

# ABBACARE AT HOME CORP

3800 Watt Avenue, Suite 201, Sacramento, CA 95821-2674  
Tel (916) 777-8800 | Fax (916) 777-0800 | Cel (916) 245-2500

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Dear Applicant,

Thank you for your interest in applying for the position that matches your qualifications and skills. We're thrilled at the prospect of welcoming you to AbbaCare At Home team.

To proceed with your application, please gather the following documents required prior to an offer of employment --

- Resume (most recent, updated)
- Professional license (current, unincumbered)
- CPR (active, current)
- CA Driver's license (current, valid)
- Proof of automobile insurance (current)
- Green Card OR Certificate of Citizenship OR US passport
- Social Security Card (original)
- Diploma or Transcript of Records
- Professional Liability Insurance (Optional)
- Negative PPD or Chest X-Ray Report (within the last 6 months)
- Physical Examination ( within the last 6 months)
- Immunization/Vaccination Record (Flu, Pneumococcal, Hepatitis B & Covid)
- Other Training certificates (if applicable)

Other Forms that you can fill out on-line and bring to the office --

- I-9- use the current year [www.uscis.gov](http://www.uscis.gov)
- W4- use the current year [www.irs.gov](http://www.irs.gov)

Kindly submit the completed forms and requested documents to the office address as stated above, or send them by email at [hr@abbacahealthcare.com](mailto:hr@abbacahealthcare.com) or you may choose to transmit them via fax at (916) 777-0800. Our recruitment team at our personnel department will reach out and contact you to schedule a phone or in-person interview as soon as we receive your application.

Your *Offer Letter* will be issued contingent after the interview and upon submission of all the completed and required documents.

Very Sincerely,

The Human Resources Department  
AbbaCare At Home Corp  
Sacramento, CA



EMPLOYMENT APPLICATION

PERSONAL INFORMATION

TODAY'S DATE	LAST NAME	FIRST	MIDDLE
HOME ADDRESS			
Home Phone	Cell Phone	Work Phone	Email Address
Emergency Contact _____	Relationship _____	Contact Number _____	Alternate Number _____
			Are you 18 years old or over <input type="checkbox"/> YES <input type="checkbox"/> NO
Alternate Contact _____	Relationship _____	Contact Number _____	Alternate Number _____
			If hired, will you be able to submit proof of age <input type="checkbox"/> YES <input type="checkbox"/> NO
Other Name/s Used _____			
			If hired, can you furnish proof that you are legally permitted to work in the United States <input type="checkbox"/> YES <input type="checkbox"/> NO
Name of relatives employed by this organization (if any)			Department
How did you learn about this opening _____			Have you previously been employed by this agency <input type="checkbox"/> YES <input type="checkbox"/> NO
			If yes, Where _____ When _____

TRAINING & EDUCATION RECORD

High School	Location	Circle Last Level Completed				Diploma <input type="checkbox"/> YES <input type="checkbox"/> NO
		9	10	11	12	
Technical School	Location	1	2	3	4	Certification
College, University	Location	1	2	3	4	Diploma & Major
Other Education, Special Courses, Or Academic Honors _____						
Colleges In Which You Are Currently Enrolled Skills (if any) _____						

Professional License, Certification/s					OFFICE USE ONLY	
Type	Number	State Issued	Date Issued	Expires On	Confirmed	<input type="checkbox"/> YES <input type="checkbox"/> NO
Type	Number	State Issued	Date Issued	Expires On	Confirmed	<input type="checkbox"/> YES <input type="checkbox"/> NO
List any Professional Organizations on which you are a Member (you may omit any which indicates sex, religion, national origin, ancestry, handicap or disability, race, age, sexual orientation, marital status, or veterans' status) _____						
Service Schools Attended (if any) _____						
Nursing Skills (please mark all that applies)						
<input type="checkbox"/> IV insertion	<input type="checkbox"/> IV Administration	<input type="checkbox"/> Wound Care	<input type="checkbox"/> Wound Vacuum	<input type="checkbox"/> Blood Draw	<input type="checkbox"/> Foley Cath Care	<input type="checkbox"/> Colostomy Care
<input type="checkbox"/> Glucometer	<input type="checkbox"/> Cardiac Care	<input type="checkbox"/> Respiratory Care	<input type="checkbox"/> Psychiatric Nursing	<input type="checkbox"/> Behavior Modification	<input type="checkbox"/> Lymphedema Care	<input type="checkbox"/> Tracheostomy Care
<input type="checkbox"/> Home Health EMR (specify) _____	<input type="checkbox"/> OASIS Documentation	<input type="checkbox"/> Plan of Care	<input type="checkbox"/> Coding	<input type="checkbox"/> QAPI	<input type="checkbox"/> Clinical Record Review	<input type="checkbox"/> Other: _____
Counties You Are Willing to Do Home Visits _____						

POSITION APPLYING FOR	DATE AVAILABLE	PAYRATE DESIRED
HOURS & DAYS AVAILABLE	Full Time <input type="checkbox"/> Yes <input type="checkbox"/> No	Part Time <input type="checkbox"/> Yes <input type="checkbox"/> No
	Per Diem <input type="checkbox"/> Yes <input type="checkbox"/> No	Weekdays <input type="checkbox"/> Yes <input type="checkbox"/> No
		Weekends <input type="checkbox"/> Yes <input type="checkbox"/> No
		Out of Area <input type="checkbox"/> Yes <input type="checkbox"/> No

EMPLOYMENT HISTORY

(start with most the recent)

<b>Employer I</b>	Telephone Number	May we contact <input type="checkbox"/> Yes <input type="checkbox"/> No
Address	Average Hours Weekly	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time
Job Title	Immediate Supervisor	Employed From _____ Employed To _____
Job Description	Starting Payrate	Payrate at End _____
Reason for Leaving _____		
Explain Time Lapse (if applicable) _____		
<b>Employer II</b>	Telephone Number	May we contact <input type="checkbox"/> Yes <input type="checkbox"/> No
Address	Average Hours Weekly	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time
Job Title	Immediate Supervisor	Employed From _____ Employed To _____
Job Description	Starting Payrate	Payrate at End _____
Reason for Leaving _____		
Explain Time Lapse (if applicable) _____		

<b>Employer III</b>	Telephone Number	May we contact <input type="checkbox"/> Yes <input type="checkbox"/> No
Address	Average Hours Weekly	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time
Job Title	Immediate Supervisor	Employed From Employed To
Job Description	Starting Payrate	Payrate at End
Reason for Leaving		
Explain Time Lapse (if applicable)		
<b>Employer IV</b>	Telephone Number	May we contact <input type="checkbox"/> Yes <input type="checkbox"/> No
Address	Average Hours Weekly	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time
Job Title	Immediate Supervisor	Employed From Employed To
Job Description	Starting Payrate	Payrate at End
Reason for Leaving		
Explain Time Lapse (if applicable)		
<b>Employer V</b>	Telephone Number	May we contact <input type="checkbox"/> Yes <input type="checkbox"/> No
Address	Average Hours Weekly	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time
Job Title	Immediate Supervisor	Employed From Employed To
Job Description	Starting Payrate	Payrate at End
Reason for Leaving		
Explain Time Lapse (if applicable)		

I hereby certify that the information contained in this application form is true and correct to the best of my knowledge and I agree to have any of the statements checked by **ABBACARE AT HOME CORP** unless I have indicated to the contrary. I authorized the references listed above to provide **ABBACARE AT HOME CORP** any and all information concerning my previous employment and any pertinent information that they may have. Further, I release all parties and persons from any and all liability for any damages that may result from furnishing such information to **ABBACARE AT HOME CORP** as well as from the use of disclosure of such information by **ABBACARE AT HOME CORP** or any of its agents, employees, or representatives. I understand that any misrepresentation, falsification, or material omission of information on this application may result in my failure to receive an offer or, if I am hired, in my dismissal from employment. In consideration of my employment, I agree to conform to the rules and standards of **ABBACARE AT HOME CORP** and agree that my employment and compensation can be terminated, with or without cause, and with or without notice, at any time, either at my option or at the option of **ABBACARE AT HOME CORP**. I understand that no employee or representative of **ABBACARE AT HOME CORP** other than the Administrator of the agency has any authority to enter into any agreement for employment for any specified period of time, or to make any agreement contrary to the foregoing. Further, the Administrator of **ABBACARE AT HOME CORP** may not alter the **"AT WILL"** nature of the employment relationship unless he does so specifically and in writing. I also understand that all offers of employment are conditioned on the provision of satisfactory proof of an applicant's identity and legal right to work in the U.S.A. I understand that any offer of employment with **ABBACARE AT HOME CORP** may be conditioned on completing a pre-employment medical examination. The purpose of medical examination is to determine whether I am able to perform the essential functions of the job I am offered with or without reasonable accommodation, to identify any reasonable accommodation if such is warranted, and to ensure that my performance of the essential functions does not present a direct threat to my health and safety or the health and safety of others. I agree to forego such pre-employment medical examination. If hired by the Agency, I further agree to undergo any periodic medical examinations which are permitted or required by Law. **ABBACARE AT HOME CORP** shall comply with Federal and State Laws which prohibit discrimination on the basis of race, color, age, sex, religion, national origin, ancestry, disability or handicap, Veteran status, medical condition (as defined by California law), sexual orientation and marital status.

