Application For Employment

It is this agency's policy to provide equal employment opportunities without regard to age, race, color, religion, military status, gender preference, genetic information, sex, marital status, national origin, or disability.

Applicant Name: _____ Email Address: _____

Present Address
City/State/Zip: _____

Home Phone: _____ Mobile Phone: _____

Social Security Number: _____ Are You at Least 18 Years Old? ☐ Yes ☐ No

Position Applying For: _____ ☐ Full Time ☐ Part Time Per Visit ☐ Part Time ☐ Pool Shift: ☐ Day ☐ Night ☐ Evening ☐ W/E

Salary Requirements: _____ Date Available _____ If you are not a US Citizen, have you the legal right to remain permanently in the US? ☐ Yes ☐ No

Do you have adequate means of transportation to get to work on time each day and when called in on short notice during normal working hours? ☐ Yes ☐ No

Have you been convicted of a crime (excluding misdemeanors and traffic offenses) and/or released from confinement following a conviction for any criminal offense within the past 7 years? ☐ Yes ☐ No If Yes, please give date, place and nature of each such conviction.

Are you presently charged with any violation of the law other than traffic violation? ☐ Yes ☐ No If Yes, give date, place and nature of each such conviction.

Educational History

Type of School	Name & Location of School	Circle Last Year Attended	Graduated	Degree
High School		9 10 11 12		
College		1 2 3 4		
College		1 2 3 4		
Other		From: To:		

List professional licenses you possess. Indicate type of license, number and state

List any memberships in professional organizations, honors or activities which you feel would enhance your application, excluding those that would indicate age, race, color, religion, military status, gender preference, genetic information, sex, marital status, national origin, or disability.

List languages spoken other than English:

List other skills applicable to the position for which you are applying, including computer experience, typing speed, etc:

In case of an emergency notify _____ Relationship _____

Out of state contact, if possible _____ Relationship _____

Reference Request

Date: _____ Check method of gathering reference data: ☐ Verbal ☐ Mail

Name of person giving reference: _____ Facility: _____

The individual named below is applying for a position as _____ and has given you as a reference. As we place great importance on the thorough screening of all our applicants, we would appreciate a prompt and thoughtful response.

Thank you in advance_____
(Name of Company Representative)

Applicant Release

Applicant _____ _____
Last First MI Maiden

Position Held _____

Social Security # _____ Dates Employed: From _____ To _____

I hereby release from all liability the company or person completing this form, and authorize them to release all information regarding my employment with them. I understand that this information may be released to clients of the requesting company and other requesting third parties on a need to know basis. I also release the requesting company from all liability for any damages from the disclosure of this information.

_____ _____
Applicant Signature Date

1) Please confirm the applicant's employment. From _____ To _____
Date Date

2) Please comment on the applicant's attributes using the following scale:
4 = Excellent 3 = Good 2 = Fair 1 = Poor N/A = Not applicable

Quality of Work _____

Knowledge & Skills_____

Reliability & Attendance _____

Cooperation_____

Competence _____

Supervisory ability & capacity _____

Grooming _____

3) Please indicate specialty areas in which the applicant has had experience: _____

_____

4) Please indicate any special considerations necessary when giving assignments to this individual:

_____

5) Is applicant eligible for rehire? ☐ Yes ☐ No If no, why not? _____

_____

Please attach any additional comments.

_____ _____ _____
Signature Position/Title Date

HCL / Reference Check
Org. 110100

NAME_____

Work History

Attach an additional sheet listing other work experience pertinent to the position for which you are applying if the space below is insufficient

Company Name	Complete Address incl City/State/Zip	Phone Number	Supervisor's Name
Date Started Date Left	Type of Business □ Full Time □ Part Time □ Per Visit Salary	Reason For Leaving	OK to Contact Supervisor □ Yes □ No
Describe your job title, responsibilities and accomplishments			

Company Name	Complete Address incl City/State/Zip	Phone Number	Supervisor's Name
Date Started Date Left	Type of Business □ Full Time □ Per Visit □ Part Time Salary	Reason For Leaving	OK to Contact Supervisor □ Yes □ No
Describe your job title, responsibilities and accomplishments			

Company Name	Complete Address incl City/State/Zip	Phone Number	Supervisor's Name
Date Started Date Left	Type of Business □ Full Time □ Part Time □ Per Visit Salary	Reason For Leaving	OK to Contact Supervisor Yes □ No □

Describe your job title, responsibilities and accomplishments

_____

NAME: _____

PERSONAL REFERENCES: (Name,Phone ,Relationship) _____

_____

_____

_____

_____

Please review and sign

In making application for employment:

- I certify that the information in this application is true and complete for all practical purposes. It may be verified by the facility or any affiliate. Should a position be offered and later it is found that the information is significantly untrue, incomplete, or misrepresented, I understand and agree that the facility or its affiliates are relieved of all commitments, financial or otherwise pertinent to employment, and that I am subject to immediate discharge without recourse.

- I understand that an investigative report may be made by a consumer reporting agency to include information as to my character, general reputation, personal characteristics, and mode of living, whichever may be applicable. If such an investigative report is made, I understand that I will receive notice that such report has been requested, and that I will have the right to make a written request for a complete and accurate disclosure of additional information concerning the nature and scope of the investigation.

- I understand and agree that if I am offered employment by the facility, my employment will be for no definite term and that either I, or the facility will have the right to terminate the employment relationship at any time, with or without cause, and with or without notice. I also understand that this status can only be altered by a written contract of employment which is specific as to all material terms and is signed by me and the Administrator of the facility.

