND PROCEDURE MANUAL

CUSTOMER SERVICE/INTERPERSONAL SKILL

1. Assists other employees where needed;
2. Is responsible and cooperative with patients/families, supervisors, fellow employees;
3. Maintains friendly working atmosphere;
4. Maintains appropriate attitude;
5. Maintains appropriate appearance;
6. Accepts constructive criticism as evidenced by appropriate changes in behavior.
7. Utilizes established channels of communication.
8. Recognizes, accepts and respects people as individuals;
9. Recognizes limitations and seeks assistance appropriately.

SPECIALIZED SKILLS AND TECHNICAL COMPETENCIES:

1. Knowledge of safe and appropriate household management skills
2. Knowledge of meal preparation.

PHYSICAL DEMANDS: The physical demands described here are representatives 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:

Moderate physical effort required. 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:

Client homes/families involves moderate exposure to physical risks, such as automobile/public transportation or personnel safety.

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 Plan of Care/Patient identifying data..

NANNIES FOR GRANNIES, INC.
POLICY AND PROCEDURE MANUAL

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:
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HHA & PCA SKILLS ASSESSMENT
ANSWERS

Name: _____ Date: _____

1. _____
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50. _____

HHH & PCA SKILLS ASSESMENT TEST

Name _____ Date _____

Score _____

Multiple Choice: Circle the correct answer. There is one answer for each question. Be sure to answer every question.

1. You are assisting your patient with a tub bath. She says she is beginning to feel faint. What should you do?

- A. Add some cold water to the water in the tub; tell the patient she'll be all right in a moment or so.
- B. Leave the patient, but only long enough to find some help.
- C. Start draining the water out of the tub. Then give the patient a drink of water.
- D. Add some hot water to the water in the tub. Then give the patient a drink of water.

2. If you are going to be later for work in the morning you should:

- A. Call the patient's physician.
- B. Ask another aide to substitute.
- C. Notify the agency as early as possible.
- D. Say nothing, but get to work as soon as possible.

3. The home health aide works under the direct supervision of a:

- A. registered nurse
- B. physician
- C. patient
- D. patient's family

4. If a patient has been acting increasingly hostile and rebellious, which response should a home health aide make?

- A. Ask the patient's family for advice on how to handle the situation
- B. Discuss the patient's behavior with the supervising nurse
- C. Tell the patient that such actions will not be allowed.
- D. Resign from the case immediately.

5. Small grease fires in a frying pan can be put out by:

- A. Turning off the heat
- B. Blowing out the flame
- C. Sprinkling water on the flame
- D. Putting baking soda on the flame

6. Which is the best method for lifting a heavy object from the floor?

- A. Keep the back straight, feet apart, and flex knees.
- B. Keep feet apart and bend from the waist.
- C. Keep both feet together and bend the knees.
- D. Put one foot in front of the other and arch the back.

7. Under which conditions do germs grow most rapidly?

- A. Cold and dry
- B. Cold and moist
- C. Warm and moist
- D. Warm and dry

8. The chief reason for cooking vegetables in a small amount of water and boiling them as a short a time as necessary is to:

- A. Preserve the vitamins
- B. Retain the color of the vegetables
- C. Keep the vegetables firms
- D. Improve the flavor

9. What furnishings should be removed from the home of a patient with partial paralysis who is beginning to walk?

- A. Easy chairs
- B. Dining table and chairs
- C. Sofa and floor lamps
- D. Scatter rugs

10. The position of a bed patient should be changed frequently to:

- A. relax the patient
- B. increase the blood circulation
- C. provide a chance to wash the patient
- D. increase the patient's appetite

11. To prevent infections, it is important to keep the skin:

- A. warm
- B. covered
- C. moist
- D. Clean

12. When you are uncertain about the details of an assignment, which action should you take?

- A. Ask another aide about the assignment.
- B. Do as much as possible and then ask the supervising nurse for help with the rest of the assignment.
- C. Question the supervising nurse before starting the assignment.
- D. Ask the patient how the assignment was done the last time.

13. Which of the following should be done for a patient with a Foley catheter:

- A. Empty the bag at the end of your shift and measure amount.
- B. Record output.
- C. Keep bag lower than the bladder
- D. All of the above.
- E. None of the above, as the aide is never involved in Foley care.

