Pleet
HOME CARE CDPAP
From Buffalo for Buffalo

YES	CHART ORDER LIST	NOTES	TAB	Outside Items Needed
	Application (3 Pages)		Application	
	Disclosure and Authorization		Application	
	Search and Exchange Authorization		Application	
	HIPPA		Orien/ Policy	
	HIV- Confidentiality/ Privacy		Orien/ Policy	
	Conflict Agreement		Policy	
	Overtime and Hospitalization Agreements		Policy	
	Social Security Card		Wages/ W-4	Copy of SSC
	Photo ID		Wages/ W-4	Copy of Photo ID
	W-4 Form		Wages/ W-4	
	Notice of Employee Wages		Wages/ W-4	
	Direct Deposit (Copy of Voided Blank Check)		Wages/ W-4	Voided Check
	Mobile Health Agreement		Medical	
	Physical (Doctor's Note Included)	Signed by the doctor and within the past year	Medical	Physical within the Year
	PPD	Lab Results within the last year	Medical	PPD Lab Results
	Rubella/ Measles/ Mumps/ Varicella	Lab Results proving immunity within the last 10 years	Medical	MMR Lab Results
	Statement of Non-Habituation		Medical	
	Hepatitis Vaccine		Medical	
	Influenza Vaccine		Medical	
	Pneumonia Vaccine		Medical	
	I-9 Form		N/A	
	Receipt for Handbook		N/A	
	Arbitration Clause		N/A	
	Medicaid Exclusion (Ok to Work)		Alisarri	

The categories listed in red must be printed and NOT handwritten from the doctor's office.
The categories in blue must NOT be expired.
The categories in green are optional to have done, not required, but require signature.

Caregiver Intake

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Intake Date: _____

Name: _____

Address:

_____

_____

Phone: _____

Alt Phone: _____

Consumer(s) paired with Caregiver:

_____

_____

Do they need a physical? (Y/N) _____

Physician: _____ Phone/Fax: _____

Address: _____

Appointment Dates:	Purpose:

Notes:

_____

_____

_____

_____

_____

Pleet Home Care

Consumer Directed Personal Assistance Program (CDPAP) Application

PLEASE PRINT CLEARLY

This application must be completed with all questions and all training and work experience answered. All information on this application is confidential. Pleet Home Care will not contact your present employer without your consent.

PERSONAL INFORMATION:

Name: _____
LAST FIRST MIDDLE

SS#: _____-_____-_____ D.O.B____/____/____ Gender: F / M

Address:_____

_____

Home Phone: _____ Cell Phone:_____

Email Address:_____

Are you 18 years or older: Yes // No

Are you prevented from lawfully becoming employed in this country because of Visa Or Immigration Status? Yes // No

US Citizen: Yes // No If No. immigrant ID/Card #: _____

Can you work overtime if necessary? Yes No

Transportation: Car _____Bus_____Other: _____

Have you ever worked here before? Yes No When? _____

Please indicate what Languages you speak: _____

EDUCATION SCHOOL:	YEARS:	CITY:	DID YOU GRADUATE IF SO, WHAT YEAR?	DIPLOMA OR DEGREE:

LICENSURE/CERTIFICATION:

POSITION APPLYING FOR: HHA // PCA // OTHER: _____

LIC#: _____ EXP. DATE: _____

SCHOOL TRAINING PROGRAM: _____

EXPERIENCE/EMPLOYMENT HISTORY

Company Name Company Phone #	Dates		Last Salary	Job Title	Reason for leaving
	To	From			

Please read and sign statement:

I understand that if I am hired I will be required to provide proof of identity and legal work authorization as well as all required documentation as required by the NYS DOH as it pertains to the employment of paraprofessional / direct care providers.

AT WILL EMPLOYMENT POLICY:

In the event that the applicant agrees to accept a position with the company, the applicant and the company agree that employment relationship between the company and the employee is an at will relationship and that the employment relationship and compensation can be terminated, with or without cause, and with or without notice at any time, at the option of either company or the employee.

