Clear Form

Print Form

Angelus Home Health
9650 Business Center Drive, Suite 118, Rancho Cucamonga CA 91730
Tel: (909)999-0587 * Fax: (909)697-2179

PERSONNEL FILE CHECKLIST

Employee Name: _____ Discipline: -_____

Application:

- [ ] Personal Information
- [ ] Education, Training, and Experience
- [ ] Employment Acknowledgment
- [ ] Employment History & Reference Check 1
- [ ] Employment History & Reference Check 2
- [ ] Employee Orientation Checklist
- [ ] Orientation Acknowledgment
- [ ] Hepatitis B Vaccine Offer
- [ ] Infection Control Plan
- [ ] Non-Discrimination Policy
- [ ] Sexual Harassment Policy
- [ ] Confidentiality Agreement
- [ ] Child/Elder Abuse Reporting
- [ ] Drug Free Workplace Regulation
- [ ] Grievance Procedure
- [ ] Electronic Signature Request
- [ ] Automobile Insurance Waiver

Employee Assessment:

- [ ] Job Description explained
- [ ] Initial competency assessment skills checklist completion
- [ ] Pre-Employment Interview / Applicant valuation
- [ ] Staff orientation
- [ ] Background check []Criminal []OIG Exclusion []National Sex Offender
- [ ] Employee / Salary Letter / Date of Hire
- [ ] Evidence of receipt of ID Badge

Mandatory Documents: Licenses and Permits

Description:	Expiration Date: (MM/DD/YYYY format)	
[ ] Professional License copy	_____	
[ ] CPR Certificate/Card Copy	_____	
[ ] Physical and Health Examination	_____	6 months prior to hire or 15 days upon hire
[ ] TB/PPD Screening or X-ray test	_____	PPD-yearly * X-ray-every 5 years
[ ] Driver's License or State ID card copy	_____	
[ ] Automobile Insurance coverage card copy	_____	
[ ] Liability Insurance coverage certificate copy	_____	Voluntary

- [ ] Social Security Card copy
- [ ] Completed and verified Form I-9
- [ ] Completed Form W-4 (Federal Income tax withholding claim form)
- [ ] Diploma/Transcripts (If applicable)

If Applicable, On-going

- [ ] Annual Performance Evaluations and Probationary Period Evaluations with Evidence of Goal Setting
- [ ] Evidence of Annual In-Services – Mandatory and Elective (Blood Borne Pathogens & Hepatitis B, Tuberculosis, Medical Device Act, Infection Control)
- [ ] Evidence of Annual Joint Visit of Clinical Staff by Supervisor or Designee
- [ ] Annual competency assessment skills checklist completion

Note: All employees will be responsible for updating information when it expires. Please turn in new copies as soon as possible. Thank you.

Received and Verified By: Human Resource Coordinator Date: _____

Angelus Home Health
9650 Business Center Drive, Suite 118, Rancho Cucamonga CA 91730
Tel: (909)999-0587 * Fax: (909)697-2179

EMPLOYMENT APPLICATION

Application Date: _____

PERSONAL INFORMATION: Please type or print legibly

Name: _____, _____ _____
Last First Middle

Home Telephone: _____ Cellular Phone No.: _____

E-mail Address: _____ Fax No.: _____

Emergency Contact: _____ Phone No.: _____

Social Security No. : _____ Driver's License No: _____

Present Address: _____ _____
Street name and number Apartment/Unit number

_____ CA. _____
City State Zip Code

Position Applying For: ☐ Visiting Nurse ☐ Administrative ☐ Other _____

Status: ☐ Full Time ☐ Part Time ☐ On-Call/Per Visit ☐ Other _____

What days and hours are you available for work? Days:_____ Hours: _____

Would you be available to work overtime if necessary? ☐ Yes ☐ No

If hired, on what date can you start work? _____ Wage desired: $_____ per [ ]hour [ ]visit

How did you hear about us? _____

Have you ever applied work for **Angelus Home Health** before? ☐ Yes ☐ No

Have you ever been excluded from participating in the Medicare/Medicaid Program?