Applicant's Name	Signature	Date

EMPLOYMENT BACKGROUND CHECK

# Acknowledgement and Authorization

## Disclosure Regarding Background Investigation

ABBACARE AT HOME CORP (“the Company”) may obtain information about you for employment purposes from a third-party consumer reporting agency. Thus, you may be the subject of a “consumer report” and/or an “investigative consumer report” which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews with sources such as your neighbors, friends, or associates. These reports may contain information regarding your credit history, criminal history, social security verification, motor vehicle records (“driving records”), verification of your education or employment history, or other background checks. Credit history will only be requested where such information is related to the duties and responsibilities of the position for which you are applying. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report and a copy of any report about you. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment is an investigation into your education and/or employment history conducted by ClearStar, Inc. (“ClearStar”), 5955 Shiloh Rd East, Suite 104, Alpharetta, GA 30005, 1-877-275-7099. The scope of this notice and authorization is all-encompassing, however, allowing the Company to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and throughout the course of your employment to the extent permitted by law. As a result, you should carefully consider whether to exercise your right to request disclosure of the nature and scope of any investigative consumer report.

I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of “consumer reports” and/or “investigative consumer reports” by the Company at any time after receipt of this authorization and throughout my employment, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by ClearStar, Inc. 5955 Shiloh Rd East, Suite 104, Alpharetta, GA 30005, 1-877-275-7099, another outside organization acting on behalf of the Company, and/or the Company itself. Their Privacy Policy can be reviewed at <http://www.clearstar.net/privacy-policy/>. I agree that a facsimile (“fax”), electronic or photographic copy of this Authorization shall be as valid as the original.

**California Applicants or Employees Only:** By signing below, you also acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. Please check this box if you would like to receive a copy of an investigative consumer report or consumer credit report at no charge if one is obtained by the Company whenever you have a right to receive such a copy under California law.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_

Other Names \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Driving License Number \_\_\_\_\_ Issuing State \_\_\_\_\_

Current Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Former Employer (Name, City, Phone) \_\_\_\_\_

Position \_\_\_\_\_ Dates of Employment \_\_\_\_\_

Former Employer (Name, City, Phone) \_\_\_\_\_

Position \_\_\_\_\_ Dates of Employment \_\_\_\_\_

Applicant's Name

Signature

Date

<sup>†</sup> This information will be used for background screening purposes only and will not be used as hiring criteria

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## REFERENCE CHECK FORM

Applicant's Name \_\_\_\_\_

Name of Employment \_\_\_\_\_ Phone \_\_\_\_\_  
(Current or Former Employer)

I, \_\_\_\_\_ (applicant), hereby authorize \_\_\_\_\_  
(former/current employer) to release information to AbbaCare At Home Corp about my  
employment information for reference check purposes necessary to process my employment  
application with AbbaCare At Home Corp. I specifically consent to disclosure in accordance with  
the provision of the Privacy Act of 1974 and similar federal and state laws.

\_\_\_\_\_  
Applicant's Name Signature Date

Phone Reference Check  Fax Reference Check  Other \_\_\_\_\_

Name of Referenced Person \_\_\_\_\_

Title \_\_\_\_\_

Employee's Position Held in the Aforementioned Company \_\_\_\_\_

Date of Employment \_\_\_\_\_

- |   |                              |                             |  |
|---|------------------------------|-----------------------------|--|
| 1. Is the above employee re-hirable?    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Refused to Answer |
| 2. Is the above employee dependable?    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Refused to Answer |
| 3. Is the above employee a team player? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Refused to Answer |
| 4. Is the above employee reliable?      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Refused to Answer |

Comments \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reference Check completed by \_\_\_\_\_ Date \_\_\_\_\_  
AbbaCare At Home Corp Personnel

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## INTERVIEW SUMMARY

Name of Applicant \_\_\_\_\_ Position Applying \_\_\_\_\_  
Date of Interview \_\_\_\_\_ Start Date Available \_\_\_\_\_

FACTORS	GOOD	FAIR	POOR
Education			
Knowledge Level of position applying for			
Credentials			
Relevant Past Work Experience			
Work Ethics			
Home Health Experience			
Tolerance to Stress/Pressure			
Critical Thinking Skills			
Availability and Flexibility of schedule			
Experience in electronic documentation			

- DISPOSITION
- Pass the initial interview
  - Did not pass the initial interview
  - Schedule for second interview on \_\_\_\_\_
  - Hired, subject to completion of application documents

### COMMENTS & RECOMMENDATIONS

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Interview completed by \_\_\_\_\_  
Human Resources Department or Supervisor \_\_\_\_\_ Date of Hire \_\_\_\_\_

## Biomechanical Demand Expectations & Qualifications

**1. In an eight (8) hour work day, I am expected to** *(one response is needed for each category)*

A. Sit	0	1	2	3	4	5	6	7	8	Hours
B. Stand	0	1	2	3	4	5	6	7	8	Hours
C. Walk	0	1	2	3	4	5	6	7	8	Hours

**2. Job Requisites**

	0% None	1-33% Occasionally	34-66% Frequently	67-100% Continuously
A. Squatting				
B. Bending				
C. Kneeling				
D. Reaching				
E. Twisting				
F. Crawling				
G. Climbing				
H. Walking (Rough Ground)				
I. Exposure to Changes of Temperature & Humidity				
J. Exposure to Dust, Fumes, or Grass				
K. Being near to Moving Equipment				
L. Working from Heights				

**3. Job Requires Organization Personnel to Lift or Carry**

	0% None	1-33% Occasionally	34-66% Frequently	67-100% Continuously
A. 0-10 Lbs				
B. 11-24 Lbs				
C. 25-34 Lbs				
D. 35-50 Lbs				
E. 51-74 Lbs				
F. 75-100 Lbs				
G. 100+ Lbs <i>(state weight)</i>				

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## RECEIPT OF EMPLOYEE HANDBOOK

This is to acknowledge that I have received, read, and understand the contents of the Employee Handbook. That I will abide by its rules and regulations and if I do not understand something, that I will ask the Human Resources or the Administrator of the agency.

## CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION

It is my responsibility to ensure that every patient's health information is protected at all times. By signing below, I acknowledge that I was oriented on Health Insurance Portability and Accountability Act (HIPAA) and protection of Patient Protected Health Information and will comply with its rules and regulations at all times.

## COMPUTER ACCESS ACKNOWLEDGEMENT

I will safeguard and not disclose my password, user ID code or PIN to anyone. I will not attempt to know or use another employee's password or user ID code to log-on to this agency's computer system or network.

## CONFLICT OF INTEREST

I have read and am fully familiar with this agency's policy regarding conflict of interest. I am not presently involved in any transaction, investment, or other matter in which I would profit or gain directly or indirectly as a result of my employment at this agency. Furthermore, I agree to disclose any such interest, which may occur in accordance with the requirements of the agency policy.

I acknowledge all the above statements, abide to its provisions and will make every effort to observe it at all times.

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Applicant's Name

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Signature

---

Date

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## Standards of Conduct

All employees of AbbaCare At Home Corp must adhere to the following Standards of Conduct. Your cooperation will maintain the high-quality standards of services and ensure your job performance.

