



PLEASE PRINT CLEARLY

This application must be completed and full, with all signatures, dates, and outside information requested to be complete. All information on this application is confidential.

1A. Personal Information

Name: (Last, First, Middle) _____

Consumer/s working with: _____

SS#: _____ - _____ - _____ DOB: ____/____/____ Gender: *F / M*

Address: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Are you 18 years or older? *Yes / No* US Citizen: *Yes / No* If No, Immigrant ID Card: _____

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

Transportation: (Car) _____ (Bus) _____ Other: _____

Have you worked with Pleet Home Care before? *Yes / No* If so, when? _____

What Languages do you speak? _____

Please indicate your last completed form of **EDUCATION** below:

Education School	Years Attended	City	Did you Graduate? If so, what year?	Diploma or Degree:

Please indicate any related **LICENSE/ CERTIFICATION** you possess, if any:

LIC#	EXP Date	School/Training Program	Other:

2A. EXPERIENCE/ EMPLOYMENT HISTORY

Company Name And Phone #	Dates Employed (Start and End)	Last Salary	Job Title	Reason for Leaving
	Start: End:	\$ _____		
	Start: End:	\$ _____		
	Start: End:	\$ _____		

Please read and sign the statement below:

I understand that if I am hired, I will provide proof of identify 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. Signing below signifies understanding 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 *(This application will not be processed without your signature)*

Date

2B. Acknowledgement of Receipt of Handbook for the Caregiver / Personal Assistant (PA)

I have been given the handbook for the personal assistant by Pleet Home Care Agency. I understand that this can be accessed on the Pleet Home Care at <https://pleetcdpap.com>. In addition, I know can request one from my intake coordinator.

Signature *(This application will not be processed without your signature)*

Date



3A. Availability (Check all that apply)

Full Time	Part Time	Weekends	Day	Night	Live In

Please provide your **schedule**:

Weekly: _____ Biweekly: _____ Other: _____

Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From:							
To:							

I understand that I must notify the consumer and Pleet Home Care Representative in advance for any time off, please see employee handbook for details.

I understand that if my assignment ends, or I am not working for more than 3 days, it will be my responsibility to make contact to all parties.

I understand that it is my duty to call emergency services (ie. #911) and contact Pleet Home Care in the case of an emergency with the consumer you are working with.

I understand that No Call No Show is ground for immediate termination.

Signature (This application will not be processed without your signature)

Date

3B. HIPPA Acknowledgement

I understand that as an employee with Pleet Home Care CDPAP, I agree to maintain the privacy and confidentiality of the consumer I am working for. I understand the civil and criminal penalties involved with violating the HIPPA Privacy Laws. I understand that when protected health information (PHI) can be disclosed and also when I am to report any violation of the Privacy Laws to the Vice President or Management of the company. My signature is acknowledgement that I understand what is required in alignment with company and governmental policy.

Signature (This application will not be processed without your signature)

Date

4A. Conflict Agreement

I, (Print Name) _____, understand that I cannot be 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 (This application will not be processed without your signature)

Date

4B. 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 Buffalo, NY, in accordance with the rules of the American Arbitration Association then in effect. Judgement may be entered on the arbitrator's award in any court having jurisdiction; the expense of such arbitration shall be borne by the Bank.

Signature (This application will not be processed without your signature)

Date

4C. Please place the COPIES OF YOUR IDENTIFICATION behind this paper.

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

Items must be updated, not past expiration. This is needed for a completed application.

Driver's License
And
Social Security

OR

Passport

Outside Items Required with this Form:

- Copy of Driver's License
- Copy of Social Security



5A. Disclosure and Authorization

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 may include information pertaining to your general character and reputation, work habits, and other employment characteristics.

By signing this disclosure and authorization

X You acknowledge receipt of this Disclosure and 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 investigate 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.

[Please Provide All Information]

Printed Full Name: _____

Home Phone: () _____ - _____ Work Phone: () _____ - _____

Social Security Number: _____ - _____ - _____

Maiden or other name used: _____

Year Last Used: _____ Date of Birth: _____

Drivers License Number: _____ State: _____

I acknowledge 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 _____ *(This application will not be processed without your signature)*

Date _____



6A. Authorization for Search and Exchange of Information

I, **(Print Name)** _____, 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 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 sustainability for employment in a position involved in direct patient/ consumer care supervision.

Signature _____ *(This application will not be processed without your signature)*

Date _____

6B. Disclosure of Findings

I hereby affirm and/or swear under Penalties of perjury that I have not been found guilty in any form 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 **(check one)** have _____ have not _____ been issued a Certificate of Relief from Civil Service 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 _____ *(This application will not be processed without your signature)*

Date _____



7A. Privacy Notice and HIV Confidentiality Agreement

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 followed:

Acknowledgement of receipt of Privacy Notice: X I have received the Pleet Home Care 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 Pleet Home Care Agency consumer, their medical record, or any client’s condition with any individual not directly associated with that consumer. 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 for making any further disclosure of this information without 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 Pleet Home Care CDPAP.