☐ Yes ☐ No If yes, explain _____

Are you at least 18 years of age? ☐ Yes ☐ No

If hired, can you present evidence of your U.S. Citizenship or proof of your legal right to work in this country? ☐ Yes ☐ No

Have you ever been convicted of a criminal offense (felony or serious misdemeanor). (Convictions for marijuana-related offenses that are more than two years old need not be listed)

☐ Yes ☐ No If yes, state nature of crime(s), when and where convicted and disposition of the case:

_____

_____

NOTE: No applicant will be denied employment solely on the grounds of conviction of criminal offense. The nature of the offense, the date of the offense, the surrounding circumstances and the relevance of the offense to the position applied for may, however, be considered.

Are you currently employed? ☐Yes ☐No

May we contact your current/Former Employer? ☐Yes ☐ No

EDUCATION, TRAINING, AND EXPERIENCE:

School	Name & Address (City)	No. Of Years Completed	Did You Graduate?	Degree or Diploma
High School			No	No
College			No	No
Vocational			No	No
Health Care			No	No

Some of our clients do not speak English. Do you speak another language, other than English?
LANGUAGE(S):

1) _____ ☐Speak ☐Write
2) _____ ☐Speak ☐Write

Do you have any other experience, training qualifications or skills, which you feel make you especially suited for work at **Angelus Home Health**? If so, please explain:

_____

_____

Please answer the following questions if you are applying for a professional position:

Are you Licensed/Certified for the job you are applying for? ☐Yes ☐ No

Name of license/certification: ☐RN ☐ LVN ☐ CHHA ☐Other

License/Certification Number: _____

Issuing date: _____ Expiration date: _____

Have you work with a Home Health Agency before? ☐Yes ☐No If yes, for how long? _____

Has your License/Certification ever been revoked or suspended? ☐Yes ☐No

If yes, state reason(s), date of revocation or suspension and date of reinstatement:

_____

_____

EMPLOYEE ACKNOWLEDGMENT

Please Read Carefully, Initial each Paragraph and Sign Below

_____ I have not knowingly withheld any information that might adversely affect my chances for employment. The answers given by me are true and correct to the best of my knowledge. I understand that my omission or misstatement of material fact on this application or on any document used to secure employment shall be grounds for rejection of this application or for immediate discharge if I am employed regardless of the time elapsed before discovery.

_____ I authorize the company to thoroughly investigate my references, work record, education and other matters related to my suitability for employment and, further, authorize the references I have listed to disclose to the company any and all information related to my work records.

_____ I agree with and support the company's commitment to protect the safety, health and well-being of its employees, patients, and all people who come into contact with its workplace(s) and property and/or use its services. Therefore, if offered employment, I will voluntarily submit to a urine analysis for the presence of illicit drugs and a background inquiry conducted by a consumer-reporting agency. Further, I understand that in the event of positive drug test result and/or an unacceptable background inquiry result, the offer of employment will be withdrawn.

_____ I understand and agree that nothing contained in this application, or said during any interview which may be granted or during my employment, if hired, is intended to create an employment contract between me and the company. In addition, I understand and agree that if I am employed, my employment is at-will. Employment "at-will" is for no definite or determinable period and may be terminated at any time, with or without cause, and with or without notice at any time by myself or by the company unless made in writing and signed by the Governing Body of **Angelus Home Health**

I have read and fully agree with the statements mentioned above.

LETTER OF COMMITMENT

I understand that my role is very significant with the organization. I look forward to working with this team and, like the others I will support the mission, vision, values and goals of the organization. I will offer my expertise to help ensure the health and success of the organization. I honor my accepted patient assignments and will do everything I can to fulfill my assigned duties for that patient. I understand that my performance and commitment to care has a huge effect on my patients' well- being. I promise with the best of my ability not to turn down or changed my mind within several hours upon accepting a patient.