_____

Signature Date

Comments: (for office only)

_____

1st day of work: _____

Availability

Please indicate your availability. Check all that may apply

Full time	**Part time**	**Weekends only**
Day	**Night**	**Live In**

Date	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From							
To							

Allergies:

_____

I am allergic to dogs Yes No

I am allergic to cat Yes No

Conditions of employment: _____

I understand that I must notify my coordinator in advance for any time off, please see employee handbook for details.
I understand that my assignment ends, or if I am not working for more than 3 days, it will be my responsibility to contact.
I understand that I am required to work every other weekend and 3 holidays per year.
I understand that I may be required to travel up to 60 minutes from my home by mass transit.
I understand that in case of emergency I must remain with my patient unless told otherwise by my coordinator. Patient abandonment will not be tolerated at any time.
I understand that a No Show No Call is ground for immediate termination.

Employee Print Name: _____

Employee Signature: _____

Date: _____

Pleet Home Care

DISCLOSURE AND AUTHORIZATION

Applicant's Name: _____

This serves to advise that in consideration for employment, a consumer report and/or investigative report may be obtained on you. This process may include verification of education; credit history; employment history; a review of any local, county, state, and federal government agency record; court public records; driving records (MVR), and employment references. Employment references may include information pertaining to your general character and reputation, work habits, and other employment related characteristics. Upon request, a copy of the credit report will be provided to you at no charge.

By signing this DISCLOSURE & AUTHORIZATION

__X__ You acknowledge receipt of this Disclosure & Authorization, as well as receipt of the summary of your rights under the Fair Credit Reporting Act.

__X__ You give us permission to obtain a consumer report and/or investigative consumer report on you for employment purposes.

Received and Authorized by:

The following is required to conduct pre-employment verifications. Date of birth and maiden name are not considered in the employment decision. This information is utilized for accurate records verification only

Printed full Name: _____
Home Phone (Include Area Code): _____
Work Phone (Include Area Code): _____
Social Security Number: _____
Maiden or other name used: _____
Year last used: _____ **Date of Birth:** _____
Drivers License Number: _____ **State:** _____

I request that this document in its original or copied form serve as my valid authorization to any and all persons, educational institutions, past and/or current employers, organizations, credit reporting agencies, law enforcement or criminal record agencies, and other agencies to release information about me and hereby release all such persons, institutions, agencies, employers, and organizations providing such information from liability in any or all claims and damages connected with their providing any requested information.

SIGNATURE : _____ DATE: _____

Pleet Home Care

AUTHORIZATION FOR SEARCH AND EXCHANGE OF INFORMATION

Statement of Disclosure of Abuse or Conviction

I,_____, hereby authorize Pleet Home Care Agency to submit a request to the Attorney General of the United States to conduct a Search of the record of the Criminal Justice information Services Division of the Federal Bureau of Investigation for any criminal history records corresponding to the fingerprints or other identification information submitted by me. I further authorize the exchange of such information between the Attorney General of the United States, the New York State Department of Health, and Pleet Home Care Agency. This information may be used only by Pleet Home Care Agency. and only for the purpose of determining my suitability for employment in a position involved in direct patient care supervision.

_____ _____

Signature of Applicant Date

DISCLOSURE OF FINDINGS

I hereby affirm and/or swear under penalties of perjury that I have not been found guilty in any forum of patient and/or resident abuse and that I have not been convicted of any crime or violation, other than traffic infractions, except the following:

DATE	COURT	SECTION OF LAW VIOLATED

I have_____have not _____ (check one) been issued a Certificate of Relief from Civil Disabilities and Forfeitures and/or Certificate of Good Conduct in conjunction with the above offenses. A copy of any such certificate is attached herewith.

_____ _____

Signature of Applicant Date

Pleet Home Care

HIPAA Acknowledgment

A Life Saver Home Care Services, Inc. provides formal education and training to employees to ensure accountability for privacy and security of Protected Health Information (PHI). I agree to maintain the privacy and confidentiality of the residents I am assigned to care for. I understand the civil and criminal penalties involved with violating the HIPAA Privacy Laws. I understand when PHI can be disclosed, and also that I am to report any violation of the Privacy Laws to the Privacy officer. My signature is proof/acknowledgment of having received said training along with the agency's HIPAA policy and procedure.