- I understand, if I have direct patient contact or contact with patient records, that the agency will perform a criminal history check per Federal Regulation, as well as check of the Nurse Aide Registry and Employee Misconduct Registry for unlicensed employees. I understand that: 1) the purpose of the Employee Misconduct Registry is to ensure that unlicensed personnel who commit acts of abuse, neglect, exploitation, misappropriation, or misconduct against residents and consumers are denied employment in DADS-regulated facilities and agencies; 2) the State of Texas maintains a registry of all nurse aides who are certified to provide services in nursing facilities and skilled nursing facilities licensed by the Texas Department of Aging and Disability Services (DADS) and they review and investigate allegations of abuse, neglect, or misappropriation of resident property by nurse aides and if there's a finding of an alleged act of abuse, neglect, or misappropriation, the nurse aide may request both an informal reconsideration and a formal hearing before the finding is placed on the registry; 3) All DADS-regulated facilities and agencies are required to check the Employee Misconduct Registry and Nurse Aide Registry before hire to determine if I am listed in either registry as having committed an act of abuse, neglect, exploitation, misappropriation, or misconduct against a resident or consumer and am, therefore, **unemployable**.

Release: I hereby authorize any prior employers to provide such information concerning my employment with them as may be requested, and also authorize the Registrar/Placement Office of all educational institutions attended to release an official copy of my transcript and, if available, faculty appraisals. I also authorize any appropriate licensing board to release full information concerning my license status and my license history.

Applicant Signature: _____

Date: _____

FOR OFFICE USE ONLY	☐ References Checked	If Hired: Position: Start Date: Salary: FT/PT/Per Visit

Job Description / Performance Evaluation

Title: Pediatric RN

Job Summary:

Primary functions are to administer skilled nursing care for maternal/child clients in their place of residence, coordinate care with the interdisciplinary team, patient/family and referring agency; and assumes the responsibility for coordination of care.

Job Qualifications:

Education: Graduate of an accredited Diploma, Associate or Baccalaureate School of Nursing
Licensure: Current Texas State license as a Registered Nurse, current Texas Drivers License
Experience: Two years experience as an Registered Nurse in pediatrics, home health experience preferred.
Skills: Nursing skills as defined as generally accepted standards of practice and pediatric competency. Good interpersonal skills. Proof of current CPR, and Hepatitis consent/declination.
Transportation: Reliable transportation. Valid and current auto liability insurance

Environmental and Working Conditions:

Works in patients home in various conditions; possible exposure to blood and bodily fluids and infections diseases; ability to work flexible schedule; ability to travel locally; some exposure to unpleasant weather; PRN emergency call.

Physical and Mental Effort:

Prolonged standing and walking required, with ability to lift up to 50 lbs and move patients. Requires working under some stressful conditions to meet deadlines and patient needs, and to make quick decisions and resource acquisition; meet patient/family individualized psycho social needs. Requires hand-eye coordination and manual dexterity.

Essential Functions	**Evaluation**
Assess home health pediatric patient/family to identify the physical, psycho social, and environmental needs as evidenced by documentation, clinical record, case conference, team report, and evaluations.	
Implement/develop/document the plan of care to ensure quality and continuity of care.	
Provide care utilizing infection control measures that protect both the staff and the patient (OSHA).	
Supervise and provide clinical directions to ensure quality and continuity of service provided.	
Assure continuity of quality patient care delivered with appropriate documentation.	
Monitor assigned cases to ensure compliance with requirements of third party payor.	
Demonstrate commitment, professional growth and competency.	
Promote Agency philosophy and administrative policies.	
Perform on-call responsibilities and provide on-call service to patients/families as assigned.	
Provide effective communication to patient/family, team members, and other health care profession.	

Statement of Understanding: I have read the above job description and essential functions. I understand and agree to carry out these responsibilities as assigned. I understand and acknowledge that nothing contained in this job description may be construed as limiting the employer's right to discipline or terminate my employment at any time for failure to perform satisfactorily

Signature:_____ **Date:**_____

Evaluation Codes: 1-Does not meet job requirements/expectations 2-Occasionally meets job requirement 3 -Normally meets job requirements 4-Meets and occasionally exceeds job 5-Regularly exceeds job requirements

Comments/Goals:_____

Use back for additional comments/goals

Signature:_____ **Date:**_____

Evaluator/Title:_____ **Date:**_____

Job Description / Performance Evaluation

Title: Licensed Vocational Nurse

Job Summary:
Primary function is to administer skilled nursing care, under the supervision of a registered nurse, for clients of all ages in their place of residence, coordinate care with the interdisciplinary team, patient/family and referring agency.

Job Qualifications:

Education: Graduate of an accredited school of vocational nursing
Licensure: Current Texas State license as a Licensed Vocational Nurse, current Texas Drivers License
Experience: Two years experience as a Licensed Vocational Nurse in a clinical care setting preferred, home health preferred
Skills: Nursing skills as defined as generally accepted standards of practice. Good interpersonal skills.
Transportation: Reliable transportation. Valid and current auto liability insurance

Environmental and Working Conditions:
Works in patients home in various conditions; proof of current CPR, and Hepatitis profile; possible exposure to blood and bodily fluids and infections diseases; ability to work flexible schedule; ability to travel locally; some exposure to unpleasant weather; PRN emergency call.

Physical and Mental Effort:
Prolonged standing and walking required, with ability to lift up to 50 lbs and move patients. Requires working under some stressful conditions to meet deadlines and patient needs, and to make quick decisions and resource acquisition; meet patient/family individualized psycho social needs. Requires hand-eye coordination and manual dexterity.