I have read and fully agree to this Letter of Commitment and look forward to assisting the organization in this role.

_____

Employee Printed Name

_____ _____

Employee Signature Date

EMPLOYMENT HISTORY & REFERENCE CHECK [1OF2]

Please list below all present and past employments starting with your most recent employer (for at least the last five years). Account for all periods of unemployment:

I authorize **Angelus Home Health** to verify the following information regarding my services and character.

_____
Employee Printed Name

_____ _____
Employee Signature Date

EMPLOYMENT HISTORY

Name of Employer	From: _____ To: _____	
Address	Your Supervisor's Name:	
City, State, Zip Code	Starting Wage:	Ending Wage:
Telephone	Position Held:	Able for Rehire:
Work Performed:	Reason for Leaving:	

REFERENCE CHECK [1 OF 2]

EVALUATION	EXCELLENT	GOOD	FAIR	POOR
Job Knowledge				
Quality				
Quantity				
Attitude				
Dependability				
Punctuality				

Eligible for Rehire? Yes ☐ No ☐ If No, why not _____
_____
_____

Procedure: ☐ Send thru Mail ☐ Faxed ☐ Telephoned
Comments: _____

Evaluation Given By: _____ Title: _____

Verified By: _____ Initial: ____ Date: _____

EMPLOYMENT HISTORY & REFERENCE CHECK [2OF2]

Please list below all present and past employments starting with your most recent employer (for at least the last five years). Account for all periods of unemployment:

I authorize **Angelus Home Health** to verify the following information regarding my services and character.

_____
Employee Printed Name

_____ _____
Employee Signature Date

EMPLOYMENT HISTORY

Name of Employer	From: _____ To: _____	
Address	Your Supervisor's Name:	
City, State, Zip Code	Starting Wage:	Ending Wage:
Telephone	Position Held:	Able for Rehire:
Work Performed:	Reason for Leaving:	

REFERENCE CHECK [2 OF 2]

EVALUATION	EXCELLENT	GOOD	FAIR	POOR
Job Knowledge				
Quality				
Quantity				
Attitude				
Dependability				
Punctuality				

Eligible for Rehire? Yes ☐ No ☐ If No, why not _____
_____
_____

Procedure: ☐ Send thru Mail ☐ Faxed ☐ Telephoned
Comments: _____

Evaluation Given By: _____ Title: _____

Verified By: _____ Initial: ____ Date: _____

EMPLOYEE ORIENTATION CHECKLIST

- ✓ I have received information and instruction concerning:
    1. Administrative structure of the agency
    2. Organization of staff
    3. Services provided

- ✓ I have received my job description and task list and understand relationship with other agency personnel.

- ✓ I have reviewed the personnel policies and will perform according to the guidelines.

- ✓ I have received a copy of the acceptable dress code and will conform to the standards set.

- ✓ I understand that the Agency is governed by State and Federal regulations and that I must perform my duties according to these requirements.

- ✓ I have received a copy of the "Patient Bill of Rights" and understand my responsibility to provide care and services according to the provision of these rights.

- ✓ I understand the difference between a legal requirement and ethical consideration and will perform my assigned duties according to the guidelines presented.

- ✓ I know where to find the agency policies and procedures and have received instructions on how to use these manuals.

- ✓ I have reviewed the agency's philosophy of care and will provide care and services according to the guidelines.

- ✓ I understand the type of attitude I should have and will approach patients as I have been instructed to do.

- ✓ I understand the definition of an unusual occurrence and will report any such events to my supervisor immediately.

- ✓ I have received instructions regarding what actions should be taken when:
  A. A fire occurs B. A disaster occurs C. An unusual occurrence occurs
  D. A patient accident occurs E. An error in providing care or services occur

I hereby acknowledge that I receive and understand the above documents from Angelus Home Health

_____
Employee Printed Name

_____ _____
Employee Signature Date

ORIENTATION ACKNOWLEDGEMENT

The following understanding has been established before my first visit for home health care.