Date: ___/___/___

Employee Name (print): _____

Employee Signature: _____

Instructor Signature: _____

Pleet Home Care

I have received the in-service literature and acknowledge understanding of the following policies, as they should be practiced in addition to any further policies and procedures, which are to be followed:

Acknowledgement of receipt of Privacy Notice: X. I have received the A Life Saver Home Care, Inc. Privacy Notice and all questions regarding this notice have been answered.

Employee statement of HIV/Confidentiality: X. I the undersigned understand the importance of observing strict confidentiality policies. Therefore, I agree, not to discuss/release any information obtained within the agency regarding any A Life Saver Home Care Services Agency, Inc. client, their medical record, or any client's condition with any individual not directly associated with that client. I also agree that any information that is released regarding the client's record will only be done with proper authorization and or in accordance with established agency policy for the release of the information.

In the event you are made aware that your patient is HIV positive. You cannot disclose this information to any other individual. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as permitted by law. Any unauthorized further disclosure is violation of State law and may result in a fine or jail sentence or both. General authorization for the release of medical or any other information is not sufficient authorization for further disclosure.

My signature on this document indicates that I understand and agree to abide by the policies, and that any breach in the policies will result in DISMISSAL from employment at A Life Saver Home Care Services, Inc.

Date: _____-_____-_____

Print Name: _____

Employee Signature: _____

Instructor Signature: _____

Pleet
HOME CARE CDPAP
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Conflict Acknowledgement

I, (Print Name)_____, understand that I cannot be a paid caregiver through the Medicaid CDPAP program at Pleet Home Care if I am an **authorized representative and/or power of attorney to the consumer,** as this is a conflict of interest. By signing this paper, I acknowledge that I am neither of these representations to the consumer and I do not have a conflict of interest.

_____ _____

Signature Date

Pleet
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Overtime Agreement

I, (Print Name) _____, understand that Pleet Home Care does not approve overtime. Dependent upon the authorization of the consumer(s) you will be working for, an employee may work up to 40 hours per week. As an employee, I understand that if I choose to work over 40 hours within a week, I will not be paid for that time.

_____ _____

Signature Date

Hospitalization Acknowledgement

Pleet Home Care CDPAP is a Medicaid run program that requires that care be given to the consumer in the home. By signing this, you acknowledge your understanding that when a Pleet consumer you are working with is hospitalized, you are unable to work with them and you will not receive payment by Pleet Home Care. I also understand it is my responsibility to inform Pleet Home Care of changes in the home, such as, but not limited to hospitalization and rehabilitation.

_____ _____

Signature Date

Please put the copies
of identification in place of this paper.

Example: Passport, Driver's License, or Social Security Card copies

Form W-4 (2019)

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

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

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

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

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

General Instructions

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

You can also use the calculator at *www.irs.gov/W4App* to determine your tax withholding more accurately. Consider using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income not subject to withholding outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2019. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

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

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

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

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

Specific Instructions

Personal Allowances Worksheet

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

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

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

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

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

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

Employee's Withholding Allowance Certificate

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

OMB No. 1545-0074

2019

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 filing separately, check "Married, but withhold at higher Single rate."	
City or town, state, and ZIP code	4 If your last name differs from that shown on your social security card, check here. You must call 800-772-1213 for a replacement card. ▶ ☐	

5 Total number of allowances you're claiming (from the applicable worksheet on the following pages) 5

6 Additional amount, if any, you want withheld from each paycheck . . . . . 6 $

7 I claim exemption from withholding for 2019, and I certify that I meet **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 boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)	9 First date of employment	10 Employer identification number (EIN)

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for yourself . . . . . A ____