1. AbbaCare At Home Corp is an “AT-WILL” employer and cannot guarantee any number of hours in a given week. Although we will try to do everything possible, we cannot guarantee you work close to home or within walking distance or on a bus line.
2. You have received a job description at the time of your employment. It is your responsibility to work within the outline of your duties.
3. Be certain that you fill out all information requested in your documentation notes and the time sheets. All signed time sheets are due at the office every other Monday. You will not receive a paycheck without signed time sheets.
4. When you accept an assignment, you are expected to be there as scheduled and on time as required. If an emergency arises that prevents you from fulfilling your assignment, call the office immediately. We have 24-hour on-call staff to take your call. Failure to call would result in immediate disciplinary action.
5. Be sure to have the patient and/or patient’s family member, DPCS or supervisor sign your time sheets and fill in all the appropriate blanks on the time sheet.
6. Please call the office each week to give your availability.
7. You must keep all information that comes to your possession, including matters related to wages and rates as a result of your employment by AbbaCare At Home Corp. and which pertains to the business of AbbaCare At Home Corp. strictly confidential. You must never discuss such information with patients, co-workers or others.
8. Any problem related to your assignment must be discussed with your supervisor, never with the patient.
9. Unprofessional or unethical behavior will result in appropriate disciplinary action up to/or including termination of employment.
10. You are expected to abide by the dress code, wear your identification badge, bring nursing/therapy license or CHHA certificate and CPR certification at all times when assigned to work.
11. If AbbaCare At Home Corp.’ patients to whom you have been assigned offers you a permanent, temporary or part-time job within 90 days of the end of the assignment, you will promptly notify AbbaCare At Home Corp. and will not accept the offer beforehand.
12. If you are injured on the job, you must notify your immediate supervisor, DPCS/ administrator immediately.
13. Staff are expected to complete daily assignments as scheduled or assigned by the supervisor. If an emergency arises, personnel are to notify their immediate supervisor as soon as possible during the workday.
14. Staff are not to leave the field or their work area without completing the scheduled visits/shifts for that day or their work assignments for that day.
15. All paperwork or electronic documentation is to be completed in a timely, accurate manner and must be submitted to the office within 48 hours of the visit. Any falsification of documentation in the clinical record and billing record may result in disciplinary action, including termination.
16. All representation of the organization in marketing literature or verbal presentations is to be accurate and truthful. Only care and services that the organization is capable of providing either directly or through written contracts is to be promised to potential referral sources. No gifts or free services will be offered to induce referrals.
17. Whenever a patient is referred to another organization (i.e., hospital, skilled nursing facility, another organization), the patient will receive an explanation of any relationship that receiving organization has to this organization, if any, including financial benefit to the home care organization.

18. All staff are to follow organization policies, especially policies relating to appropriate admitting, transferring, referral, and discharging practices within the organization. Billing personnel are to follow financial policies for assuring accuracy of bills and billing practices.
19. Staff must not allow their private interests to conflict with those of their patients.
20. Staff are not permitted to ask for or accept a loan or gift of money or any object of material value from patients, their families, or caregivers.
21. Failure to adhere to any of the following or falsification of any employment financial, billing or patient record as well as documentation within the course of one's workday will result in immediate dismissal:
  - a. Refusal or deliberate failure to carry out instructions given by supervisor
  - b. Fighting or creating a disturbance on organization premises or in a patient's home
  - c. Willful idleness or loafing during working hours
  - d. Unauthorized possession or use of intoxicants or non-prescription narcotics
  - e. Reporting for duty under the influence of intoxicants which could interfere with proper work performance
  - f. Falsification of employment applications, payroll cards, billing records, or any patient clinical record
  - g. Theft
  - h. Deliberate or negligent misuse of organization or patient property
  - i. Failure to follow or unauthorized alteration of organization policies and procedures
  - j. Obscene or indecent conduct
  - k. Smoking in unauthorized areas
  - l. Solicitation
  - m. Possession of weapons or explosives
  - n. Threatening or interfering with work of others
  - o. Excessive absenteeism or tardiness
  - p. Endangering the welfare of others
  - q. Divulging confidential information concerning patients, organization personnel, or the organization, including posting that information on social media sites such as Facebook, Twitter, LinkedIn, etc.
  - r. Leaving organization premises on a scheduled workday without authorization
  - s. Failure to maintain personal appearance

Clinical Personnel Only

22. Clinical staff are to adhere to the following guidelines:
  - a. Post ALL your visit notes on a DAILY basis so we will know your availability
  - b. Dress according to organization policy.
  - c. Avoid engaging in personal discussion with patients, families, or caregivers.
  - d. Avoid voicing personal opinions about patients, families, or caregivers.
  - e. Do not offer medical advice.
  - f. Do not smoke during home visits.
  - g. Do not expect or accept meals from patients, families, or caregivers.
  - h. Avoid abusing patient's hospitality; use the telephone only in emergency situations or to call the office.
  - i. Be punctual and responsible.
  - j. Do not transport patients, families, or caregivers in a car.
  - k. Do not take anyone into the patients' homes with you.
  - l. Complete all patient care documentation like notes, evaluations, physician orders, etc accurately and in a timely manner (within 48 hours) to comply with all federal and state laws, rules and regulations.
  - m. Do not falsify dates, signatures or notes in the patient's clinical record.
23. All clinical staff are expected to communicate with the office to confirm itinerary and to give and receive reports according to organization policy.

I have read, understand and will follow the code of conduct and ethical behavior set forth by the company.

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Applicant's Name

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Signature

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Date

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## Code Of Conduct STANDARDS OF PRACTICE

### 1. Relationships with Patients

- Patients are accepted to our services based on the reasonable expectation that the patient's medical, nursing and social needs can be met in the patient's place of residence. (Admission Criteria)
- Patients are informed that the choice of which Agency will provide care is their decision to make, and no entity or individual will exert direct or indirect influence over patients or physicians to encourage use of this Agency. (Prohibition of Referral Steering)
- Every patient is informed of his/her rights upon admission and receives a written copy in the patient admission materials (i.e., Patient Admission Book, Patient Rights and Responsibilities)
- Patients who are in need of immediate care and who are unable to pay for care may be admitted for free or reduced cost care. (Charity or Partial Waiver)
- There are identified guidelines for the determination of when a patient will be discharged, and the patient and physician are notified of the intent to discharge except in emergency situations. (Discharge Planning) Abandonment of the patient is prohibited.

As a part of our commitment to integrity, each patient (or caregiver, if patient is unable) is requested to sign the recap at the time a visit is made as evidence that the visit was actually made (Visit Verification).

### 2. Relationships with Physicians

- We are committed to maintaining ethical Relationships with Physicians and we do not pay physicians in any way to refer patients to the Agency. (Prohibition of Illegal Remuneration)
- No employee of this organization is permitted to enter into any agreement with physicians or other entities that are linked to the referral of patients.
- We provide care to qualified patients under the order of a physician. We will communicate with the physician when patient condition warrants physician intervention. (Communication with Physician's Office, Plan of Care)

### 3. Relationships with Payor Sources (Business Practices)

- We are committed to maintaining accurate and ethical standards in the financial aspects of our business.
- We will not bill for items and services not rendered or medically unnecessary; misrepresent the type or level of service rendered; bill for non-covered services; bill for services rendered by other providers; or misrepresent facts in order to obtain payment.

### 4. Relationships with Government Agencies

- We will adhere to all applicable federal and state regulations.
- We have established and enforced policies ensuring our compliance with OSHA. It is of highest importance that the organization maintains safe and effective processes to carry out our responsibilities. (Potentially Unsafe Conditions)
- We will not misrepresent the attributes of this or any other Agency or health care professional, and we will attempt to coordinate services with other involved agencies to maximize patient care and avoid duplication of services.

- Agency funds or resources are not used to contribute to political campaigns, or for gifts or payments to any political party or organization, unless it is expressly permitted by state and federal law and approved by the Compliance Officer or designee.

5. Responsibilities of all Agency Employees

- Employees are expected to comply with Agency policies, and disciplinary action may be taken for non-compliance.
- Agency assets, including company time, materials, supplies, equipment and information are to be used only for Agency goals and purposes. If you observe any improper use of Agency resources, it is your responsibility to report this to your supervisor.
- All information obtained through Agency business shall remain strictly confidential.
- All employees will ensure that outside activities or personal interests will not influence your ability to perform your job.
- Agency employees may accept non-recurring gifts of no greater than \$50.00 in value. Cash gifts should never be accepted.
- Employees will not report to work while under the influence of alcohol or illegal drugs.
- Employees are advised that it is their responsibility to report known or suspected fraud or abuse without fear of reprisal.
- Licensed nurses are to report any reasonable suspicion that a licensed nurse has exposed or is likely to expose a patient or other person unnecessarily to a risk of harm, has engaged in unprofessional conduct, has failed to care adequately for a patient, or has failed to conform to the minimum standards of acceptable nursing practice, or that a licensed nurse's practice is or is likely to be impaired by chemical dependency.
- Each employee shall respect the rights and views of fellow employees and treat them with fairness, courtesy and good faith.

6. Responsibilities of the Organization to Employees

- We are committed to providing effective orientation and on-going education to all employees.
- We will respond to known or suspected fraud or abuse offenses promptly and effectively according to policy.
- We are committed to providing a fair and equal opportunity work environment in compliance with federal, state, and local laws. Harassment or discrimination will not be tolerated, and any known or suspected harassment or discrimination should be reported to the Compliance Officer or appropriate supervisor immediately. (Americans with Disabilities Act, Sexual Harassment)

7. Use of the Compliance Plan

- We have developed a plan to demonstrate our commitment to integrity and ethical business practices, and we call this our "Compliance Plan."
- Each employee has a significant role in maintaining the integrity of this organization.
- The Agency and its employees intend to cooperate fully with any legitimate investigation while maintaining confidentiality and protecting other rights/obligations that may exist. Employees of this Agency have certain rights and responsibilities in the event of being contacted by an outside investigator or by the media. Employees are requested to notify the Compliance Officer, Agency/Executive Administrator/Director or other supervisory personnel if contacted by any person or organization requesting information prior to any interview being arranged.