1. I have been instructed and properly oriented to all specifications regarding:

a. General orientation to organization, including philosophy, mission and purpose
b. Review of organizational chart and lines of authority and responsibility
c. Hours of work, dress and appearance, Identification Card
d. Job related responsibilities
e. Care and services provided by the organization
f. Baseline skills assessments as applicable to job classification
g. Infection prevention and control within the organization and the home care setting
h. Performance standards/ Skilled Nursing Visit guidelines
i. Confidentiality of organization and patient information & HIPPA
j. Documentation requirements and Nursing Notes Guidelines
k. OSHA compliance, Standard precaution, Blood borne pathogens, TB exposure control plan
l. Medical Device Reporting & Safe medical device act
m. Equal Employment Opportunity Act
n. Ethical issue identification and resolution
o. Sexual Harassment Act
p. Child/Elder abuse, neglect and exploitation reporting
q. Compensation and benefits information
r. Unemployment and workers' compensation
s. Malpractice coverage, as applicable
t. Collective bargaining information, as applicable
u. Drug testing and NIOSH approved N95 mask fitting, hand washing technique
v. Family/State Medical Leave Act
w. Marketing, Protected Health Information (PHI) & Illegal remuneration
x. Complaint/ Grievance process/ Personnel grievance
y. Bag technique, Medication Error
z. Orientation Manual, Performance Improvement and in-services

This will acknowledge that I have received a **Angelus Home Health** Home Health Services orientation together with the orientation packet including but not limited to, Policies and Procedures. I understand that prior to being assigned to a Home Health nursing case or duty, I must review my received orientation packet. I agree to abide by Policies and Procedures of **Angelus Home Health**

_____
Employee Printed Name

_____ _____
Employee Signature Date

_____
Preceptor's Signature

INFORMATION ON VOLUNTARY AUTHORIZATION FOR THE ADMINISTRATION OF HEPATITIS VACCINE

THE DISEASE: Hepatitis B is a viral infection that affects the liver. The incubation period ranges from 40 to 180 days. The course of acute Hepatitis can be mild and completely without outward symptoms, or it can be severe, prolong, and possible fatal. Health care workers can be exposed to Hepatitis B form contaminated needle punctures or blood spills on broken skin or mucous membranes. Other body fluids, such as bloody urine, bloody wound drainage, or semen, may also be infectious. The greatest threat to health care workers is the nearly one million Hepatitis B carriers in the country, 80 to 90 percent of who are not identified.

RECOMBINANT HEPATITIS B VACCINE: The vaccine is for protection against Hepatitis B. The vaccine is recommended for those with frequent exposure to the above source. Three doses are required: The initial dose, a second dose a month later, and third dose five months later. A booster dose may be needed after five to seven years for continued protection. Documentation of exposure incidents must continue even after the vaccine series completed.

Hepatitis B vaccine will not prevent Hepatitis caused by other agents, such as Hepatitis A virus, non-A, non-B Hepatitis viruses, or by other viruses known to the liver. Although information available to date indicates that the vaccine is highly effective in protecting against Hepatitis B, it has not proven totally effective in preventing Hepatitis B among all persons vaccinated (those who are immune-suppressed or those with presence of any serious active infection). Hepatitis B vaccine is prepared form recombinant yeast cultures and is free of association with human blood or blood products.

Follow-up studies indicate that the most common side effect is infection site soreness. Less common local reactions are redness, swelling, and warmth, which usually subside within 48 hours. Low-grade fever occurs occasionally. Other complaints include malaise, fatigue, headache, nausea, dizziness, and joint pain. These symptoms are infrequent and limited to the first few days following the vaccine. Each has been reported rarely.

PRECAUTIONS Recombinant Hepatitis B vaccine is contraindicated for individuals who are hypersensitive to yeast or any component of the vaccine is reason to delay the vaccine.