14. Before transferring a patient to the wheelchair, the Home Health Aide should:

- A. Make sure the patient is wearing a bathrobe.
- B. Lock the wheels of the wheelchair.
- C. Offer the patient the bedpan.
- D. Bathe the patient.

15. Which of the following are low in salt?

- A. Ketchup and barbeque sauce.
- B. Cheddar cheese and Colby cheese.
- C. Carrots and apples.
- D. Potato chips and instant soups.

16. A diabetic patient must:

- A. Eat at regular intervals.
- B. Stay on a prescribed diet.
- C. Use a sugar substitute instead of sugar.
- D. All of the above.

17. Which are NOT allowed on a low salt diet?

- A. Garlic salt and Accent (monosodium glutemante)
- B. Garlic powder and onion powder
- C. Oregano and basil
- D. Pepper and chili pepper

18. A patient is receiving oxygen through a nasal tube. What safety precautions should the home health aide take?

- A. Keep the television set at least 5feet from the oxygen tank
- B. Do not permit the patient to drink soda.
- C. Allow no smoking in the patient's room.
- D. Do not use any lotions that contain oil in the patient's care.

19. An elderly male patient occasionally wets his trousers. What should the home health aide do?

- A. Give him fluids with his meals only.
- B. Avoid giving him coffee and tea.
- C. Tell him that if he urinates on himself he will have to be put in diapers.
- D. Encourage him to go to the bathroom at least every two hours.

20. Diabetics are prone to infection and are very slow in healing, therefore:

- A. Never cut their nails.
- B. Keep feet clean and dry.
- C. Observe for infection.
- D. All of the above.
- E. None of the above.

21. What is the chief reason for covering your mouth or nose when coughing or sneezing?

- A. To prevent the escape of bad odors.
- B. To prevent the spread of germs.
- C. To avoid injury to the lining of the nose and mouth.
- D. To avoid getting clothing dirty.

22. Which of these fluids is highest in protein?

- A. Vegetable broth.
- B. Lemonade.
- C. Tomato juice.
- D. Eggnog.

23. Milk is a good source of calcium. Which of these foods is also high in calcium?

- A. Cheese
- B. Bananas
- C. Orange juice
- D. Raisins

24. When patients do not have enough fluids, they may develop which of these problems?

- A. Diarrhea
- B. Swelling
- C. Constipation
- D. Dandruff

25. Hands should be washed when soiled but especially:

- A. Before preparing food.
- B. After using the toilet.
- C. Before and after giving personal care.
- D. After touching nose or mouth.
- E. All of the above.

26. Gloves should be worn when:

- A. Touching blood-soiled items.
- B. Touching body fluids and secretions.
- C. Touching contaminated surfaces.
- D. All of the above.

27. In general, when you are involved in assisting families and patients in their home, you must:

- A. Accept their ethnic and cultural background.
- B. Be sensitive to the individuals needs.
- C. Respect their privacy.
- D. Be careful with their personal belongings and property.
- E. All of the above.

28. Of the following, which might the Home Health Aide be expected to do:

- A. give injections
- B. give pills and other medication
- C. give a bed bath
- D. give oxygen

29. In order to maintain safety when caring for an elderly patient, you should:

- A. assist the patient slowly and allow them to move at his/her own pace
- B. never leave a patient alone in the bathtub
- C. put side rails in upright position when leaving patient unattended
- D. all of the above.

30. List 4 measures you should take in an effort to prevent skin breakdown in a bedridden patient.

- A.
- B.
- C.
- D.

31. The objectives of the HHA are:

- A. keeping the whole house clean
- B. providing good patient care, while keeping the patient safe and comfortable
- C. make the family happy

32. Communicable diseases are:

- A. diseases discussed in class so that we know more about them
- B. diseases which can be transmitted from one person to another
- C. diseases which no longer pose a health hazard

33. Mrs. Jones fell and broke her hip. In caring for her you should:

- A. consider what she can do, not can't do
- B. tell her she doesn't have to worry, you will do everything for her
- C. encourage her to cry it out
- D. discourage her family from visiting