Essential Functions	**Evaluation**
Under the direction of the RN, assist in identifying the patient's physical, psycho social, and environmental needs as evidenced by documentation, clinical record, case conference, team report, and evaluations.	
Participate in planning and implementing care in conjunction with the RN, in accordance with the POC.	
Provide care utilizing infection control measures that protect both staff and patient (OSHA).	
Assure the continuity of care through delivery of quality patient care.	
Provide effective communication to patient/family, team members, and other health care professionals as evidenced by clinical notes, case conferences, communication notes, and evaluations.	
Monitor assigned cases to ensure compliance with requirements of third party payor.	
Demonstrate commitment, professional growth and competency.	
Promote Agency philosophy and administrative policies to ensure quality of care.	

Statement of Understanding: I have read the above job description and essential functions. I understand and agree to carry out these responsibilities as assigned. I understand and acknowledge that nothing contained in this job description may be construed as limiting the employer's right to discipline or terminate my employment at any time for failure to perform satisfactorily.

Signature:_____ **Date:**_____

Evaluation Codes: 1-Does not meet job requirements/expectations 2-Occasionally meets job requirement
3 -Normally meets job requirements 4-Meets and occasionally exceeds job 5-Regularly exceeds job requirements

Comments/Goals:_____

Use back for additional comments/goals

Signature:_____ **Date:**_____

Evaluator/Title:_____ **Date:**_____

Personnel File Checkl...

Name:_____ **Date:**_____

Section I

___ Completed, signed Application for Employment form.

___ Documentation of employment ***Reference Checks*** [at least two]

___ Texas Employer New Hire Reporting Form

Section II

___ Signed ***Job Description.***

___ Competency ***Skills Competency Checklist.*** [per regs or policy] HHA____ ***Written exam***_____

___ Signed ***Orientation Checklist***

___ ***Employee Acknowledgment***

___ Statement of Employability, to include telephone results of Employee Misconduct Registry (EMR) and Nurse Aide Registry (NAR) for all unlicensed clinical staff as well as documentation that Criminal History Check was completed on-line

___ ***Social Security Card*** (Copy not required in personnel file, may file with I 9 form)

___ *W-4* tax withholding form. (Download most current version at www.irs.gov/pub/irs-pdf/fw4.pdf)

___ Miscellaneous

Section III

___ Documentation/copy of current ***License, Registration/Certification, or Competency.*** [ST-CCC& license , MSW - Masters Degree & license]

___ ***Verification of current License/Certification*** by verbal contact with licensing board or through written verification. [as required by State regulation]

___ Current ***CPR***, [if required]

___ Current ***Drivers License***

___ Current ***Automobile Liability***

Section IV

___ Inservice Records

___ Performance evaluations [at least annually or per policy] counseling forms, commendations

Health File/ I-9 Checklist

NAME:_____ DATE:_____

Health Information File (All health files may be maintained in a sealed envelope in personnel file or in a separate file/binder in a secure location. The Joint Commission and ACHC require a separate binder)

— ***TB clearance*** [if required] *(according to agency policy)*

— ***Hepatitis B*** consent / declination

— ***Hepatitis B vaccination*** tracking form

Other health forms if applicable

— HBV / HIV exposure and exposure follow up.

— Workers compensation forms and related documents.

— Medical Leave of Absence forms and related documents.

— Medical information related to accommodation

— Miscellaneous documentation of illness.

I-9 Form (Download most current version at www.uscis.gov/files/form/i-9.pdf) should not be in the personnel file but kept in a separate file folder/binder in a secure location. May attach copy of SS card here but not required.

Criminal Background History Check Form should not be in the personnel file but kept in a separate file folder/binder in a secure location.

EMPLOYEE ACKNOWLEDGMENT

Confidentiality: Agency maintains confidentiality of operations, activities, and business affairs of the Agency and the clients according to 1996, Health Information Portability and Accountability Act (HIPAA). Due to the nature of our work, each employee will gain, directly or indirectly, sensitive and confidential information on clients/patients and staff members. The health care professional safeguards the client's right to privacy by judiciously protecting information of a confidential nature including medical treatment information, diagnosis, medical records, personal patient information, etc. This information should be shared only with those persons who, due to their position, have a need to know. Sensitive or confidential information must never be used as the basis for social conversation or gossip. If an employee is in doubt as to whether or not certain information may be shared, s/he should consult with his/her supervisor.

Drug Testing Policy: Agency conducts "on hire and random/for cause" drug testing on its employees. Agency maintains a drug free workplace policy with regard to the possession, use, distribution and sale of drugs or alcohol. All employees are prohibited from the unlawful or unauthorized manufacture, distribution, dispensing, possession or use of a controlled substance or any alcoholic beverages while in the workplace or on Company paid time Violation of ths policy can result in disciplinary action, up to and including termination of employment. I acknowledge I have received a copy of the agency's policy on drug testing.

Harassment Policy: This agency is committed to providing a work environment, that is free from all forms of discrimination and unlawful harassment including sexual harassment. This policy applies to all employees including management personnel. Sexual harassment is any unwelcome sexual advances either explicit or implicit as a term or condition of employment. Improper behavior may be verbal, visual, or physical in nature and/or the creation of a hostile environment. Management will investigate complaints of sexual harassment promptly, impartially and without fear of retaliation to the employee. An employee should report the alleged incident immediately and confidentially to the appropriate manager or Human Resources.

Non Solicitation/Illegal Remuneration: Agency does not reimburse or provide incentives to physicians, durable equipment providers, family or other referral entities for patient referrals for home health services. Employees may not solicit patients for the agency. Employees found in violation of this non-solicitation policy will be subject to discipline up to and including termination of employment.