B Enter "1" if you will file as married filing jointly . . . . . B ____

C Enter "1" if you will file as head of household . . . . . C ____

D Enter "1" if:
- You're single, or married filing separately, and have only one job; or
- You're married filing jointly, have only one job, and your spouse doesn't work; or
- Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less. . . . . D ____

E **Child tax credit.** See Pub. 972, Child Tax Credit, for more information.
- If your total income will be less than $69,801 ($101,401 if married filing jointly), enter "4" for each eligible child.
- If your total income will be from $69,801 to $175,550 ($101,401 to $339,000 if married filing jointly), enter "2" for each eligible child.
- If your total income will be from $175,551 to $200,000 ($339,001 to $400,000 if married filing jointly), enter "1" for each eligible child.
- If your total income will be higher than $200,000 ($400,000 if married filing jointly), enter "-0-" . . . . . E ____

F **Credit for other dependents.**
- If your total income will be less than $69,801 ($101,401 if married filing jointly), enter "1" for each eligible dependent.
- If your total income will be from $69,801 to $175,550 ($101,401 to $339,000 if married filing jointly), enter "1" for every two dependents (for example, "-0-" for one dependent, "1" if you have two or three dependents, and "2" if you have four dependents).
- If your total income will be higher than $175,550 ($339,000 if married filing jointly), enter "-0-" . . . . . F ____

G **Other credits.** If you have other credits, see Worksheet 1-6 of Pub. 505 and enter the amount from that worksheet here . . G ____

H Add lines A through G and enter the total here . . . . . ▶ H ____

For accuracy, complete all worksheets that apply.
- If you plan to **itemize or claim adjustments to income** and want to reduce your withholding, or if you have a large amount of nonwage income and want to increase your withholding, see the **Deductions, Adjustments, and Additional Income Worksheet** below.
- If you **have more than one job at a time** or are **married filing jointly and you and your spouse both work**, and the combined earnings from all jobs exceed $52,000 ($24,000 if married filing jointly), see the **Two-Earners/Multiple Jobs Worksheet** on page 4 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 above.

Deductions, Adjustments, and Additional Income Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income.

1 Enter an estimate of your 2018 itemized deductions. These 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. See Pub. 505 for details . . . . . 1 $ ____

2 Enter:
- $24,000 if you're married filing jointly or qualifying widow(er)
- $18,000 if you're head of household
- $12,000 if you're single or married filing separately . . . . . 2 $ ____

3 **Subtract** line 2 from line 1. If zero or less, enter "-0-" . . . . . 3 $ ____

4 Enter an estimate of your 2018 adjustments to income and any additional standard deduction for age or blindness (see Pub. 505 for information about these items) . . . . . 4 $ ____

5 **Add** lines 3 and 4 and enter the total . . . . . 5 $ ____

6 Enter an estimate of your 2018 nonwage income (such as dividends or interest) . . . . . 6 $ ____

7 **Subtract** line 6 from line 5. If zero, enter "-0-". If less than zero, enter the amount in parentheses . . . 7 $ ____

8 **Divide** the amount on line 7 by $4,150 and enter the result here. If a negative amount, enter in parentheses. Drop any fraction . . . . . 8 ____

9 Enter the number from the **Personal Allowances Worksheet**, line H above . . . . . 9 ____

10 **Add** lines 8 and 9 and enter the total here. If zero or less, enter "-0-". If you plan to use the **Two-Earners/Multiple Jobs Worksheet**, also enter this total on line 1, page 4. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 10

Two-Earners/Multiple Jobs Worksheet

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

1 Enter the number from the **Personal Allowances Worksheet**, line H, page 3 (or, if you used the **Deductions, Adjustments, and Additional Income Worksheet** on page 3, the number from line 10 of that worksheet) . . . . . 1 _____

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you're married filing jointly and wages from the highest paying job are $75,000 or less and the combined wages for you and your spouse are $107,000 or less, don't enter more than "3" . . . . . 2 _____

3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet . . . . . 3 _____

Note: If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4 Enter the number from line 2 of this worksheet . . . . . 4 _____