Print Name _____

Date _____

Signature _____ *(This application will not be processed without your signature)*

8A. W-4 FORMS:
Please fill out all steps on the next page and do not miss the signature.

EXAMPLE

Form W-4 **Employee's Withholding Certificate** OMB No. 1545-0074

Department of the Treasury Internal Revenue Service **2020**

▶ 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 widow(er)) <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, when to use the online estimator, and privacy.

Step 2: Multiple Jobs or Spouse Works

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

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

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

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

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

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

Step 3: Claim Dependents

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

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

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

Add the amounts above and enter the total here **3** \$ _____

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

▶ **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)
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Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

OMB No. 1545-0074

▶ **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.**

2020

Step 1: Enter Personal Information	(a) First name and middle initial	Last name	(b) Social security number
	Address		▶ Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov .
	City or town, state, and ZIP code		
	(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly (or Qualifying widow(er)) <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, when to use the online estimator, and privacy.

Step 2:
Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

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

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

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

Step 3: Claim Dependents	If your income will be \$200,000 or less (\$400,000 or less if married filing jointly):		
	Multiply the number of qualifying children under age 17 by \$2,000 ▶ \$ _____		
	Multiply the number of other dependents by \$500 ▶ \$ _____		
	Add the amounts above and enter the total here	3	\$ _____
Step 4 (optional): Other Adjustments	(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income	4(a)	\$ _____
	(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here	4(b)	\$ _____
	(c) Extra withholding. Enter any additional tax you want withheld each pay period	4(c)	\$ _____

Step 5:
Sign Here

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

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

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

General Instructions

Future Developments

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

Purpose of Form

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

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

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

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

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

1. Expect to work only part of the year;
2. Have dividend or capital gain income, or are subject to additional taxes, such as the additional Medicare tax;
3. Have self-employment income (see below); or
4. Prefer the most accurate withholding for multiple job situations.

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

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

Specific Instructions

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

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

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

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



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

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

Step 4 (optional).

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

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

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

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



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

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

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

- 2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.
 - a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a **2a** \$ _____
 - b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b **2b** \$ _____
 - c Add the amounts from lines 2a and 2b and enter the result on line 2c **2c** \$ _____

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

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

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



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

- 2 Enter: $\left\{ \begin{array}{l} \bullet \$24,800 \text{ if you're married filing jointly or qualifying widow(er)} \\ \bullet \$18,650 \text{ if you're head of household} \\ \bullet \$12,400 \text{ if you're single or married filing separately} \end{array} \right\}$ **2** \$ _____

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

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

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

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

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

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

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



Notice and Acknowledgement of Pay Rate and Payday/Aviso y reconocimiento de la tarifa de pago y del día de pago Under Section 195.1 of the New York State Labor Law/En virtud del Artículo 195.1 de la Ley de Trabajo del estado de Nueva York Notice for Hourly Rate Employees/Aviso para los empleados con tarifas por hora

1. Employer Information/Información del empleador
Name/Nombre:
Pleet Home Care CDPAP
Doing Business As (DBA) Name(s)/Nombre comercial:
FEIN (optional)/FEIN (opcional):
Physical Address/Dirección física:
Mailing Address/Dirección postal:
Phone/Teléfono:

- 3. Employee's rate of pay/Tarifa de pago del empleado:
\$ _____ per hour/por hora
4. Allowances taken/Asignaciones tomadas:
[X] None/Ninguna
[] Tips/Propinas _____ per hour/por hora
[] Meals/Comidas _____ per meal/por comida
[] Lodging/Alojamiento _____
[] Other/Otro _____
5. Regular payday/Día de pago regular: _____
6. Pay is/El pago es:
[] Weekly/Semanal
[X] Bi-weekly/Bisemanal
[] Other/Otro _____
7. Overtime Pay Rate/Tarifa de horas extras:
\$ _____ per hour/por hora (This must be at least 1 1/2 times the worker's regular rate with few exceptions.)/(esto debe ser por lo menos 1 1/2 veces la tarifa regular del trabajador, con algunas excepciones).