Non-Discrimination: Agency does not discriminate against clients or volunteers based on age, race, color, religion, military status, gender preference, genetic information, sex, marital status, national origin, disability, or source of payment.

Abuse, Neglect, and Exploitation: Agency employees will report suspected abuse, neglect and/or exploitation to the state departments of both the Texas Department of Family and Protective Services, the Department of Aging and Disability Services, and Agency management. Agency employees suspected of abuse, neglect, or exploitation will be suspended immediately, an investigation will be conducted, and if the investigation validates the claim, the employee will be terminated.

Workers' Compensation: Agency is a subscriber to workers' compensation insurance. An employee who incurs an injury on the job that requires emergency medical treatment or is life threatening should proceed to the nearest emergency room. Emergency medical treatment (non life threatening) or non-emergency treatment should be referred to the agency's designated clinic. Notify the agency of an injury within 24 hours to complete paperwork. Medical expenses for injuries are covered with the exception of the following: employee's willful intent to hurt self or others, intoxication or drug use, horseplay, acts of God, and/or acts of a third party.

Progressive Discipline Policy: Agency utilizes a progressive discipline process in cases of misconduct or unacceptable performance. This includes verbal warning, written warning and final warning. Disciplinary action may begin at an advanced stage of the process or may result in immediate termination based upon the nature and severity of the offense, employee's past record and other circumstances.

Agency Policies: I acknowledge that I have read, understand, and will comply with all applicable agency policies and guidelines.

Employee:_____ Date:_____

(B) **A person may also be barred from employment the duties of which involve direct conact with a client in a facility if convicted of any of the following crimes within the past 5 years:**

- **An offense under Section 22.01, Penal Code (assault punishable as a Class A misdemeanor or as a felony);**
- **An offense under Section 30.02 , Penal Code (burglary);**
- **An offense under Chapter 31, Penal Code (theft that is punishable as a felony);**
- **An offense under Section 32.45, Penal Code (misapplication of fiduciary property or property of a financial institution), that is punishable as a Class A misdemeanor or a felony; or**
- **An offense under Section 32.46, Penal Code (securing execution of a document by deception punishable as a Class A misdemeanor or a felony) .**
- **An offense under Section 37.12, Penal Code (false identification as a peace officer); or**
- **An offense under Section 42.01 (a) (7), (8), or (9), Penal Code (disorderly conduct).**

(C) **In addition to the prohibitions on employment prescribed by Subsections (A) and (B), a person for whom a facility licensed under Chapter 242 or 247 is entitled to obtain criminal history record information may not be employed in a facility licensed under Chapter 242 or 247 if the person has been convicted:**

- **Of an offense under Section 30.02, Penal Code (burglary); or**
- **Under the laws of another state, federal law, or the Uniform Code of Military Justice for an offense containing elements that are substantially similar to the elements of an offense under Section 30.02, Penal Code.**

(D) **For purposes of this section, a person who is placed on deferred adjudication community supervision for an offense listed in this section, successfully completes the period of deferred adjudication community supervision, and receives a dismissal and discharge in accordance with Section 5(c), Article 42.12, Code of Criminal procedure, is not considered convicted of the offense for which the person received deferred adjudication community supervision.**

I acknowledge that if I am found to have been convicted of any other offense(s), that these offenses may also bar my employment. I understand that all information obtained by this agency regarding any criminal history will remain confidential.

I certify that the information on this form contains no willful misrepresentation and that the information given is true and complete to the best of my knowledge.

Signature of Applicant _____ Date _____

For Agency Use Only: Criminal History, Employee Misconduct Registry (EMR), and Nurse Aide Registry (NAR) checks completed:

❑ Criminal History Check completed on-line ❑ Other Convictions identified on Criminal History. (Document reason hiring in Comments below)

❑ NAR ❑ EMR checked online at https://emr.dads.state.tx.us/DadsEMRWeb/
❑ Applicant employable ❑ Applicant not employable ❑ Comments: _____

Verified By _____ Date _____

CONFIDENTIALITY OF PATIENT INFORMATION

I plan to utilize electronic documentation of patient care.

I will ensure confidentiality and security of patient information by password protecting the device or program utilized.

I agree to change the password at least quarterly or following a breach of security.

I will not provide my password to anyone.

I have been informed of the Agency's Confidentiality Policy and Safeguarding of Medical Records Policy and I agree to abide by these policies.

_____ _____

Employee Date

Influenza Vaccination Program

Who Should Get Vaccinated? Everyone 6 months and older. Health-care personnel should receive the vaccine annually as you care for people at high risk for developing flu-related complications.

Who Should NOT be Vaccinated? People who have: a severe allergy to chicken eggs; or a severe reaction to an influenza vaccination; or a moderate to severe illness with a fever; or a history of Guillain-Barré Syndrome.

When Should Vaccination Occur? As soon as flu vaccine is available, even if as early as August.

What are the Influenza Vaccine Options? There are two (2) types of vaccine, each of which take about 2 weeks to become effective and last a year:

1. Trivalent inactivated vaccine (TIV) - a vaccine containing killed virus that is given intramuscularly (IM), usually in the arm. There are three different kinds of TIV: regular TIV (for everyone), a high dose TIV (for people 65 and older) and an intradermal TIV vaccine (for people 18 - 64 years of age).

2. Live, Attenuated Intranasal Influenza Vaccine (LAIV) - a nasal spray for people 18 - 64 years of age.

Package inserts should be consulted for recommended age groups and possible contraindications for each vaccine in addition to information regarding additional components of various vaccine formulations.

What are Possible Side Effects?