5 Enter the number from line 1 of this worksheet . . . . . 5 _____

6 **Subtract** line 5 from line 4 . . . . . 6 _____

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . . . 7 $ _____

8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . . 8 $ _____

9 **Divide** line 8 by the number of pay periods remaining in 2018. For example, divide by 18 if you're paid every 2 weeks and you complete this form on a date in late April when there are 18 pay periods remaining in 2018. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck . . . . . 9 $

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $5,000	0	$0 - $7,000	0
5,001 - 9,500	1	7,001 - 12,500	1
9,501 - 19,000	2	12,501 - 24,500	2
19,001 - 26,500	3	24,501 - 31,500	3
26,501 - 37,000	4	31,501 - 39,000	4
37,001 - 43,500	5	39,001 - 55,000	5
43,501 - 55,000	6	55,001 - 70,000	6
55,001 - 60,000	7	70,001 - 85,000	7
60,001 - 70,000	8	85,001 - 90,000	8
70,001 - 75,000	9	90,001 - 100,000	9
75,001 - 85,000	10	100,001 - 105,000	10
85,001 - 95,000	11	105,001 - 115,000	11
95,001 - 130,000	12	115,001 - 120,000	12
130,001 - 150,000	13	120,001 - 130,000	13
150,001 - 160,000	14	130,001 - 145,000	14
160,001 - 170,000	15	145,001 - 155,000	15
170,001 - 180,000	16	155,001 - 185,000	16
180,001 - 190,000	17	185,001 and over	17
190,001 - 200,000	18		
200,001 and over	19		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $24,375	$420	$0 - $7,000	$420
24,376 - 82,725	500	7,001 - 36,175	500
82,726 - 170,325	910	36,176 - 79,975	910
170,326 - 320,325	1,000	79,976 - 154,975	1,000
320,326 - 405,325	1,330	154,976 - 197,475	1,330
405,326 - 605,325	1,450	197,476 - 497,475	1,450
605,326 and over	1,540	497,476 and over	1,540

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

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

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

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

NEW YORK
STATE OF
OPPORTUNITY

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):

FEIN (optional):

Physical Address:

Mailing Address:

Phone:

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.

X _____

Print Employee Name

X _____

Employee Signature

X _____

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.

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.

Notice and Acknowledgement ofPay Rate and Payday/*Aviso y Acuse de Recibo de Tasa de Pago y Día de Cobro*
Under Section 195.1 of the New York State Labor Law/*Bajo la Sección 195.1 de La Ley de Trabajo del Estado de Nueva York*
Notice for HourlyRate Employees/*Aviso para empleados con tasa de pago por hora*

1. Employer Information/*Información del Empleador*

Name/*Nombre*:

Doing Business As (DBA) name(s)/ *Nombre(s) comercial(es)*:

FEIN (optional)/ Número de Identificación Federal *(opcional)*:

Physical Address/*Dirección Física*:

Mailing Address/*Dirección postal u oficial*:

Phone/*Teléfono*:

2. Notice given/*Aviso emitido*:

- [X] At hiring/ En la *contratación*
- [ ] On or before February 1/*En o antes del 1 de Febrero*
- [ ] Before a change in pay rate(s), allowances claimed or payday. *Antes de un cambio en tasa de pago, créditos tomados, o día de cobro*

3. Employee's Pay Rate/*Tasa de pago del empleado:*

$_____ per hour/*por hora*

4. Allowances taken/*Créditos tomados:*

- [X] None/*ninguno*
- [ ] Tips/*Propinas* _____per hour/ *por hora*
- [ ] Meals/*Comidas* _____ per meal/ *por comida*
- [ ] Lodging/ *Hospedaje* _____
- [ ] Other/*Otra* _____

5. Regular payday/*Día de Cobro Regular*:

_____

6. Pay is/*El pago es*:

- [ ] Weekly/ *Semanal*
- [X] Bi-weekly/*Quincenal*
- [ ] Other/*Otro* _____

7. Overtime Pay Rate/*Tasa de Pago de Horas Extras (más de 40 horas trabajadas en una semana):*

$_____ per hour/*por hora* (This must be at least 1½ times the worker's regular rate, with few exceptions.)/*Con pocas excepciones, esta tasa debe ser por lo menos 1½ veces la tasa de pago regular para el trabajador.*