Employees with history of cardiopulmonary disease are at risk from a possible febrile or systematic reaction and must consult their private physician prior to receipt of the vaccine and have an authorization from their private physician for administration of the vaccine.
The Hepatitis B vaccine is not recommended for use by pregnant women or nursing mothers.

How can HCWs be protected?
Immunization is the best protection. The vaccine is recommended to anyone who may be exposed to blood or body fluids. It is given in three intramuscularly injections over a six month period.

Are there side effects of the vaccine?
There may be but they are usually minor such as soreness in the arm. A few people report nausea, minor joint pain, rash, and slight fever.

What other protection is advised besides the vaccine?
HCWs should use: Universal Precautions – consider all blood and body fluids to be contaminated and avoid direct contact of head and foot covering (as appropriate to the situation).

If exposure occurs, what should be done?
The exposure should be reported immediately. An incident report should be completed. Your employer will make available a confidential medical evaluation and follow-up as needed.

HEPATITIS B VACCINE ACCEPTANCE/ DECLINATION

☐ DECLINATION

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

I decline to receive a Hepatitis B Vaccination because I have been previously vaccinated. I agree to provide ANGELUS HOME HEALTH with a record of the vaccination and any antibody testing that may have been performed.

Signature/ Title: _____ Date: _____

☐ ACCEPTANCE

Allergies: _____ Date of Exposure _____ Location _____

Type of exposure: _____

I have been informed of the complications/ side effects of receiving Hepatitis B vaccine and I choose to have the Vaccine administered to me.

Signature/ Title: _____ Date: _____

HEPATITIS B VACCINE QUESTIONNAIRE

Please answer the following questions regarding your medical history in reference to **Hepatitis B** Vaccine. This information will be kept as part of your personnel file. Please contact the office or supervisor in writing should any of the information change in the future.

Should you have any doubt about the answers to any of these questions, please contact your physician before answering them. Please check which ever applies.

[ ] I received a copy of Hepatitis sheet information on Voluntary Authorization of the Administration of Hepatitis B Vaccine.

[ ] I have completed a Hepatitis B Vaccination series

_____
Employee Printed Name

_____ _____
Employee Signature Date

INFECTION CONTROL PLAN

1. **ANGELUS HOME HEATLH**, will educate all personnel on infection control policies, procedures, and their responsibilities for implementation as contained throughout this section. New personnel will receive a copy of the standard precautions (see "Standard Precautions" Policy No. C:2-046) in their orientation packets.

2. Personnel will be provided training on the basics of transmission of pathogens to patients and personnel, bloodborne diseases, the use of standard precautions, infectious waste management, and other infection control procedures when their work activities, as indicated below, may result in an exposure to blood, other potentially infectious materials, or under circumstances in which differentiation between body fluid types is difficult or impossible.

3. Infection control inservices will be scheduled no less than annually.
   A. Attendance will be mandatory and will be documented.
   B. Records of inservice attendance will be maintained in the personnel file.

4. The organization will utilize its safety and performance improvement process to identify risks for the acquisition and transmission of infectious agents on an ongoing basis.

5. The infection control plan will be monitored and evaluated in the annual program evaluation and in conjunction with the review of the organization's safety and performance improvement activities.
   A. Success or failure of interventions for preventing and controlling infection will be addressed.
   B. Evolution of relevant infection control and prevention guidelines based on evidence and/or expert consensus will be considered.

6. The Performance Improvement Coordinator will be responsible for managing and coordinating infection control activities and reporting of infection control activities to the Performance Improvement Committee and other appropriate authorities. The Performance Improvement Coordinator will maintain qualifications for infection control responsibility through ongoing education and training.

I am provided with a copy of the standard precautions in my orientation packet together but not limited to tuberculosis exposure control plan, infection control precautions, bloodborne pathogens and Hepatitis B exposure control plan, and safe medical device act.

I agree to abide with all the policies and procedures mentioned above.