1. The viruses in the injectable influenza vaccine (TIV) are inactivated so they do not cause influenza. Minor side effects can include soreness, redness or swelling at the injection site, fever (low grade), or aches. If these occur, they begin soon after vaccination and usually last 1 or 2 days. Other rare side effects have been reported. More information is available at http://www.cdc.gov/vaccines/pubs/vis/downloads/vis-flu.pdf.

2. LAIV is made from weakened viruses and does not cause influenza. The vaccine can cause mild illness in some people. Minor side effects can include runny nose, headache, sore throat, or cough. More information is available at http://www.cdc.gov/vaccines/pubs/vis/downloads/vis-flulive.pdf.

How is Influenza Spread? Influenza viruses are spread from person to person primarily through large-particle respiratory droplet transmission (e.g., when an infected person coughs or sneezes). Transmission via large-particle droplets requires close contact between source and recipient persons, because droplets do not remain suspended in the air and generally travel only a short distance (less than or equal to 1 meter) through the air. Contact with respiratory-droplet contaminated surfaces is another possible source of transmission. The typical incubation period is 1 - 4 days (average 2 days). Uncomplicated influenza illness typically resolves after 3 - 7 days for the majority of persons, although cough and malaise can persist for more than 2 weeks. Influenza virus infections can cause primary influenza viral pneumonia; exacerbate underlying medical conditions, e.g., pulmonary or cardiac disease; lead to secondary bacterial pneumonia, sinusitis, or otitis media or contribute to coinfections with other pathogens.

What are Signs/Symptoms of Influenza? For most people, symptoms last only a few days. They include: fever/chills; sore throat; muscle aches; fatigue; cough; headache; runny or stuffy nose.

I understand that the Agency strongly recommends that I take the influenza vaccine annually.

The box checked below reflects my influenza vaccine status for the current year:

☐ I have already received the current year influenza vaccine.

☐ I refuse the current year influenza vaccine for the following reason(s):

☐ Medically contraindicated due to:
- ☐ Severe allergy to chicken eggs
- ☐ Severe reaction to an influenza vaccination
- ☐ Moderate to severe illness with a fever
- ☐ History of Guillain-Barré Syndrome
- ☐ Other medical contraindication: _____

☐ Other reason:
- ☐ Religious preference
- ☐ Fear of needles
- ☐ Opposed to vaccinations
- ☐ Unpleasant prior experience
- ☐ Personal choice_____
- ☐ Other _____

☐ I have not received the current year influenza vaccine. I understand that I have the option of obtaining the vaccine at local pharmacies, grocery stores, drug stores, clinics, physician office, or health department.

☐ I accept the influenza vaccine as provided by the agency.

I understand that the seasonal influenza vaccine is the most important way of preventing seasonal influenza virus infections and potentially severe complications, including death.

I understand that non-vaccine control and prevention measures include using appropriate respiratory hygiene measures, hand hygiene measures and standard precautions.

_____ _____

Employee Signature Date

ORIENTATION CHECKLIST

I. Introduction
- Welcome
- Home Health Overview
- Agency Mission/Philosophy/Goals
- Overview of Agency
  - Organizational Chart
  - Operating Hours
  - Scope of Services
  - Geographical Coverage

II. Agency/Employee Commitment and Responsibilities
- Community and Customer Relations
- Discrimination and Harassment/ Reasonable Accommodation
- Drug Free / Smoke Free Workplace
- *HIPAA/Confidentiality
- Professional Conduct / Attendance
- Professional Appearance/Dress Code
- Telephone Usage/Courtesy
- Cultural Diversity
- Quality Assurance Performance Improvement Program (QAPI)
- Code of Conduct to include; Fraud and Abuse in Home Care, Business/Patient Ethics and Ethics Committee

III. Human Resources / Personnel Administration
- Employment Information
- Personnel File Maintenance
- HR Policies and Practices
- In-service / Education
  - Employee Performance
  - Employee Grievance / Complaint Resolution
  - Progressive Discipline
  - Patient Complaints

IV. Compensation
- Compensation
- Work Schedules / Time Sheets/Records
- Pay Checks/Deductions /Overtime/ Holidays

V. *Safety
- Risk Management
- Personal Safety (Driving Safety & Body Mechanics)
- Fire Safety Procedures
  - Office / Patient Residence
- Workplace Security/Safety/Violence
- Exposure Control
  - Standard Precautions / HIV / Hep B & C / Personal Protective Equipment / Hazardous Waste / Infection Control / Hand Hygiene
- Emergency Preparedness (Plan / Procedure / Potential Disasters / Safety Tips)
- Equipment Safety/Maintenance
- Incident / Occurrence Reports
- Abuse and Neglect
- Adverse / Inclement Weather
- National Patient Safety Goals

VI. Tour of Office
- Policy/Procedure Manual
- *MSDS Information
- Medical Supplies / Equipment

VII. Direct Care Staff
- Case Management
- Patient Care Policies / Procedures
  - On Call / Alternative Communication
  - *Advance Directives
  - Cultural Diversity
  - *Safety (Employee / Patient in Home)
    - Basic Personal/Patient Safety in Home
    - National Patient Safety Goals
    - Medication Safety / Compliance
    - Medical Equipment
    - Restraints
    - Abuse / Neglect / Exploitation
- State and Federal Regulations
- Documentation
  - *Patient Consent / Bill of Rights / Responsibilities
- Death and Dying
- Pain Management

Employee Signature:_____ **Date:**_____

Supervisor Signature:_____ **Date:**_____

* Orientation to this key safety content item required prior to provision of patient care/treatment/service.