- 8. Employee Acknowledgement/Aceptación del empleado:
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./En este día, he sido notificado sobre mi tarifa de pago, la tarifa de horas extras (si soy elegible), las asignaciones y el día de pago designado en la fecha que se presenta a continuación. Le informé a mi empleador cuáles mi idioma principal.
Check one/Seleccione una opción:
[] I have been given this pay notice in English because it is my primary language./Se me proporcionó este aviso de pago en inglés porque ese es mi idioma principal.
[] My primary language is/Mi idioma principal es _____ 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./Se me proporcionó este aviso de pago en inglés únicamente porque el Departamento de Trabajo aún no ofrece el formulario de aviso de pago en mi idioma principal.
Print Employee Name/Nombre del empleado en letra de molde
Employee Signature/Firma del empleado
Date/Fecha

Preparer's Name and Title/Nombre y puesto del preparador
The employee must receive a signed copy of this form.
The employer must keep the original for 6 years./El empleado debe recibir copia firmada de este formulario.
El empleador debe conservar el original durante 6 años.
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./Tenga en cuenta lo siguiente: Es ilegal que a un empleado se le pague menos que a un empleado del sexo opuesto por el mismo trabajo. Los empleadores tampoco les pueden prohibir a los empleados que hablen de sus salarios con los compañeros de trabajo.

**13A. Notice and Acknowledgement of Pay Rate and Pay Date (Pt. 2)**

Employer

Company Name: Pleet Home Care Agency

Street Address: 420 Niagara Street

City and State: Buffalo, NY

Zip Code: 14201

Employee

Name: _____

Street Address (Include Apartment):

City: _____ State: _____ Zip Code: _____

Phone: () _____ - _____

Your rate of pay: \$_____. _____ per hour

Overtime Rate of Pay: \$_____. _____ per hour

Please note that Pleet Home Care does not offer overtime hours*Designated Pay Date:** Friday, Bi-Weekly

First Pay Date: _____ (Given by office after completed application is reviewed)

I acknowledge I have been notified of my pay rate, designated pay rate, overtime pay rate and Pleet Home Care overtime policy; my signature below signifies these items to be true.

Signature (This form will not be processed without your signature)_____
Date_____
Preparer's Signature (Pleet Home Care Employee)_____
Date

PLEET HOME CARE CONSUMER DIRECTED ASSISTANCE PROGRAM (CDPAP) APPLICATION
Please allow up to five business days for this application to be processed. Thank you.

14A. 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 saving account, please attach a blank deposit slip. *Please note that before direct deposit is active, you will have two live paychecks.*

Please check one of the options below:

- New Direct Deposit (Option for New Employees)
- Change to existing direct deposit
- Cancel Direct Deposit

Personal Information:

Name: _____

Street Address (Include Apartment):

City: _____ State: _____ Zip Code: _____

Phone: () _____ - _____

Banking Information:

Name and Address of Financial Institution:

Account Number	#
Routing Number	#
Account Type	Checking / Savings / Other: _____

Outside Items Required with this Form:

- Voided Blank Check (from the account you wish to use)**
 - If you cannot get a voided blank check, we will also accept a **Direct Deposit Authorization Form** from your bank. This should be a typed and printed document you can ask for at your bank with your accounting and routing number, your name and the banks name.

Authorization: I (hereinafter referred to as the employee) hereby authorize Pleet Home Care to make deposits from the 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 adjustments be made electronically and under the rules of the Automated Clearing House Association (ACHA). This authorization will remain in effect until Pleet Home Care receives written notice of termination from the Employee or upon termination of the Employee's employment with Pleet Home Care Agency. I have retained a completed copy of this authorization for my record. I acknowledge that the origin of ACH transactions to my account must comply with the provisions of the US law.

Signature _____ (This form will not be processed without your signature)

Date _____

PLEET HOME CARE CONSUMER DIRECTED ASSISTANCE PROGRAM (CDPAP) APPLICATION
Please allow up to five business days for this application to be processed. Thank you.

15A. Medical Items Needed

Please attach any doctor's reports/results that are needed behind this paper. These items below are required to be in compliance in the state and Pleet Home Care's regulations.

Outside Items Required with this Form:

- 15AA. Physical** - Within the past year, that shows you are able to work
- 15AB. MMR** – Proof of Immunity within the past 10 Years through Lab Reports/ Results, typed and printed
- 15AC. PPD** – Within the past year through Lab Reports/ Results, typed and printed

If you need a physical form, you can use the Pleet Home Care physical form provided at the end of this application. It is NOT necessary to have our companies exact form, however, all the information we ask for on our physical is necessary for a complete physical in your application.

Are you missing any of these items? Do you need to make an appointment?

MOBILE HEALTH

Pleet Home Care CDPAP agency will pay for to get an updated physical, PPD, and/or updated MMR (Titers or Vaccination), if needed to get you started. Please notify your intake coordinator that you would like to make an appointment at one of our Mobile Health locations.