8. Employee Acknowledgement/*Acuse de Recibo del Empleado*: On this day, I received notice of my pay rate, overtime rate if eligible, allowances, and designated payday in English and my primary language. I told my employer that my primary language is **Spanish**. *En esta fecha, se me ha informado de mi tasa de pago, mi tasa de pago de horas extras (si elegible), créditos, y del día de cobro en inglés y en mi lengua materna. Le indiqué al empleador de que mi lengua materna es* ***español.***

X _____
Print Employee Name/*Escriba el nombre del empleado en letra de imprenta*

X _____
Employee Signature/*Firma del Empleado*

X _____
Date/*Fecha*

_____
Preparer Name and Title/*Nombre y Título del Preparador de este Documento.*

The employee must receive a signed copy of this form. The employer must keep the original for 6 years./*El empleado debe recibir una copia firmada, de este documento. El original debe permanecer con el empleador por 6 años.*

LS 54S (03/11)

Pleet Home Care

Notice and Acknowledgement of Pay Rate and Payday

Employer
Company Name: Pleet Home Care Agency
Street address: 209 Beach 125th Street
City and state: Belle Harbor, NY
Zip code: 11694
Phone: (718) 513-3770

Preparer's name: _____

Preparer's title: _____

Employee
Name: _____

Street address (include apartment): _____

_____

_____

City: _____

State and zip code: _____

Phone: ( )_____

Your rate of pay:_____**Per Hour**

Your overtime rate of pay:_____**Per Hour**

Designated pay day: Friday, Bi-Weekly, First Pay Date:_____

I have been notified of me pay rate, overtime rate, and designated payday on the date given below

X _____
Date Employee's Signature

_____
Date Preparer's signature

Fleet Home Care

209 Beach 125th Street
Belle Harbor, NY 11355

Direct Deposit Application

If you would like your paycheck deposited into your checking account, you must attach a voided blank check. ★

If you wish to have your paycheck deposited into your savings account, please attach a blank deposit slip.

Please check one of the options below

- ☐ New Direct Deposit
- ☐ Change to existing direct deposit
- ☐ Cancel Direct Deposit

Personal Information:

Employee Name: (Last, First)
Address:
Social Security Number:
Telephone Number:

Bank Information:

Name and Address of Financial Institution:
Account Number:
Routing Number:
Account Type: Checking (Attach a voided check) Savings (Attach a deposit slip)

Authorization: I (hereinafter referred to as the employee) hereby authorize A Life Saver Home Care to make deposits from time to time in the account identified about at my Depository Financial Institution (hereinafter referred to as the Bank) and authorize the Bank to accept these deposits. Adjusting entries to the correct errors are also authorized. It is agreed that this deposits and adjustment be made electronically and under the Rules of the Automated Clearing House Association (ACHA). This authorization will remain in effect until A Life Saver Home Care receives written notice of termination from the Employee or upon termination of the Employee's employment with A Life Saver Home Care. I have retained a completed copy of this Authorization for my record. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of the US law.

Employee Signature: X _____ Date: X _____

This form will not be processed without your signature.

Pleet
HOME CARE CDPAP
From Buffalo for Buffalo

Mobile Health Agreement

I, (Print Name)_____, understand that any results from Mobile Health are property of Pleet Home Care. Due to agency pay, these records will not be released. Pleet offers Mobile Health as an option for you to have the necessary physical, PPD/ QuantiFERON and any titers or immunizations to start employment through Pleet Home Care. However, you also have the option of going to your own doctor for the necessary forms needed for employment.

By signing this form, you are stating that you understand your right to receive these forms from your doctor, through your insurance or private pay. In addition, your signature denotes that if Pleet Home Care Agency pays for your Mobile Health appointment and/or testing, any results and/or records given to Pleet Home Care are property of Pleet Home Care and will not be released.