September 27, 2013

Winners Wellness Services Inc.
1810 Cedar Ridge Dr.
Mesquite, TX 75181

My Fellow Employees,

As you may know, new health care reform regulations mandating insurance coverage go into effect starting Jan. 1, 2014. The changes are meant to help expand access to adequate and affordable health care coverage. Every state will have a Health Insurance Marketplace (an online exchange) where individuals can shop for health insurance coverage.

This letter is to direct you to the Federal Marketplace since winners wellness service Providers DFW will **not** offer major medical insurance to you. Attached is a document labeled "New Health Insurance Marketplace Coverage Options and Your Health Coverage" that the U.S. Department of Labor requires us to provide you. (See attached information to use to purchase individual coverage).

As part of the Affordable Care Act, workers with household incomes between 100% and 400% of the federal poverty level may be eligible for subsidies to help offset health insurance costs when purchased through Texas Health Insurance Marketplace. To calculate if you qualify for a subsidy, visit: kff.org/interactive/subsidy-calculator.

Effective Oct. 1, 2013, you can learn about coverage options and costs at the FEDERAL Marketplace by visiting: https://www.healthcare.gov/marketplace. Additional health care reform information is available at healthcare.gov.

Thank You,

Patsy Iroha/Administrator/RN

STATEMENT OF EMPLOYABILITY

By execution of this document, I acknowledge that I have been informed by the Agency and agree that the Agency may conduct a State of Texas criminal history check. I agree to a search of the Nurse Aide Registry and the Employee Misconduct Registry prior to employment and at least every 12 months if hired. I understand that these checks will determine if I have a criminal conviction or have committed certain conduct that will bar me from employment with this Agency. I understand that I am unemployable if listed in the NAR or EMR per TAC §93.3 and TxH&SC Chapter 253.

Criminal History Check

I have informed this agency of all names (i.e., maiden, aliases) that I have used in the past. I understand that my employment is pending the results of the criminal history check, and that I may not have face-to-face patient contact until results are returned. I will be notified of results.

CONVICTIONS BARRING EMPLOYMENT.

(A) **A person for whom the facility is entitled to obtain criminal history record information may not be employed in a facility if the person has been convicted of an offense listed in this subsection:**

- **An offense under Chapter 19, Penal Code (criminal homicide);**
- **An offense under Chapter 20, Penal Code (kidnaping and unlawful restraint);**
- **An offense under Section 21.02, Penal Code (continuous sexual abuse of a young child or children);**
- **An offense under Section 21.08, Penal Code (indecent exposure);**
- **An offense under Section 21.11, Penal Code (indecency with a child);**
- **An offense under Section 21.12, Penal Code (improper relationship between educator and student);**
- **An offense under Section 21.15, Penal Code (improper photography or visual recording);**
- **An offense under Section 22.011, Penal Code (sexual assault);**
- **An offense under Section 22.02, Penal Code (aggravated assault);**
- **An offense under Section 22.021, Penal Code (aggravated sexual assault);**
- **An offense under Section 22.04, Penal Code (injury to a child, elderly individual, or a disabled individual);**
- **An offense under Section 22.041, Penal Code (abandoning or endangering a child);**
- **An offense under Section 22.05, Penal Code (deadly conduct);**
- **An offense under Section 22.07, Penal Code (terroristic threat);**
- **An offense under Section 22.08, Penal Code (aiding suicide);**
- **An offense under Section 25.031, Penal Code (agreement to abduct from custody);**
- **An offense under Section 25.08, Penal Code (sale or purchase of a child);**
- **An offense under Section 28.02, Penal Code (arson);**
- **An offense under Section 29.02, Penal Code (robbery);**
- **An offense under Section 29.03, Penal Code (aggravated robbery);**
- **An offense under Section 33.021, Penal Code (online solicitation of a minor);**
- **An offense under Section 34.02, Penal Code (money laundering);**
- **An offense under Section 35A.02, Penal Code (Medicaid fraud);**
- **An offense under Section 42.09, Penal Code (cruelty to animals);**
- **An offense under Section 36.06, Penal Code (obstruction or retaliation);**
- **An offense under Section 42.09, Penal Code (cruelty to livestock animals);**
- **An offense under Section 42.092, Penal Code (cruelty to nonlivestock animals); or**
- **A conviction under the laws of another state, federal law, or the Uniform Code of Military Justice for an offense containing elements that are substantially similar to the elements of an offense listed by this subsection.**
- **An offense the Agency determines to be contraindicated to employment with the consumers the Agency serves**

(B) **A person may also be barred from employment the duties of which involve direct contract with a client in a facility if convicted of any of the following crimes within the past 5 years:**

- **An offense under Section 22.01, Penal Code (assault punishable as a Class A misdemeanor or as a felony);**
- **An offense under Section 30.02 , Penal Code (burglary);**
- **An offense under Chapter 31, Penal Code (theft that is punishable as a felony);**
- **An offense under Section 32.45, Penal Code (misapplication of fiduciary property or property of a financial institution), that is punishable as a Class A misdemeanor or a felony; or**
- **An offense under Section 32.46, Penal Code (securing execution of a document by deception punishable as a Class A misdemeanor or a felony) .**
- **An offense under Section 37.12, Penal Code (false identification as a peace officer); or**
- **An offense under Section 42.01 (a) (7), (8), or (9), Penal Code (disorderly conduct).**

(C) **In addition to the prohibitions on employment prescribed by Subsections (A) and (B), a person for whom a facility licensed under Chapter 242 or 247 is entitled to obtain criminal history record information may not be employed in a facility licensed under Chapter 242 or 247 if the person has been convicted:**