Missed Appointments: Please note that if you miss a scheduled appointment and do not give Pleet Home Care notice more than 24 hours before to cancel your appointment, in line with our policy, we will not make another appointment at agency pay.

15B. Statement of Non-Habituation

I, (Print Name) _____, certify that I am not using or habituated or addicted to depressants, stimulants, narcotics, alcohol, or other drugs that may alter behavior and that I am fully able to perform the duties of caregiver requested by Pleet Home Care CDPAP Agency and the needs of the Consumer.

Signature (This application will not be processed without your signature)

Date

16A. 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 *(This application will not be processed without your signature)*

Date

16B. 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 *(This application will not be processed without your signature)*

Date

16C. 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 *(This application will not be processed without your signature)*

Date

THE FOLLOWING THREE VACCINATIONS ARE NOT NECESSARY TO BE EMPLOYED WITH PLEET HOME CARE, THEY ARE OPTIONAL.

Please note some vaccinations are seasonal. If you decide to accept a vaccination, please follow up with your intake coordinator to set up an appointment with our service provider.

17A. Vaccination Statements: Either accept or decline for all vaccinations.

Vaccination	Circle One	Notes/ Comments, if any:
1. Hepatitis B Vaccination	Accept / Decline	
2. Influenza Vaccination	Accept / Decline	
3. Pneumococcal Pneumonia Vaccination	Accept / Decline	

I, (Print Name) _____, 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 understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B Vaccine. I've been offered an opportunity to receive this vaccine 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.

In addition, I have had read, or explained to me, information regarding the influenza and pneumococcal pneumonia vaccination and I understand the benefits and risks of being vaccinated from this illness. I acknowledge that I have been offered the opportunity to be vaccinated for Hepatitis B Virus, Influenza and Pneumococcal Pneumonia. My signature undersigned signifies my acknowledgement of all written items and my statement of acceptance or denial of the shots circled (or written) above.

Signature (This application will not be processed without your signature)

Date

EXAMPLE



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):

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



Employer Completes Next Page





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.

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



Employer Completes Next Page



420 Niagara Street,
Buffalo, NY 14201
Phone: (716) 261-2111
Fax: 1 (716) 954-7162



Doctor Office Contact Info.
Phone: _____
Fax: _____

PRE-EMPLOYMENT PHYSICAL ASSESSMENT - ANNUAL - RETURN TO WORK/ LOA – OTHER:

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

Name: _____ Title: _____ Sex: _____
Address: _____
SS#: _____ Date of Birth: _____
Comments: _____

Head/ ENT:					
Eyes					
Neck					
Breasts					
Lungs					
Cardiovascular					
Musculoskeletal					
Abdomen					
Genitourinary					
Central Nervous System					
HT:	WT:	B/P:	PLUSE:	RESP:	TEMP:

TEST	DATE PERFORMED		RESULTS PROVIDE LAB VALUES AND INTERPRETATIONS (mmxmm)
PPD/QUANTIFERON (ANNUALLY)	Implanted:	Read:	
CHEST X-RAY (+ PPD)	Implanted:	Read:	

Immunizations	Date (Dose One)	Date (Dose Two)	Date and/or Results
Rubeola/ Measles			Non-Immune/ Immune Lab Value:
Rubella			Non-Immune/ Immune Lab Value:

Please Check One:

- This individual is free from any health impairment that is 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):

Physician Signature: _____ **LIC#** _____ **Date:** _____



Caregiver: _____

Consumer: _____

Page/ Section	Document	Complete?	Notes <i>Items Outside of Application Needed</i>
1A	Personal Information		
2A	Experience and Employment History		
2B	Receipt of Handbook		
3A	Availability		
3B	HIPPA Acknowledgement		
4A	Conflict Agreement		
4B	Arbitration Clause		
4C	Identification		License and SS Card
5A	Disclosure and Authorization		
6A	Search and Exchange of Information		
6B	Disclosure of Findings		
7A	Privacy/ HIV Confidentiality Agreement		
8A – 11A	W-4 FORMS		
12A	Notice & Acknowledgement of Pay Rate and Pay Date (Pt. 1)		
13A	Notice & Acknowledgement of Pay Rate and Pay Date (Pt. 2)		
14A	Direct Deposit Application		Voided Blank Check or DDA Form
15A	Medical Items		
15AA	Physical		Complete Physical from Doctor
15AB	MMR		Complete MMR Lab Results from Doctor
15AC	PPD		Complete PPD Lab Results from Doctor
15B	Statement of Non-Habitation		
16A	Mobile Health Agreement		
16B	Hospitalization Acknowledgement		
16C	Overtime Agreement		
17A	Vaccination Statements		
18A- 19A	Form I-9 (Example and Pg. 1)		

Intake Coordinator: _____

Notes: _____