Lastly, this signature confirms your understanding that after any missed mobile health appointments, a following appointment will not be made on agency pay.

Signature: X_____ Date: X_____

Pleet Home Care

209 Beach 125th Street
Belle Harbor, NY 11355

PHYSICAL FORM

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

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

COMMENTS:

HEAD/ENT:					
EYES:					
NECK:					
BREASTS:					
LUNGS:					
CARDIOVASCULAR:					
MUSCULOSKELETAL:					
ABDOMEN:					
GENITOURINARY:					
CENTRAL NERVOUS SYSTEM:					
HT:	WT:	B/P:	PULSE:	RESP:	TEMP:

****LABORATORY TEST RESULTS MUST BE ACCOMPANIED BY LAB REPORTS****

TEST	DATE PERFORMED		RESULTS PROVIDE LAB VALUES AND INTERPRETATIONS
PPD/QuantiFERON (ANNUALLY)	1. DATE IMPLANTED	1. DATE READ	RESULTS (mmxmm)
PPD 2ND DOSE	2. DATE IMPLANTED	2. DATE READ	RESULTS (mmxmm)
CHEST X-RAY (+PPD)	DATE:	RESULTS:	

IMMUNIZATIONS:	DATE	DATE	DATE &/or RESULTS
RUBEOLA/MEASLES:	1.	2.	• NON-IMMUNE • IMMUNE LAB VALUE:
RUBELLA:	1.	2.	• NON-IMMUNE • IMMUNE LAB VALUE:
DRUG SCREEN:	1.	POSITIVE OR NEGATIVE:	
HEPATITIS B VACCINE:	1.	POSITIVE OR NEGATIVE:	

Please circle one:

- This individual 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 drugs or alcohol.
- This individual is able to work with the following limitations:
- This individual is not physically/mentally able to work. *(specify reason):*

1.
2.
3.

Physician Signature: **LIC. No.** **Date:**

Please,

put any doctor's reports

that are included in place of this sheet.

Examples: Any Clinical Notes, PPD, Rubella, Measles, Mumps, Varricalla

Pleet Home Care

209 Beach 125th Street
Belle Harbor, NY 11694

STATEMENT OF NON-HABITUATION

I _____ certify that I am not using or
(Print Employee's Name)
habituated or addicted to depressants, stimulants, narcotics , alcohol, or other

drugs that may alter my behavior and that I am fully able to perform the duties of a

RN LPN HHA PCA requested by A Life Saver Home Care Services, Inc.
(circle applicable job classification)

_____ _____
(Employee's Signature) (Date)

Pleet
HOME CARE CDPAP
From Buffalo for Buffalo

The next three pages of

VACCINATION STATEMENTS are NOT REQUIRED by Pleet Home Care for employment.

However, if you accept, Pleet Home Care will send you for the vaccination through Mobile Health at agency pay.

Please note that you cannot accept and decline, choose one. Thank you.

Pleet Home Care

HEPATITIS B VACCINATION STATEMENT

Decline [_____ 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 vaccination at no charge to myself.

or

Decline [_____ 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 want to be vaccinated with hepatitis B vaccine, I can receive the vaccination at no charge to me. Pleet Home Care Agency offers the hepatitis B vaccination to all employees whether or not they are at risk of exposure to HBV infection.

Decline [

Employee Name (print): _____

Employee Signature: _____

Date: _____

or

Pleet Home Care Services Agency, Inc. offers the hepatitis B vaccination to all employees whether they are at risk of exposure to HBV infection.

Accept [____ I accept this offer and request the HBV vaccination.

Accept [

Employee Name (print): _____

Employee Signature: _____

Date: _____

Pleet Home Care

INFLUENZA VACCINATION STATEMENT

Name:_____

_____I have read, or have had explained to me, information regarding the influenza vaccination and I understand the benefits and risks of being vaccinated from this illness. I have been given the opportunity to be vaccinated.

