ABC
Home Care Agency

NO CONFLICT ATTESTATION

In order to qualify to act as the Personal Assistant for this Consumer, I attest to the ALL of following:

1. I am NOT the Consumer's Designated Representative.
2. The Consumer is NOT my child who is under 21 years of age.
3. I am NOT the Consumer's spouse.

Do you live at the same address as the Consumer? ☐ Yes ☐ No

If I answer YES to ANY of the 3 points listed above, I understand that I CANNOT act as the Personal Assistant for this Consumer and that any attempt to do so, would be `considered a violation of this CDPAP agreement and an act of fraud.

In addition, I attest to understanding that my employer is the Consumer and not ABC Home Care.

Personal Assistant Name: _____

Personal Assistant Signature: _____ Date: _____

Employment Application
CDPAP

For Office Use Only:
DATE OF HIRE: _____

Last Name: _____ First: _____ Middle initial: _____

Address: _____Apt #_____ City_____ State_____ Zip code _____

Home Phone Number: _____ Cell Phone Number: _____

Languages: _____

Country of Birth: _____

Ethnicity: _____

May we send you text messages if necessary? No__ Yes__, please provide telephone #_____

You understand and agree that text messages will be provided for informational purposes only. Some fees and text messaging rates may apply based on the plan you have with your cellphone carrier.

Emergency Contact: _____ Phone Number: _____ Relation: _____

Education:	Do you have a High School Diploma:	Yes ☐	No ☐
Training:	Do you have a HHA Certificate?	Yes ☐	No ☐
	Do you have a PCA Certificate?	Yes ☐	No ☐

ABC Home Care Agency *does not discriminate because of age, sex, physical handicap,race, creed, sexual orientation and any other protected classification, or national origin. This agency is an equal employment opportunity employer.*

I affirm that the information in this application is complete and true. I understand that if employed, false statements will be a cause for dismissal.

Signature: _____ **Date:** _____

EMERGENCY CONTACT FORM

Your Name: _____

First Contact Information

Contact Name: _____

Relationship to Employee: _____

Emergency Contact Home Phone#: _____

Emergency Contact Cell Phone #: _____

***

Second Contact Information

Contact Name: _____

Relationship to Employee: _____

Emergency Contact Phone Home #: _____

Emergency Contact Cell Phone #: _____

WORK AVAILABILITY

NAME: _____

TELEPHONE: _____

DAYS AND HOURS: **COMMENTS:**

___Saturday	___AM	___PM	_____
___Sunday	___AM	___PM	_____
___Monday	___AM	___PM	_____
___Tuesday	___AM	___PM	_____
___Wednesday	___AM	___PM	_____
___Thursday	___AM	___PM	_____
___Friday	___AM	___PM	_____

Are Pets OK?	___YES	___NO	_____
Is Smoking OK?	___YES	___NO	_____
Kosher Experience?	___YES	___NO	_____
Is vehicle available for work?	___YES	___NO	_____

Shift Preference: ☐ 4 hour ☐ 8 hour ☐ 12 hour ☐ Live-In

Location(s): ☐ Brooklyn ☐ Queens ☐ Bronx ☐ Manhattan

☐ Long Island ☐ Staten Island

Employment Eligibility Verification

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

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

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

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

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

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

STOP *Employer Completes Next Page* STOP

Form W-4 (2017)

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

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2017 expires February 15, 2018. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you can't claim exemption from withholding if your total income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions don't apply to supplemental wages greater than $1,000,000.

Basic instructions. If you aren't exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2017. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	**A** _____
B	Enter "1" if: { • You're single and have only one job; or • You're married, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less. } . . .	**B** _____
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	**C** _____
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	**D** _____
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . .	**E** _____
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit . . . (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	**F** _____
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child.	**G** _____
H	Add lines A through G and enter total here. (**Note:** This may be different from the number of exemptions you claim on your tax return.) ►	**H** _____

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Separate here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

► **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2017

1	Your first name and middle initial	Last name	**2** **Your social security number**
	Home address (number and street or rural route)	**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
	City or town, state, and ZIP code	**4** **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ► ☐	

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	**5**	
6	Additional amount, if any, you want withheld from each paycheck	**6**	$
7	I claim exemption from withholding for 2017, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here . . . . . ►	**7**	

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

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

8	Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number (EIN)

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:

Doing Business As (DBA) Name(s):
ABC Home Care Health

FEIN (optional):

Physical Address:

Mailing Address:

Phone: 716-939-7676

2. Notice given:

- ☑ At hiring
- ☐ Before a change in pay rate(s), allowances claimed or payday

3. Employee's rate of pay:

$ _____ 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:

$ _____ 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

_____
Preparer's Name and Title

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

HEPATITIS B VACCINE ACCEPTANCE / DECLINATION FORM

ACCEPTANCE:
I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of being infected by bloodborne pathogens, including Human Immunodeficiency Virus (HIV) and Hepatitis B Virus (HBV).
This is to certify that I have been informed about the symptoms and the hazards associated with these viruses, as well as the modes of transmission of bloodborne pathogens. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. In addition, I have received information regarding the Hepatitis B (HBV) vaccine. Based on the training I have received; I am making an informed decision to accept the Hepatitis B (HBV) vaccine.