I acknowledge and confirm that I have received and read the Code of Conduct, understand it, and will abide by it.

---

Applicant's Name

---

Signature

---

Date

# ABBACARE AT HOME CORP

3800 Watt Avenue, Suite 201, Sacramento, CA 95821-2674  
Tel (916) 777-8800 | Fax (916) 777-0800 | Cel (916) 245-2500

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## ABUSE REPORTING REQUIREMENT

### **BATTERED WOMEN and DOMESTIC VIOLENCE REPORTING**

**AB 1652** State Law effective January 1, 1995. Law requires every health practitioner employed in a health care facility, clinic or doctor's office who has knowledge or observes a patient who he/she knows or reasonably suspects is suffering from a wound or injury which is a result of assaultive or abusive conduct to make a report to local law enforcement by telephoning immediately and providing a written report within 36 hours of receiving information concerning incident. Failure to make a report may result in 6 months in jail and/or a \$1,000.00 fine. A health practitioner cannot apply the "privilege to refuse disclosure" in relationship to any reports filed. Health care practitioners making the report are covered by civil and criminal immunity. If any action is brought against them, they make a claim of up to \$50,000.00 for attorney's fees.

**AB 890** State law implemented to reinforce the education and training of health care professionals around the issue of spousal/partner abuse and improve facility involvement in identification of victims of spousal/partner abuse. The bill requires that applications for several professional licenses matriculating after January 1, 1995, show completed course work in spousal/ partner abuse (MD, RN, LCSW, MFCC, Psychology) and it encourages/permits continuing education on spousal/partner abuse. If it becomes required, licensees will have four years to complete the requirement. The law also requires that the Medical Board of California periodically disseminate information and educational materials on detection/treatment of spousal /partner abuse to each physician/surgeon and to each acute care hospital in the state. All licensed clinics and acute care hospitals are likewise required to have written policies and procedures in place by January 1, 1995, for identification, documentation and education of staff on spousal/partner abuse, as well as guidelines on advising patients of resources available. Failure to have written policies and procedures in place results in misdemeanor violation of the law.

### **DEPENDENT ADULT, ELDER and CHILD ABUSE REPORTING REQUIREMENTS**

California Welfare and Institution Code, Chapter 4.5, Division 8.5 for Dependent Adult and Elder and California Penal Code Section III66.5 for Child Care require healthcare agencies to provide all elder or dependent adult and child care custodians, medical practitioners and nonmedical practitioners employed after January 1, 1985, with the following statement.

#### **REPORTING REQUIREMENTS**

Any elder, dependent adult and child care custodian, medical practitioner or nonmedical practitioner who has actual knowledge (or in the instance of dependent adult abuse, he or she observes a physical injury consistent with the victim's statements or other corroborating evidence) that an elder or dependent adult whom he or she observes in his or her professional capacity or within the scope of his or her employment has been the victim of physical abuse shall report the suspected instance of physical abuse to an elder protective agency or local law enforcement agency immediately or as soon as practically possible by telephone and shall prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

When two or more persons who are required to report are present and jointly have knowledge of a suspected instance of elder or dependent adult abuse, and when there is an agreement among them, the telephone agreement and a single written report may be made and signed by the selected members of the reporting team.

Any member who has knowledge of the member designed to report has failed to do so, shall thereafter make the report. Any person knowingly failing to report, when required, an instance of elder or dependent adult and child abuse is guilty of a misdemeanor or punishable by imprisonment in the county jail not exceeding six months, by a fine not to exceed one thousand (1,000.00) dollars or both.

The identity of all persons who report under shall be confidential and disclosed only by court order or between elder protective agencies. In addition to the reporting requirement of Section 15630 of the Welfare and Institution Code for Elder Abuse Reporting and Section 502 and 11166 of the Penal Code for Child Abuse Reporting, any employee making a report to Adult Protective and Child Protective Services or local law enforcement agency is also to follow his/her agency policy and the procedures for completing a Special Report of the observed, known or suspected dependent adult and child abuse.

### **REPORTING PARTY DEFINITIONS**

#### **ELDER OR DEPENDENT ADULT CARE CUSTODIAN**

Defined as an administrator or employee of a Health Care Facility, Home Health Agency, Sheltered Workshop, Camp, Respite Care Facility, Residential Care Institution including foster homes and group homes; Community Care Facility; Adult Day Care Facility, including adult day health care facilities; Regional Center for persons with developmental disabilities; Licensing Worker or Evaluator; Public Assistance Worker; Patient's Rights Advocate; Nursing Home Ombudsman Skilled Nursing Facility, Intermediate Care Facility, and other person who provides goods or services necessary to avoid physical harm or mental suffering and who performs such duties.

#### **CHILD CARE CUSTODIAN**

Defined as a teacher, administrative officer, supervisor of child welfare and attendance, of certified public employee of any public or private school, an administrator of a private or public day camp; a licensed day care worker, employee of a community day care facility licensed to care for children; head start teachers; a licensing worker or evaluator; public assistance worker; employee of a child care institution including, but not limited to, foster parents, group home personnel and personnel of residential care facilities, a social worker or a probation officer.

#### **MEDICAL PRACTITIONER**

Defined as a physician and surgeon, psychiatrists, psychologists, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist or any other person currently licensed under Division 2 (commencing with section 500) of the Business and Professions Code.

#### **NONMEDICAL PRACTITIONER**

Defined as a state or county public health employee who treats a minor for venereal disease or any other condition; a coroner; a paramedic; a marriage, family or child counselor; a religious practitioner who diagnose, examines or treat adults and children.

I CERTIFY THAT I HAVE READ AND UNDERSTOOD THIS STATEMENT AND WILL COMPLY WITH MY OBLIGATIONS UNDER THE CHILD & ELDER ABUSE REPORTING LAW

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Applicant's Name

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Signature

---

Date

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## EQUAL EMPLOYMENT OPPORTUNITY DATA

Completion of this form is **entirely voluntary**, all information will remain confidential and will not affect your application for employment with **ABBACARE AT HOME CORP**. The information requested is required by the regulations of the Department of Fair Employment and Housing and is for data purposes only. Employers in California are required to keep records on file for a period of 2 years.

It is understood by **ABBACARE AT HOME CORP** that this information will not affect your eligibility for employment or other benefits that **ABBACARE AT HOME CORP** offers.

Name \_\_\_\_\_ Sex  Male  Female  
Position Applied For \_\_\_\_\_ Gender Identity \_\_\_\_\_

Race or Ethnicity

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> American Indian  | <input type="checkbox"/> Caucasian (White)  | <input type="checkbox"/> Middle Eastern       |
| <input type="checkbox"/> Alaskan Native   | <input type="checkbox"/> Filipino           | <input type="checkbox"/> Native Hawaiian      |
| <input type="checkbox"/> Asian            | <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> Mixed or Multiracial |
| <input type="checkbox"/> Black or African | <input type="checkbox"/> Pacific Islander   | <input type="checkbox"/> Other Race           |

Government contractors must take affirmative action, employ and advance qualified individuals subject to the Rehabilitation Act of 1973 and the Viet ERA Veterans Readjustment Act of 1974. Completing the following information is voluntary and will assist us in proper placement and reasonable accommodation. If you wish to be identified as qualifying for such placement or accommodations, please check where applicable:

- Vietnam Veteran
- Disabled Veteran
- Individual With Disability

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To be Completed by the HR

EEO – Category	<input type="checkbox"/> Manager	<input type="checkbox"/> Registered Nurse
	<input type="checkbox"/> Licensed Vocational Nurse	<input type="checkbox"/> Home Health Aide
	<input type="checkbox"/> Therapist	<input type="checkbox"/> Dietician
	<input type="checkbox"/> Medical Social Worker	<input type="checkbox"/> Office and Clerical

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## EMPLOYEE TRANSPORTATION LIABILITY WAIVER

Dear Employee:

During the course of your employment with **ABBACARE AT HOME CORP**, it is necessary for you to utilize your personal automobile to perform your scheduled visits. Therefore, you are required to accept full responsibility for maintaining and obtaining insurance coverage for your vehicle. The agency does not cover your car maintenance as well.

**ABBACARE AT HOME CORP** cannot accept the responsibility for any personal injury or damage that may result from an employee during the course of providing scheduled or un-scheduled patient visits nor making available transportation to or on behalf of the patient.

It is necessary for us to obtain the following information for your records. It will be part of your personnel file.