Agree [_____I agree to have the influenza vaccine.

or

Decline [_____I decline the influenza vaccination for this season. I understand that I may rescind this declination at any time. Please check the following reason for your refusal:

(Please check one)

_____Medically contraindicated
_____Against my religious belief
_____Already received the influenza vaccination on:_____

X_____ X_____

Employee Signature *Date*

(please have your doctor complete the bottom portion of this form.)

To be completed by the administering doctor:

Name and Address of facility where the Influenza Vaccine was administered to the above mentioned:

_____
_____

_____ _____ _____

Vaccine Type *Date* *Signature*

Pleet Home Care

PNEUMOCOCCAL PNEUMONIA VACCINATION STATEMENT

Name: _____

I have read, or have had explained to me, information regarding the pneumococcal pneumonia vaccination and I understand the benefits and risks of being vaccinated from this illness. I have been given the opportunity to be vaccinated.

However,

Decline

_____I decline the vaccine currently because:

_____The Pneumococcal vaccine is medically contraindicated.

_____It is against my religious belief to have the Pneumococcal vaccine.

Already Received

_____I have already received the Pneumococcal immunization.
_____The administrator of the vaccine was:

The vaccine dosage was:_____

The date of the vaccine was:_____

OR

Accept

_____I accept this offer and request arrangements to be made for me to receive the Pneumococcal vaccine.

Signature: X_____ Date: X_____

(Please have your doctor complete the bottom portion of this form)

Type of Vaccine(s):_____

Vaccine Manufacturer:_____

Dose of Vaccine(s):_____ Vaccine Lot#:_____

Date of Vaccination:_____ Site of Administration:_____

Vaccine Administrator: _____

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

Employment Eligibility Verification

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

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

Section 2. Employer or Authorized Representative Review and Verification

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

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

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

Additional Information

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

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

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

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

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

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code
420 Niagara Street	Buffalo	NY	14201

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

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

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

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

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

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

Please use for the next page.

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

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

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Pleet Home Care

Acknowledgment of Receipt of Handbook for the Personal Assistant

I have been given the handbook for the personal assistant by Pleet Home Care Agency.

X _____

Signature of Personal Assistant

X _____

Date

Pleet Home Care

ARBITRATION CLAUSE

Any dispute or controversy arising under or in connection with this Agreement shall be settled exclusively by arbitration, conducted before an arbitrator in New York, New York, in accordance with the rules of the American Arbitration Association then in effect. Judgment may be entered on the arbitrator's award in any court having jurisdiction; the expense of such arbitration shall be borne by the Bank.

EMPLOYEE/APPLICANT FULL NAME:
EMPLOYEE/APPLICANT SIGNATURE:

Pleet
HOME CARE CDPAP
From Buffalo for Buffalo

Are you finished with your application?

Check how far you have gone with the caregiver application checklist!

- **Fill out every paper of the application.**
  - Double check to make sure you got *all signatures* and information. It can be easy to miss some and we cannot process your application until it is complete!
- **Set up an appointment with your doctor for as soon as possible.**
  - You need to have a physical (including immunization list) filled out by your doctor within the last year.
  - Lab reports typed and printed for PPD (within the year) and MMR (proven immune and within the last 10 years).
  - Make sure the doctor signed AND put their license number.
  - Attach a printed copy of your immunization records from the doctor to your application.
- **Direct deposit is required when working with Pleet Homecare**
  - If you do not have a bank account, please set one up. Any account that has a routing and accounting number that money can be direct deposited into will work.
  - Make sure to include a copy of a blank voided check. If you do not have a check, you can have a direct deposit authorization form printed from your back with the account information on it.
- **Have copies made of your forms of identification.**
  - The forms of ID needed are different for every caregiver. Usually, a social security card and driver's license are best.
    - At least one form of photo identification and/or what forms you choose from the I-9 form will be what you copy.
    - Check that your ID is not expired. Expired ID's will not be accepted.

Questions? Call your Pleet Homecare Representative.

Name: _____ Phone # _____

Fax # 1-716-954-7162