- **Of an offense under Section 30.02, Penal Code (burglary); or**
- **Under the laws of another state, federal law, or the Uniform Code of Military Justice for an offense containing elements that are substantially similar to the elements of an offense under Section 30.02, Penal Code.**

(D) **In addition to the prohibitions on employment prescribed by Subsections (A), (B) and (C), a nurse aide listed as unemployable per amendment to TAC 40, §94.10(l) and §94.11(c) (d) and is listed on the NAR or EMR stating a finding of abuse, neglect or misappropriation will not be recertified therefore, is unemployable.**

(E) **For purposes of this section, a person who is placed on deferred adjudication community supervision for an offense listed in this section, successfully completes the period of deferred adjudication community supervision, and receives a dismissal and discharge in accordance with Section 5(c), Article 42.12, Code of Criminal procedure, is not considered convicted of the offense for which the person received deferred adjudication community supervision.**

I acknowledge that if I am found to have been convicted of any other offense(s), that these offenses may also bar my employment. I understand that all information obtained by this agency regarding any criminal history will remain confidential.

I certify that the information on this form contains no willful misrepresentation and that the information given is true and complete to the best of my knowledge.

Signature of Applicant _____ **Date** _____

For Agency Use Only: Criminal History, Employee Misconduct Registry (EMR), and Nurse Aide Registry (NAR) checks completed:

❑ Criminal History Check completed on-line ❑ Other Convictions identified on Criminal History. (Document reason hiring in Comments below)

❑ NAR ❑ EMR checked online at https://emr.dads.state.tx.us/DadsEMRWeb/
❑ Applicant employable ❑ Applicant not employable ❑ Comments: _____

Verified By _____ Date _____

HCL / Background Check Rvd. 010112

Texas Employer New Hire Reporting Form

Submit within 20 calendar days of new employee's first day of work to:

ENHR Operations Center, P.O. Box 149224
Austin, TX 78714-9224
Phone: 1-800-850-6442 FAX: 1-800-732-5015
Online: www.employer.texasattorneygeneral.gov

To ensure the highest level of accuracy, please print neatly in capital letters and avoid contact with the edges of the boxes. The following will serve as an example:

A	B	C		1	2	3

Employer Information

1. Federal Employer ID Number (FEIN):
Please use the same FEIN that appears on quarterly wage reports.

2	7	4	2	4	9	1	1	8

2. State Employer ID Number (Optional):

3. Employer Name:

W	I	N	N	E	R	S		W	E	L	L	N	E	S	S		S	E	R	V	I	C	E	S

4. Employer Address (Please indicate the address where the Income Withholding Orders should be sent):

1	8	1	0		C	E	D	A	R			R	I	D	G	E		D	R	I	V	E		

5. Employer City (if US):

M	E	S	Q	U	I	T	E			

6. State (if US):

T	X

7. ZIP Code (if US):

7	5	1	8	1	–				

8. Province/Region (if foreign):

9. Country (if foreign):

10. Postal Code (if foreign):

11. Employer Telephone (Optional):

4	6	9	6	8	2	6	5	3	2

12. Employer FAX (Optional):

9	7	2	2	2	2	9	2	2	6

13. New Hire Contact Person (Optional):

Employee Information

14. Social Security Number (SSN):

15. Date of Hire (MM/DD/YYYY):

16. Employee First Name:

17. Employee Middle Name:

18. Employee Last Name:

19. Employee Home Address:

20. Employee City (if US):

21. State (if US):

22. ZIP Code (if US):

23. Province/Region (if foreign):

24. Country (if foreign):

25. Postal Code (if foreign):

26. State Where Employee Was Hired (Optional):

27. Employee DOB (MM/DD/YYYY) (Optional):

28. Employee's Salary (Dollars and Cents) (Optional):

29. Salary Frequency (Check One ONLY) (Optional):

☐ Hourly ☐ Weekly ☐ Biweekly ☐ Semi-Monthly ☐ Monthly ☐ Annually

INSTRUCTIONS FOR COMPLETING THE TEXAS EMPLOYER NEW HIRE REPORTING FORM

The purpose of the Texas New Hire Reporting Form is to allow employers to fulfill new hire reporting requirements. You may enter your employer information and photocopy a supply and then enter employee information on the copies.

REPORTING OF NEW HIRES IS REQUIRED:

All required items (numbers 1, 3, 4, 5, 6, 7, 14, 15, 16, 17, 18, 19, 20, 21, 22) on this form must be completed.

Box 1: Federal Employer ID Number (FEIN). Provide the 9-digit employer identification number that the federal government assigns to the employer. This is the same number used for federal tax reporting. Please use the same FEIN that appears on quarterly wage reports.

Box 2: State Employer ID Number (Optional). Identification number assigned to the employer by the Texas Workforce Commission.

Box 3: Employer Name. The employer name as listed on the employee's W4 form. Please do not provide more than one employer name (for example, "ABC, Inc DBA. John Doe Paint and Body Shop" is not correct).

Box 4: Employer Address. Please indicate the address where the Income Withholding Orders should be sent. Do not provide more than one address (for example, P.O. Box 123, 1313 Mockingbird Lane is not correct).

Box 8: Employer Province/Region (if foreign). Provide this information if the employer address is not in the United States.

Box 9: Employer Country (if foreign). Provide the two letter country abbreviation if the employer address is not in the United States.

Box 10: Postal Code (if foreign). Provide the postal code if the employer address is not in the United States.

Box 13: New Hire Contact Person (Optional). Providing the name of a contact staff person will facilitate communication between the employer and the Texas Employer New Hire Reporting Program.