Name of Insurance Company \_\_\_\_\_  
Policy Number \_\_\_\_\_  
Expiration Date \_\_\_\_\_ State \_\_\_\_\_

I agree to notify the agency in writing or through my supervisor if my license becomes suspended, revoked or is not renewed at the time of expiration.

I agree to notify the agency of any changes, cancellation or non-renewal of my automobile insurance policy.

I agree not to hold the agency responsible for any injury I may sustain while operating my own vehicle in the performance of my job.

I agree to indemnify and hold harmless **ABBACARE AT HOME CORP**, their agents and employees from and against any and all loss, expense, damage or other liability of bodily injury including death sustained by any person or persons or on account of damages to property including loss of use thereof arising out of or in making available transportation to or on behalf of the patient.

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Applicant's Name

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Signature

---

Date

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## RECEIPT OF EQUIPMENT & SUPPLIES

I, \_\_\_\_\_ (name) hereby acknowledged that I received from **ABBACARE AT HOME CORP** the following items.

Home Health Equipment	Date Received	Emp Initial	Date Returned	Agency Initial
Blood Pressure Monitor				
Stethoscope				
Pulse Oximeter				
Thermometer				
Medical or Nursing Bag				
*Weighing Scale				
*INR Monitor (Coagulometer)				
*Glucometer				
*Electronic Tablet				
*Cellphone				
<i>*when assigned as appropriate</i>				

That, I am fully responsible for the safe keeping, care and return of this/these items in its original and usable form/s when asked to do so. This includes but not limited to theft, and in the event of termination from this company.

In the event that I cannot return this/these items in its original and usable form/s, I hereby agree to pay ABBACARE AT HOME CORP a reasonable amount to be deducted from my final paycheck. If my final paycheck cannot pay off the balance, I further agree to be personally responsible to make payments to ABBACARE AT HOME CORP for the said item/s.

\_\_\_\_\_  
Employee Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agency Representative

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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## STAFF CONFIDENTIALITY And NON-DISCLOSURE AGREEMENT

Our agency's information systems contain confidential records pertaining to our patients, business associates, health care professionals, and staff. Because this information is vital to the operation of our agency in providing quality care and services to our clients, it must be protected. As such, in accordance with current HIPAA regulations and agency policies governing the access, use, and disclosure of protected health or agency information, you have the responsibility to protect such data.

As a staff member of **ABBACARE AT HOME CORP**, you may have access to protected information. The purpose of this agreement is to provide you with information to assist you in understanding your duty and obligations relative to confidential information. Your signature of this document indicates that the information contained herein has been explained to you, you have received a copy of this document, and that you understand the rules set forth. YOU AGREE --

1. To respect the privacy and confidentiality of any information you may have to access through our computer system or network, and that you will access or use only the information necessary to perform your job.
2. To refrain from communicating information about a patient in a manner that would allow others to overhear such information or to discuss a client's information with anyone not permitted access to such information in accordance with the agency's established policies or client's wishes (Example: Friends, relatives, visitors, family members of patients, etc)
3. To disclose confidential patient, business, financial, or staff information ONLY to those authorized to receive it.
4. To safeguard and not disclose your password or user ID code or any other authorization you may have that allows your access to protected information. You accept responsibility for all entries and actions recorded using your password and user ID code.
5. Not attempt to learn or use another employee's password and user ID code to log-on to our agency's computer system or network.
6. To immediately report to the HIPAA Compliance Officer any suspicions that your password and user ID code has been compromised.
7. Not to release or disclose the contents of any patient or agency record or report except to fulfill your work assignment.
8. Not to remove or copy any protected information or reports from their storage location except to fulfill your work assignment.
9. Not to sell, loan, alter or destroy any protected information or reports except as properly authorized within the scope of your job assignment.
10. Not to leave your computer terminal or workstation unattended without logging off or using your system's screen saver function before leaving your work area, or securing hardcopy information so that it may not be disclosed to unauthorized persons.
11. Not to access or request any protected information that is not necessary to perform your assigned job function.
12. Not to permit others to access our agency's computer system or network using your password or ID code.

13. To permit your access to our agency's information to be monitored.
14. Not to download or make copies of any software or applications without proper authorization or license.
15. Not to access or download any pornography or other illegal materials or perform any illegal activity such as gambling while on the agency's computer system or network.
16. Not to use our agency's computer system or network to send/forward harassing, insulting, defamatory, obscene, offending or threatening messages.
17. To report any suspected or known unauthorized access, use, or disclosure of protected information.
18. To abide by the HIPAA policies and procedures set forth by the agency as well as current regulations governing privacy practices.
19. To restrict personal use of the agency's computer system or network to meal and break periods, and to follow the agency's established policies governing such personal use.

I further understand that the duties and obligations set forth in this document will continue after the termination, expiration and cancellation of this agreement to include my termination of employment. I also understand my password and user ID code can be temporarily or permanently revoked if I fail to abide by the rules set forth.

_____ Employee Name	_____ Signature	_____ Date
_____ HIPAA Compliance Officer	_____ Signature	_____ Date
_____ Administrator	_____ Signature	_____ Date

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## EMPLOYEE EXIT INTERVIEW

(CONFIDENTIAL)

<b>Employee Name</b>	<b>Date of Term Notice</b> <input type="checkbox"/> Employee <input type="checkbox"/> Agency
Forwarding Address	<b>Last Paycheck Due</b> <input type="checkbox"/> Immediately <input type="checkbox"/> Next Payroll
Phone Number	
<b>The Following Information Must be Completed Prior to Employee Receiving Final Check</b>	
<input type="checkbox"/> Payroll Department notified immediately upon decision; "Exit" faxed <input type="checkbox"/> System Security Competency form <input type="checkbox"/> Voicemail Password(s) <input type="checkbox"/> Mobile Password <input type="checkbox"/> Advance Check <input type="checkbox"/> Yes <input type="checkbox"/> NA <input type="checkbox"/> Severance Check <input type="checkbox"/> Yes <input type="checkbox"/> NA	<input type="checkbox"/> Computer / Mobile phone returned <input type="checkbox"/> Keys / ID Badge / Other returned <input type="checkbox"/> Agency-purchased uniforms returned <input type="checkbox"/> Car Stock / Equipment / PPE returned
<i>Note: Employee will receive COBRA information regarding all insurance benefits via mail</i>	

<b>Reason for Exit</b>
<input type="checkbox"/> DISCHARGE <input type="checkbox"/> RESIGNATION <input type="checkbox"/> With Notice - Two Weeks <input type="checkbox"/> Without Notice <input type="checkbox"/> Attach resignation letter, if applicable <input type="checkbox"/> OTHER (Transfer, Retirement, Death, Leave expired) <input type="checkbox"/> This person would be eligible for re-hire <input type="checkbox"/> Not eligible for re-hire
<b>Explanation</b>

OVERALL PERFORMANCE RATING	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Satisfactory	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
Performance	Excellent	Good	Satisfactory	Fair	Poor
Productivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attendance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Safety Record	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attitude	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Exit Interview</b>
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<b>Have you (the employee) identified any Compliance Issues</b> (If yes, explain)
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Employee Name	Signature	Date
Supervisor	Signature	Date
Administrator	Signature	Date

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## PRE-EMPLOYMENT PHYSICAL EXAM

Employee Name \_\_\_\_\_

Home Address \_\_\_\_\_

Date \_\_\_\_\_ Date of Birth \_\_\_\_\_

Please Complete the Following Information	Date Given	Date Read	Results
Skin PPD Test			
Chest X-Ray			
Interferon-Gamma Release Assay (IGRA)			

Immunization, Inoculation, Booster Shots	First Dose	Second Dose	Booster
Flu Vaccine			
COVID Vaccine			
Hep A Vaccine			
Hep B Vaccine			
Other Vaccination			

The above named individual is physically and mentally capable of assuming all duties related to his/her job classification: Please mark ( ) Yes ( ) No

I have examined the above-named individual and to the best of my knowledge, he/she is in good physical and mental health, free from any infections or communicable disease and is able to function in his/her job at full capacity.

I certify that the employee is free from any health condition which would interfere with the employee's ability to perform assigned duties.

\_\_\_\_\_  
Physician, or NP, or PA Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date of Physical

\_\_\_\_\_  
Physician's Medical License Number

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone Number

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## Tuberculosis (TB) Questionnaire Screening For Signs And Symptoms of TB

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Home Address \_\_\_\_\_  
Job Title \_\_\_\_\_ Telephone Number \_\_\_\_\_

Check the appropriate spot for any symptoms that you have experienced for three or more weeks		
Excessive Fatigue: Malaise	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Unexplained Weight Loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Loss of Appetite (Anorexia)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Persistent Low Grade Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Night Sweats (drenching proportion)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Coughing Up Blood (hemoptysis)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pain in Chest	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Explain any YES answer/s

---

Employee Name

---

Signature

---

Date

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## HEPATITIS B VACCINE Consent / Declination Form

INSTRUCTIONS: *Review the three options below and sign the box indicating your choice for Hepatitis B vaccination at this time*

Print Name \_\_\_\_\_

Last 4 Digits of SSN \_\_\_\_\_

### PREVIOUS HBV VACCINATION

NOTE: If your series is incomplete and you wish to continue or restart the series, sign the "Consent Statement" section of this document.