DECLINATION:
I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

CHECK ONLY ONE: _____ I DECLINE Hepatitis B vaccine inoculation:

OR

_____ I ACCEPT Hepatitis B vaccine inoculation.

_____
Employee's Name (Please print)

_____ _____
Employee's Signature Date

Agreement between ABC Home Care Agency and Personal Assistant Live-In

1. All personal assistants (PA's) assigned to live-in cases are to be present in the consumer home for 24 hours each working day.
2. During each live in day, based on a 13 hour day, PA's are to perform tasks in accordance with the verbal or written care plan. PA's may not work in excess of 13 hours in any day and no more than 5 Live in days per week
3. During each 24 hour day, PA's are to take eleven hours for personal time which will include hours of sleep, meal breaks and other personal time, remaining on premises at all such times.
    - 8 hours of sleep time
    - 2 hours meal breaks
    - 1 hours of personal time- reading, watching television, etc.

4. If any PA finds it impossible to take the specified breaks from work duties because such times are constantly interrupted by the needs of the patient, she/he must call the administrator

I understand and will abide by the agency's rules stated in this agreement regarding time worked on live- in cases.

_____

Signature

_____

Print Name

_____

Date

THE PERSONAL ASSISTANT'S GUIDE TO THE
CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM

ACKNOWLEDGMENT OF RECEIPT

I have received the Personal Assistant's guide and I have chosen to participate in the CDPAP as a Personal Assistant. I understand that *ABC Home Care Agency* is the fiscal intermediary and I am hired, supervised, scheduled and trained by the consumer and/or designated representative.

Print Name: _____

Signature: _____ **Date:** _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE PRIVACY PRACTICES

I acknowledge that I have been provided with a copy of an *ABC Home Care Agency* Notice of Privacy Practices that provides a description of protected information uses and disclosures, and that I have had an opportunity to ask questions about anything that I did not understand.

Signature: _____

Print Name: _____

Date: _____

Personal Assistant Transportation

(Please sign only one)

I **will** provide *ABC Home Care Agency* with my driver's license and insurance card in order to transport my patient in my car and/or the patient's car.

_____ _____

Personal Assistant Signature **Date**

OR

I **will not** be transporting my patient in my car and/or my patient's car.

_____ _____

Personal Assistant Signature **Date**

START DATE ACKNOWLEDGEMENT

I, _____, acknowledge that I will not be able to start working as a Personal Assistant for the CDPAP program until I am specifically informed by *ABC Home Care Agency* that I am able to begin working on the case. Any allowance to work, that does not come directly from ABC, will be considered invalid. If I work under an invalid authorization I realize that I will not be able to be paid by ABC for the time that I worked. I understand that, generally, instructions to begin working as a Personal Assistant will be provided to me along with a caregiver code and an explanation of the process for clocking in and out.

Signature: _____

Flu Vaccine Declination

□ I will NOT be getting the flu vaccine for the 2016-2017 Flu season. I will wear a surgical mask during any time spent with any patients.

I understand that failure to comply with these requirements will put me and the patient I care for at risk, and my employment with *ABC HCA* is conditional on meeting these requirements.

_____ _____ _____

Name of Employee (print) Signature of Employee Date

Acknowledgement Of
HHA Mandatory Compliance Responsibilities

I, _____, Personal Assistant, understand that I have been oriented regarding mandatory compliance responsibilities of the agency with the Department of Health. Although ABC Home Care reminds me of annual compliance needs 6 weeks before expiration, it is my sole responsibility to:

1. To have completed a pre-employment physical, PPD and toxicology drug screen.
2. To have obtained Rubella and Rubeola Titers prior to employment
3. To obtain an Annual physical, drug screen and PPD
4. If I have a history of a Positive PPD, I will submit an annual TB Questionnaire and a copy of a Chest X-ray report to EHHC.

I acknowledge that I am solely responsible to submit these required documentations in order to continue my employment with ABC Home Health Care. I acknowledge that for the safety of the patients whom I will service, I will not be able to work with patients if I do not have these requirements completed. I have read, understand and agree with ABC Home Care Agency Personnel Policy and will abide by it.

_____ _____

PA's Signature **Date**