Box 15: Date of Hire. List the date in month, day and year order. Use four digits for the year (for example, 2001). This should be the first day that services are performed for wages by an individual. If you are reporting a rehire (where a new W-4 is prepared) use the return date, not the original date of hire.

Box 23: Employee Province/Region (if foreign). Provide this information if the employee does not reside in the United States.

Box 24: Employee Country (if foreign). Provide the two letter country abbreviation if the employee address is not in the United States.

Box 25: Postal Code (if foreign). Provide the postal code if the employee address is not in the United States.

Box 26: State Where Employee was Hired. Use the abbreviation recognized by the U.S. Postal Service for the state in which the employee was hired.

Box 27: Employee DOB (Date of Birth) (Optional). List the date in month, day and year order. Use four digits for the year (for example, 1985).

Box 28: Employee Salary (Optional). Enter employee's exact wages in dollars and cents. This should correspond to the salary pay frequency indicated in Box 29.

Box 29: Salary (Check One ONLY) (Optional). Check the appropriate box relating to the employee's salary pay frequency. Check " Bi-weekly" if the salary is based on 26 pay periods. Check "Semi-monthly" if the salary is based on 24 pay periods. Check "Annually" if salary payment is a one-time distribution.

SUBMISSION OF NEW HIRE REPORTS. The Texas Employer New Hire Reporting Program offers a variety of methods that employers can use to submit new hire reports. For further information on which method may be best for you, call 1-800-850-6442. Employers are encouraged to keep photocopies or electronic records of all reports submitted. When the form is completed, send it to the Texas Employer New Hire Reporting Program using one of the following means:

- **FAX:** 1-800-732-5015
- **U.S. Mail:**

ENHR Operations Center
P.O. Box 149224
Austin, TX 78714-9224

- **Telephone Submissions:** 1-800-850-6442
- **Internet Submissions: www.employer.texasattorneygeneral.gov**

Employers must provide all of the required information within 20 calendar days of the employee's first day of work to be in compliance. State law provides a penalty of $25 for each employee an employer knowingly fails to report, and a penalty of $500 for conspiring with an employee to 1) fail to file a report or 2) submit a false or incomplete report.

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

►START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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

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

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

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	E-mail Address	Telephone Number
	___-___-____		

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

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

☐ A citizen of the United States

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

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

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

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date *(mm/dd/yyyy):*

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

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

Signature of Preparer or Translator:			Date *(mm/dd/yyyy):*
Last Name *(Family Name)*	First Name *(Given Name)*		
Address *(Street Number and Name)*	City or Town	State	Zip Code

STOP ***Employer Completes Next Page*** STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

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

3-D Barcode
Do Not Write in This Space

Certification

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

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

Signature of Employer or Authorized Representative	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
Last Name *(Family Name)* First Name *(Given Name)*		Employer's Business or Organization Name
Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State / Zip Code

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

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

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

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

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

Signature of Employer or Authorized Representative:	Date *(mm/dd/yyyy):*	Print Name of Employer or Authorized Representative:

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

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

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.

Form W-4 (2016)

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

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2016 expires February 15, 2017. See Pub. 505, Tax Withholding and Estimated Tax.

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

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

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

The exceptions do not apply to supplemental wages greater than $1,000,000.

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

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

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

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

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

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

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2016. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

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

Personal Allowances Worksheet (Keep for your records.)

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

For accuracy, complete all worksheets that apply.

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

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

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

Employee's Withholding Allowance Certificate

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

OMB No. 1545-0074

2016

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

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	**5**
6	Additional amount, if any, you want withheld from each paycheck	**6** $
7	I claim exemption from withholding for 2016, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ►	**7**

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

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

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

Deductions and Adjustments Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2016 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1952) of your income, and miscellaneous deductions. For 2016, you may have to reduce your itemized deductions if your income is over $311,300 and you are married filing jointly or are a qualifying widow(er); $285,350 if you are head of household; $259,400 if you are single and not head of household or a qualifying widow(er); or $155,650 if you are married filing separately. See Pub. 505 for details	1	$
2	Enter: { $12,600 if married filing jointly or qualifying widow(er); $9,300 if head of household; $6,300 if single or married filing separately }	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2016 adjustments to income and any additional standard deduction (see Pub. 505)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2016 Form W-4* worksheet in Pub. 505.)	5	$
6	Enter an estimate of your 2016 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero or less, enter "-0-"	7	$
8	**Divide** the amount on line 7 by $4,050 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note: Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**)	1	
2	Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3"	2	
3	If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet	3	

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

4	Enter the number from line 2 of this worksheet	4	
5	Enter the number from line 1 of this worksheet	5	
6	**Subtract** line 5 from line 4	6	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here	7	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	$
9	Divide line 8 by the number of pay periods remaining in 2016. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2016. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	$

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $6,000	0	$0 - $9,000	0
6,001 - 14,000	1	9,001 - 17,000	1
14,001 - 25,000	2	17,001 - 26,000	2
25,001 - 27,000	3	26,001 - 34,000	3
27,001 - 35,000	4	34,001 - 44,000	4
35,001 - 44,000	5	44,001 - 75,000	5
44,001 - 55,000	6	75,001 - 85,000	6
55,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 100,000	10	140,001 and over	10
100,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $75,000	$610	$0 - $38,000	$610
75,001 - 135,000	1,010	38,001 - 85,000	1,010
135,001 - 205,000	1,130	85,001 - 185,000	1,130
205,001 - 360,000	1,340	185,001 - 400,000	1,340
360,001 - 405,000	1,420	400,001 and over	1,600
405,001 and over	1,600		

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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.