- I have been previously vaccinated for Hepatitis B
- I have completed the vaccine series but am unsure of my immunity status
- I do not want to repeat the vaccine series at this time
- I have completed the vaccine series and had a POSITIVE HBV antibody titer

Date of Completion \_\_\_\_\_ Antibody Titer Results \_\_\_\_\_  Unknown

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_ Date \_\_\_\_\_

### CONSENT STATEMENT

I have read the information about Hepatitis B and the Hepatitis B Vaccine. I have had an opportunity to ask questions and understand the risk and benefits of this vaccine. I understand that I must have three doses of the vaccine to confer immunity. (Immunity may not be conferred with the three doses of the vaccine.) I understand that in the event my employment is terminated during the (6) month period of the injection series, the agency will not be responsible for the administration nor cost of the remaining doses.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_ Date \_\_\_\_\_

### DECLINATION STATEMENT

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

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_ Date \_\_\_\_\_

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## Influenza (Flu) Vaccination Declination Form

**AbbaCare Care At Home Corp** recommends that I, \_\_\_\_\_, receive influenza vaccination to protect myself, patients, staff, and others in the home environment where I provide intervention and treatment.

I acknowledge that I am aware of the following facts (please read and check each box):

- Influenza is a serious respiratory disease. Each year in the United States, influenza kills thousands of people and causes hundreds of thousands of hospitalizations.
- Influenza vaccination is recommended for me and all other healthcare personnel to protect our staff and our facility's patients from influenza, its complications, and death.
- If I contract influenza, I can shed the virus for 24 hours before any influenza symptoms appear. During the time I shed the virus, I can transmit influenza to patients and staff in this facility.
- If I become infected with influenza, even if my symptoms are mild or non-existent, I can spread influenza to others. Symptoms that are mild or non-existent in me can cause serious illness and death in others.
- I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't change, my immunity declines over time. This is why vaccination against influenza is recommended every year.
- I understand that it is impossible to get influenza from influenza vaccine.
- The consequences of my refusal to be vaccinated could have life-threatening consequences for my health and the health of everyone with whom I have contact, including my coworkers and all patients in this healthcare facility.

Despite these facts, I am choosing to decline influenza vaccination for the following reasons:

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- I understand that I can change my mind at any time and accept influenza vaccination.

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I have read and fully understand the information on this declination form.

\_\_\_\_\_  
Employee Name *(print)*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

<sup>†</sup>REFERENCE: CDC. Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices — United States. Access links to current ACIP recommendations at [www.cdc.gov/acip-recs/hcp/vaccine-specific/flu.html](http://www.cdc.gov/acip-recs/hcp/vaccine-specific/flu.html)

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## RECORD OF VACCINATION SERIES

*\*Recommended schedule: second vaccine - at least one month after first injection; third vaccine - six months after first injection*

DATE	Lot No Exp Date	Administered By	Date To Return
1			
2			
3			
Booster (if applicable)			

## ANTIBODY (HBsAb) TITER TESTING

*\*1-2 months after third vaccination*

DATE	Result	Further Action Required	ACTION
		<input type="checkbox"/> No, HBsAb $\geq$ 10 mIU/ml	
		<input type="checkbox"/> Yes, HBsAb $<$ 10 mIU/ml	<input type="checkbox"/> Repeat series of vaccinations (one time only)* <input type="checkbox"/> Refer to physician or health professional HBV testing

\*Use additional *Hepatitis B Vaccine Consent or Declination* form and attach to this form if subsequent vaccine series is required.

### Summary of Actions *(physician referral, recommendations, employee counseling, etc)*

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Supervisor's Name	Supervisor's Signature	Date
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# Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.

Give Form W-4 to your employer.

Your withholding is subject to review by the IRS.

# 2026

### 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 <a href="http://www.ssa.gov">www.ssa.gov</a> .
City or town, state, and ZIP code		
(c) <input type="checkbox"/> Single or Married filing separately		
<input type="checkbox"/> Married filing jointly or Qualifying surviving spouse		
<input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		
<b>Caution:</b> To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.		

**TIP:** Consider using the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App) to determine the most accurate withholding for the rest of the year if you: are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

**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, and when to use the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App).

### 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](http://www.irs.gov/W4App) for the most accurate withholding for this step (and Steps 3-4). If you or your spouse have self-employment income, use this option; **or**
- (b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**
- (c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(b) is more accurate . . . . .

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

### Step 3: Claim Dependent and Other Credits

If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly):			
(a) Multiply the number of qualifying children under age 17 by \$2,200 . . . . .	3(a)	\$	
(b) Multiply the number of other dependents by \$500 . . . . .	3(b)	\$	
Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here . . . . .	<b>3</b>	\$	

### Step 4: Other Adjustments

(a) <b>Other income (not from jobs).</b> 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) <b>Deductions.</b> Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) Enter the result here . . . . .	4(b)	\$
(c) <b>Extra withholding.</b> Enter any additional tax you want withheld each pay period . . . . .	4(c)	\$

Exempt from withholding I claim exemption from withholding for 2026, and I certify that I meet **both** of the conditions for exemption for 2026. See *Exemption from withholding* on page 2. I understand I will need to submit a new Form W-4 for 2027 . . . . .

### 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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## General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

### 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](http://www.irs.gov/FormW4).

### Purpose of Form

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

**Exemption from withholding.** You may claim exemption from withholding for 2026 if you meet both of the following conditions: you had no federal income tax liability in 2025 **and** you expect to have no federal income tax liability in 2026. You had no federal income tax liability in 2025 if (1) your total tax on line 24 on your 2025 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), 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 2026 tax return. To claim exemption from withholding, certify that you meet both of the conditions by checking the box in the *Exempt from withholding* section. Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2027.

**Your privacy.** Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

**When to use the estimator.** Consider using the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App) if you:

1. Are submitting this form after the beginning of the year;
2. Expect to work only part of the year;
3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;
4. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or
5. Prefer the most accurate withholding for multiple job situations.

**TIP:** Have your most recent pay stub(s) from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

**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](http://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. Submit a separate Form W-4 for each job.

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

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



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

**Step 3.** This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You (and/or your spouse if married filing jointly) must have the required social security number to claim certain credits. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

### Step 4.

**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 15, if you expect to claim deductions other than the basic standard deduction on your 2026 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for qualified tips, overtime compensation, and passenger vehicle loan interest; student loan interest; IRAs; and seniors. You (and/or your spouse if married filing jointly) must have the required social security number to claim certain deductions. For additional eligibility requirements, see Pub. 501.

**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 when you file your tax return.

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



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

**Note:** If more than one job has annual wages of more than \$120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at [www.irs.gov/W4App](http://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 5. 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 5 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 5 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 (plus any other additional amount you want withheld) . . . . . **4** \$ \_\_\_\_\_

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



See the Instructions for Schedule 1-A (Form 1040) for more information about whether you qualify for the deductions on lines 1a, 1b, 1c, 3a, and 3b.

1 Deductions for qualified tips, overtime compensation, and passenger vehicle loan interest.

a **Qualified tips.** If your total income is less than \$150,000 (\$300,000 if married filing jointly), enter an estimate of your qualified tips up to \$25,000 . . . . . **1a** \$ \_\_\_\_\_

b **Qualified overtime compensation.** If your total income is less than \$150,000 (\$300,000 if married filing jointly), enter an estimate of your qualified overtime compensation up to \$12,500 (\$25,000 if married filing jointly) of the “and-a-half” portion of time-and-a-half compensation . . . . . **1b** \$ \_\_\_\_\_

c **Qualified passenger vehicle loan interest.** If your total income is less than \$100,000 (\$200,000 if married filing jointly), enter an estimate of your qualified passenger vehicle loan interest up to \$10,000 . . . . . **1c** \$ \_\_\_\_\_

2 Add lines 1a, 1b, and 1c. Enter the result here . . . . . **2** \$ \_\_\_\_\_

3 **Seniors age 65 or older.** If your total income is less than \$75,000 (\$150,000 if married filing jointly):

a Enter \$6,000 if you are age 65 or older before the end of the year . . . . . **3a** \$ \_\_\_\_\_

b Enter \$6,000 if your spouse is age 65 or older before the end of the year and has a social security number valid for employment . . . . . **3b** \$ \_\_\_\_\_