34. To cut down on the amount of salt in a diet, you would purchase:

- A. fresh vegetables
- B. canned vegetables
- C. TV dinners
- D. ready-prepared food

35. Mr. Desmond is 79 years old. He lives alone and is on a low fat diet. Select the best menu from the ones below.

- A. Fried chicken, baked potato with butter, green beans, apple pie, whole milk
- B. Baked ham, potato salad, green peas, bread and butter, chocolate ice cream, tea
- C. Baked chicken, boiled potatoes with parsley, steamed carrots, fresh peaches, skim milk
- D. Meat loaf, French fried potatoes, mixed vegetables, jello with whipped cream, tea

36. The safest way to shape the fingernails of a client is to use:

- A. a pair of nail clippers
- B. a pair of nail scissors
- C. any scissors you can find
- D. an emery board/nail file

37. When transferring a client from a bed to a wheelchair, you should place the wheelchair:

- A. facing the bed
- B. at the foot of the bed
- C. alongside the bed facing the client
- D. alongside the bed away from the client

38. In using proper hand washing technique, you should:

- A. wash your hands up to the palms
- B. rinse hands so water and soap can drain the elbow
- C. repeat the washing process once
- D. wash the tap before turning off the water

39. If an elderly person seems to be anxious or upset the Home Health Aide should:

- A. encourage the client to tell you what is bothering him
- B. tell him he has nothing to worry about
- C. discourage his family from visiting
- D. ignore him

40. Of the following observations, which would be important to tell your supervisor?

- A. the menu for dinner
- B. the activities of the client's family
- C. the new clothing the client received
- D. the refusal of the client to take her medication

41. When the client cannot control bladder and bowel movements, it is called:

- A. diarrhea
- B. constipation
- C. urination
- D. incontinence

TRUE OR FALSE: Read the following statements. Circle T if the statement is true, and circle F if the statement is false.

- 42. A Home Health Aide worker may work with a physically disabled client. T or F
- 43. Problems on the job should be reported to your supervisor. T or F
- 44. The patient is always encouraged to help in his/her own care. T or F
- 45. As people get older they need to eat more food. T or F
- 46. If elderly people have trouble getting around, they should be encouraged
to sit all day. T or F
- 47. Elderly people are not able to learn anything new. T or F
- 48. Elderly people may want to talk more about their past than the present. T or F
- 49. A stroke can change the personality of a person. T or F
- 50. Elderly people who are not able to take care of their own needs should be
treated like children. T or F

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: _____

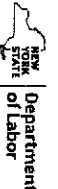
Date: _____

190R

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:



Notice and Acknowledgement of Pay Rate and Payday
Under Section 195.1 of the New York State Labor Law
Notice for Hourly Rate Employees

1. Employer Information

Name: Nannies for Grannies Inc

Doing Business As (DBA) Name(s): Nannies for Grannies

FEIN (optional):

Physical Address: 34 Sunset Lane Patchogue NY 11772

Mailing Address: 34 Sunset lane Patchogue NY 11772

Phone: 631-730-8500

- 2. Notice given:**
- At hiring
 - Before a change in pay rate(s), allowances claimed or payday

3. Employee's rate of pay:
\$ 17.00 per hour

- 4. Allowances taken:**
- None
 - Tips _____ per hour
 - Meals _____ per meal
 - Lodging _____
 - Other _____

5. Regular payday: _____

- 6. Pay is:**
- Weekly
 - Bi-weekly
 - Other

7. Overtime Pay Rate:
\$ 25.50 per hour (This must be at least 1½ times the worker's regular rate with few exceptions.)

8. Employee Acknowledgement:
On this day I have been notified of my pay rate, overtime rate (if eligible), allowances, and designated pay day on the date given below. I told my employer what my primary language is.

Check one:

- I have been given this pay notice in English because it is my primary language.
- My primary language is _____ I have been given this pay notice in English only, because the Department of Labor does not yet offer a pay notice form in my primary language.

Print Employee Name _____

Employee Signature _____

Date _____

Patricia Thelian/President
Preparer's Name and Title _____

The employee must receive a signed copy of this form. The employer must keep the original for 6 years.

Please note: It is unlawful for an employee to be paid less than an employee of the opposite sex for equal work. Employers also may not prohibit employees from discussing wages with their co-workers.