4 Add lines 3a and 3b. Enter the result here . . . . . **4** \$ \_\_\_\_\_

5 Enter an estimate of your student loan interest, deductible IRA contributions, educator expenses, alimony paid, and certain other adjustments from Schedule 1 (Form 1040), Part II. See Pub. 505 for more information . . . . . **5** \$ \_\_\_\_\_

6 **Itemized deductions.** Enter an estimate of your 2026 itemized deductions from Schedule A (Form 1040). Such deductions may include qualifying:

a **Medical and dental expenses.** Enter expenses in excess of 7.5% (0.075) of your total income . . . . . **6a** \$ \_\_\_\_\_

b **State and local taxes.** If your total income is less than \$505,000 (\$252,500 if married filing separately), enter state and local taxes paid up to \$40,400 (\$20,200 if married filing separately) . . . . . **6b** \$ \_\_\_\_\_

c **Home mortgage interest.** If your home acquisition debt is less than \$750,000 (\$375,000 if married filing separately), enter your home mortgage interest expense (including mortgage insurance premiums) . . . . . **6c** \$ \_\_\_\_\_

d **Gifts to charities.** Enter contributions in excess of 0.5% (0.005) of your total income . . . . . **6d** \$ \_\_\_\_\_

e **Other itemized deductions.** Enter the amount for other itemized deductions . . . . . **6e** \$ \_\_\_\_\_

7 Add lines 6a, 6b, 6c, 6d, and 6e. Enter the result here . . . . . **7** \$ \_\_\_\_\_

8 **Limitation on itemized deductions.**

a Enter your total income . . . . . **8a** \$ \_\_\_\_\_

b Subtract line 4 from line 8a. If line 4 is greater than line 8a, enter -0- here and on line 10. Skip line 9 . . . . . **8b** \$ \_\_\_\_\_

9 Enter: { • \$768,700 if you’re married filing jointly or a qualifying surviving spouse } . . . . . **9** \$ \_\_\_\_\_  
 { • \$640,600 if you’re single or head of household }  
 { • \$384,350 if you’re married filing separately }

10 If line 9 is greater than line 8b, enter the amount from line 7. Otherwise, multiply line 7 by 94% (0.94) and enter the result here . . . . . **10** \$ \_\_\_\_\_

11 **Standard deduction.**

Enter: { • \$32,200 if you’re married filing jointly or a qualifying surviving spouse } . . . . . **11** \$ \_\_\_\_\_  
 { • \$24,150 if you’re head of household }  
 { • \$16,100 if you’re single or married filing separately }

12 **Cash gifts to charities.** If you take the standard deduction, enter cash contributions up to \$1,000 (\$2,000 if married filing jointly) . . . . . **12** \$ \_\_\_\_\_

13 Add lines 11 and 12. Enter the result here . . . . . **13** \$ \_\_\_\_\_

14 If line 10 is greater than line 13, subtract line 11 from line 10 and enter the result here. If line 13 is greater than line 10, enter the amount from line 12 . . . . . **14** \$ \_\_\_\_\_

15 Add lines 2, 4, 5, and 14. Enter the result here and in Step 4(b) of Form W-4 . . . . . **15** \$ \_\_\_\_\_

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

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

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

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

**Married Filing Jointly or Qualifying Surviving Spouse**

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$0	\$480	\$850	\$850	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020
\$10,000 - 19,999	0	480	1,480	1,850	2,050	2,220	2,220	2,220	2,220	2,220	2,220	2,620
\$20,000 - 29,999	480	1,480	2,480	3,050	3,250	3,420	3,420	3,420	3,420	3,420	3,820	4,820
\$30,000 - 39,999	850	1,850	3,050	3,620	3,820	3,990	3,990	3,990	3,990	4,390	5,390	6,390
\$40,000 - 49,999	850	2,050	3,250	3,820	4,020	4,190	4,190	4,190	4,590	5,590	6,590	7,590
\$50,000 - 59,999	1,020	2,220	3,420	3,990	4,190	4,360	4,360	4,760	5,760	6,760	7,760	8,760
\$60,000 - 69,999	1,020	2,220	3,420	3,990	4,190	4,360	4,760	5,760	6,760	7,760	8,760	9,760
\$70,000 - 79,999	1,020	2,220	3,420	3,990	4,190	4,760	5,760	6,760	7,760	8,760	9,760	10,760
\$80,000 - 99,999	1,020	2,220	3,420	4,240	5,440	6,610	7,610	8,610	9,610	10,610	11,610	12,610
\$100,000 - 149,999	1,870	4,070	6,270	7,840	9,040	10,210	11,210	12,210	13,210	14,210	15,360	16,560
\$150,000 - 239,999	1,870	4,100	6,500	8,270	9,670	11,040	12,240	13,440	14,640	15,840	17,040	18,240
\$240,000 - 319,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,780	14,980	16,180	17,380	18,580
\$320,000 - 364,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,860	15,860	17,860	19,860	21,860
\$365,000 - 524,999	2,720	5,920	9,390	12,260	14,760	17,230	19,530	21,830	24,130	26,430	28,730	31,030
\$525,000 and over	3,140	6,840	10,540	13,610	16,310	18,980	21,480	23,980	26,480	28,980	31,480	33,990

**Single or Married Filing Separately**

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$90	\$850	\$1,020	\$1,020	\$1,020	\$1,070	\$1,870	\$1,870	\$1,870	\$1,870	\$1,870	\$1,970
\$10,000 - 19,999	850	1,780	1,980	1,980	2,030	3,030	3,830	3,830	3,830	3,830	3,930	4,130
\$20,000 - 29,999	1,020	1,980	2,180	2,230	3,230	4,230	5,030	5,030	5,030	5,130	5,330	5,530
\$30,000 - 39,999	1,020	1,980	2,230	3,230	4,230	5,230	6,030	6,030	6,130	6,330	6,530	6,730
\$40,000 - 59,999	1,020	2,880	4,080	5,080	6,080	7,080	7,950	8,150	8,350	8,550	8,750	8,950
\$60,000 - 79,999	1,870	3,830	5,030	6,030	7,100	8,300	9,300	9,500	9,700	9,900	10,100	10,300
\$80,000 - 99,999	1,870	3,830	5,100	6,300	7,500	8,700	9,700	9,900	10,100	10,300	10,500	10,700
\$100,000 - 124,999	2,030	4,190	5,590	6,790	7,990	9,190	10,190	10,390	10,590	10,940	11,940	12,940
\$125,000 - 149,999	2,040	4,200	5,600	6,800	8,000	9,200	10,200	10,950	11,950	12,950	13,950	14,950
\$150,000 - 174,999	2,040	4,200	5,600	6,800	8,150	10,150	11,950	12,950	13,950	14,950	16,170	17,470
\$175,000 - 199,999	2,040	4,200	6,150	8,150	10,150	12,150	13,950	15,020	16,320	17,620	18,920	20,220
\$200,000 - 249,999	2,720	5,680	7,880	10,140	12,440	14,740	16,840	18,140	19,440	20,740	22,040	23,340
\$250,000 - 449,999	2,970	6,230	8,730	11,030	13,330	15,630	17,730	19,030	20,330	21,630	22,930	24,240
\$450,000 and over	3,140	6,600	9,300	11,800	14,300	16,800	19,100	20,600	22,100	23,600	25,100	26,610

**Head of Household**

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$280	\$850	\$950	\$1,020	\$1,020	\$1,020	\$1,020	\$1,560	\$1,870	\$1,870	\$1,870
\$10,000 - 19,999	280	1,280	1,950	2,150	2,220	2,220	2,220	2,760	3,760	4,070	4,070	4,210
\$20,000 - 29,999	850	1,950	2,720	2,920	2,980	2,980	3,520	4,520	5,520	5,830	5,980	6,180
\$30,000 - 39,999	950	2,150	2,920	3,120	3,180	3,720	4,720	5,720	6,720	7,180	7,380	7,580
\$40,000 - 59,999	1,020	2,220	2,980	3,570	4,640	5,640	6,640	7,750	8,950	9,460	9,660	9,860
\$60,000 - 79,999	1,020	2,610	4,370	5,570	6,640	7,750	8,950	10,150	11,350	11,860	12,060	12,260
\$80,000 - 99,999	1,870	4,070	5,830	7,150	8,410	9,610	10,810	12,010	13,210	13,720	13,920	14,120
\$100,000 - 124,999	1,870	4,270	6,230	7,630	8,900	10,100	11,300	12,500	13,700	14,210	14,720	15,720
\$125,000 - 149,999	2,040	4,440	6,400	7,800	9,070	10,270	11,470	12,670	14,580	15,890	16,890	17,890
\$150,000 - 174,999	2,040	4,440	6,400	7,800	9,070	10,580	12,580	14,580	16,580	17,890	18,890	20,170
\$175,000 - 199,999	2,040	4,440	6,400	8,510	10,580	12,580	14,580	16,580	18,710	20,320	21,620	22,920
\$200,000 - 249,999	2,720	5,920	8,680	10,900	13,270	15,570	17,870	20,170	22,470	24,080	25,380	26,680
\$250,000 - 449,999	2,970	6,470	9,540	12,040	14,410	16,710	19,010	21,310	23,610	25,220	26,520	27,820
\$450,000 and over	3,140	6,840	10,110	12,810	15,380	17,880	20,380	22,880	25,380	27,190	28,690	30,190



# Employment Eligibility Verification

## Department of Homeland Security

### U.S. Citizenship and Immigration Services

**USCIS**  
**Form I-9**  
OMB No.1615-0047  
Expires 05/31/2027

**START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the [Instructions](#).**

**ANTI-DISCRIMINATION NOTICE:** All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

**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 (if any)	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number (if any)	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number		Employee's Email Address		Employee's Telephone Number	
<p><b>I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.</b></p>		Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):				
		<input type="checkbox"/> 1. A citizen of the United States				
		<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)				
		<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)				
<input type="checkbox"/> 4. An alien authorized to work until _____ (exp. date, if any)						
If you check <b>Item Number 4.</b> , enter one of these:						
USCIS A-Number		OR	Form I-94 Admission Number		OR	Foreign Passport Number and Country of Issuance
Signature of Employee				Today's Date (mm/dd/yyyy)		

**If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the [Preparer and/or Translator Certification](#) on Page 3.**

**Section 2. Employer Review and Verification:** Employers or their authorized representative must complete and sign **Section 2** within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)	<p><b>Additional Information</b></p>    <p>Check here if you used an alternative procedure authorized by DHS to examine documents.</p>				
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

<p><b>Certification:</b> I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears 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.</p>		First Day of Employment (mm/dd/yyyy):
Last Name, First Name and Title of Employer or Authorized Representative		Signature of Employer or Authorized Representative
		Today's Date (mm/dd/yyyy)
Employer's Business or Organization Name		Employer's Business or Organization Address, City or Town, State, ZIP Code

**For reverification or rehire, complete [Supplement B, Reverification and Rehire](#) on Page 4.**

## LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.

\* Documents extended by the issuing authority are considered unexpired.

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

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

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
<ol style="list-style-type: none"> <li>1. U.S. Passport or U.S. Passport Card</li> <li>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</li> <li>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</li> <li>4. Employment Authorization Document that contains a photograph (Form I-766)</li> <li>5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole:               <ol style="list-style-type: none"> <li>a. Foreign passport; and</li> <li>b. Form I-94 or Form I-94A that has the following:                   <ol style="list-style-type: none"> <li>(1) The same name as the passport; and</li> <li>(2) An endorsement of the individual's status or parole 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.</li> </ol> </li> </ol> </li> <li>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</li> </ol>	OR	<ol style="list-style-type: none"> <li>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, sex, height, eye color, and address</li> <li>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, sex, height, eye color, and address</li> <li>3. School ID card with a photograph</li> <li>4. Voter's registration card</li> <li>5. U.S. Military card or draft record</li> <li>6. Military dependent's ID card</li> <li>7. U.S. Coast Guard Merchant Mariner Card</li> <li>8. Native American tribal document</li> <li>9. Driver's license issued by a Canadian government authority</li> <li style="text-align: center;"><b>For persons under age 18 who are unable to present a document listed above:</b></li> <li>10. School record or report card</li> <li>11. Clinic, doctor, or hospital record</li> <li>12. Day-care or nursery school record</li> </ol>	AND	<ol style="list-style-type: none"> <li>1. A Social Security Account Number card, unless the card includes one of the following restrictions:               <ol style="list-style-type: none"> <li>(1) NOT VALID FOR EMPLOYMENT</li> <li>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</li> <li>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</li> </ol> </li> <li>2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)</li> <li>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</li> <li>4. Native American tribal document</li> <li>5. U.S. Citizen ID Card (Form I-197)</li> <li>6. Identification Card for Use of Resident Citizen in the United States (Form I-179)</li> <li>7. Employment authorization document issued by the Department of Homeland Security               <p style="margin-left: 20px;">For examples, see <a href="#">Section 7</a> and <a href="#">Section 13</a> of the M-274 on <a href="https://uscis.gov/i-9-central">uscis.gov/i-9-central</a>.</p> <p style="margin-left: 20px;">The Form I-766, Employment Authorization Document, is a List A, <b>Item Number 4</b>, document, not a List C document.</p> </li> </ol>
<p><b>Acceptable Receipts</b></p> <p>May be presented in lieu of a document listed above for a temporary period.</p> <p>For receipt validity dates, see the M-274.</p>				
<ul style="list-style-type: none"> <li>• Receipt for a replacement of a lost, stolen, or damaged List A document.</li> <li>• Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual.</li> <li>• Form I-94 with "RE" notation or refugee stamp issued to a refugee.</li> </ul>	OR	<ul style="list-style-type: none"> <li>• Receipt for a replacement of a lost, stolen, or damaged List B document.</li> </ul>	AND	<ul style="list-style-type: none"> <li>• Receipt for a replacement of a lost, stolen, or damaged List C document.</li> </ul>

\*Refer to the Employment Authorization Extensions page on [I-9 Central](#) for more information.



# Supplement A, Preparer and/or Translator Certification for Section 1

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

USCIS  
Form I-9  
Supplement A  
OMB No. 1615-0047  
Expires 05/31/2027

Last Name ( <i>Family Name</i> ) from <b>Section 1</b> .	First Name ( <i>Given Name</i> ) from <b>Section 1</b> .	Middle initial (if any) from <b>Section 1</b> .
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**Instructions:** This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

**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		Date ( <i>mm/dd/yyyy</i> )	
Last Name ( <i>Family Name</i> )	First Name ( <i>Given Name</i> )		Middle Initial ( <i>if any</i> )
Address ( <i>Street Number and Name</i> )	City or Town	State	ZIP Code

**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		Date ( <i>mm/dd/yyyy</i> )	
Last Name ( <i>Family Name</i> )	First Name ( <i>Given Name</i> )		Middle Initial ( <i>if any</i> )
Address ( <i>Street Number and Name</i> )	City or Town	State	ZIP Code

**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		Date ( <i>mm/dd/yyyy</i> )	
Last Name ( <i>Family Name</i> )	First Name ( <i>Given Name</i> )		Middle Initial ( <i>if any</i> )
Address ( <i>Street Number and Name</i> )	City or Town	State	ZIP Code

**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		Date ( <i>mm/dd/yyyy</i> )	
Last Name ( <i>Family Name</i> )	First Name ( <i>Given Name</i> )		Middle Initial ( <i>if any</i> )
Address ( <i>Street Number and Name</i> )	City or Town	State	ZIP Code



# Supplement B, Reverification and Rehire (formerly Section 3)

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

**USCIS**  
**Form I-9**  
**Supplement B**  
OMB No. 1615-0047  
Expires 05/31/2027

Last Name ( <i>Family Name</i> ) from Section 1.	First Name ( <i>Given Name</i> ) from Section 1.	Middle initial (if any) from Section 1.
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**Instructions:** This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the [Handbook for Employers: Guidance for Completing Form I-9 \(M-274\)](#)

Date of Rehire ( <i>if applicable</i> )	New Name ( <i>if applicable</i> )		
Date ( <i>mm/dd/yyyy</i> )	Last Name (Family Name)	First Name (Given Name)	Middle Initial

**Reverification:** If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) ( <i>mm/dd/yyyy</i> )
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**I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.**

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date ( <i>mm/dd/yyyy</i> )
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Additional Information (Initial and date each notation.)	Check here if you used an alternative procedure authorized by DHS to examine documents.
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Date of Rehire ( <i>if applicable</i> )	New Name ( <i>if applicable</i> )		
Date ( <i>mm/dd/yyyy</i> )	Last Name (Family Name)	First Name (Given Name)	Middle Initial

**Reverification:** If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) ( <i>mm/dd/yyyy</i> )
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**I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.**

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date ( <i>mm/dd/yyyy</i> )
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Additional Information (Initial and date each notation.)	Check here if you used an alternative procedure authorized by DHS to examine documents.
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Date of Rehire ( <i>if applicable</i> )	New Name ( <i>if applicable</i> )		
Date ( <i>mm/dd/yyyy</i> )	Last Name (Family Name)	First Name (Given Name)	Middle Initial

**Reverification:** If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) ( <i>mm/dd/yyyy</i> )
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**I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.**

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date ( <i>mm/dd/yyyy</i> )
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Additional Information (Initial and date each notation.)	Check here if you used an alternative procedure authorized by DHS to examine documents.
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