_____
Employee Printed Name

_____ _____
Employee Signature Date

NON-DISCRIMINATION POLICY

In accordance with Title VI of the Civil Rights Act of 1964 and its implementing regulation, ANGELUS HOME HEALTH will, directly or through contractual or other arrangement, admit and treat all persons without regard to race, religion, age, gender, sexual orientation, disability (mental or physical), communicable disease, or place of national origin in its provision of services and benefits, including assignments or transfers within facilities.

In accordance with Section 504 of the Rehabilitation Act of 1973 and its implementing regulations, ANGELUS HOME HEALTH, will not, directly or through contractual or other arrangements, discriminate on the basis of disability (mental or physical) in admissions, access, treatment or employment.

In accordance with the Age Discrimination Act of 1975 and its implementing regulation, ANGELUS HOME HEALTH, will not, directly or through contractual or other arrangements, discriminate on the basis of age in the provision of services unless age is a factor necessary to the normal operation or the achievement of any statutory objective.

In accordance with Title II of the Americans with Disabilities Act of 1990, ANGELUS HOME HEALTH will not, on the basis of disability, exclude or deny a qualified individual with a disability from participation in, or benefits of, the services, programs or activities of the organization.

SEXUAL HARASSMENT POLICY AGREEMENT

ANGELUS HOME HEALTH, is committed to a policy of prohibiting any personnel from engaging in any verbal or physical sexual harassment of other personnel, job applicants, or patients. Any personnel violating this policy may be subject to immediate termination. If personnel feel they have been sexually harassed, they must notify the Executive Director/Administrator immediately and in writing. The complaint will be investigated in accordance with the Personnel Grievance Process procedure. (See "Personnel Grievance Process" Policy No. C:3-013 and all applicable laws and regulations.)

As an employee of **Angelus Home Health,** I understand and agree to the terms of the Agency's nondiscrimination and sexual harassment policy. I will abide by the standards and expectations set forth in this policy, and I understand that violation of this policy can result in disciplinary action.

_____

Employee Printed Name

_____ _____

Employee Signature Date

QUALITY MANAGEMENT/ PERFORMANCE IMPROVEMENT

CONFIDENTIALITY AGREEMENT

As a profession involved in the measurement, assessment, and improvement of the performance of governance, management, clinical, and/or support functions and processes of the organization, or as one involved in the screening and/or in-depth assessment of patient care information to support the quality management, utilization management, and risk management activities of the medical/professional staff, administration, and the governing body, I recognize that confidentiality is vital. I also acknowledge the obligation to maintain the confidentiality of patient records under the California Civil Code (Section 56.01, *et seq*.).

Therefore, I agree to respect and maintain the confidentiality of all discussions, deliberations, records, and other information generated in connection with my activities, and to make no disclosures of such information except to persons authorized to receive it in the conduction of administrative, governing nature of information, whether access is by computer, medical record, interview, meeting, conversation, or any other means. I acknowledge my responsibility to abide by any relevant provisions of the bylaws of the governing body and/or medical/professional staff, as well as all applicable organization policies and procedures, concerning the confidentiality of information.

Furthermore, my participation in these organizational performance improvement activities, and in the improvement of care and services provided by the organization is in reliance on my belief that the confidentiality of these activities will be similarly preserved by every member of the governing body, medical/professional staff, administration, and by every other individual involved.

This agreement is made to support the purpose and to comply with the applicable provisions of the federal Health Care Quality Improvement Act and the California Evidence Code, Section 1156 and 1157.

I realize that if I breach this agreement, the organization may terminate this relationship and may seek civil penalties against me.

I have been formally instructed in maintaining the confidentiality of the medical records, and I understand that the medical information regarding the patient may not be discussed with anyone, either inside or outside the agency (except as needed to conduct the business of the day).

I understand that no medical records are to be removed from the Home Health Agency, unless a "Release for Information" form has been completed and signed by the patient. It is my understanding that such discussion or release of information is cause for dismissal. I have been formally instructed in the Policies and Procedures of **Angelus Home Health**

I have attended a formal orientation, and have read and signed a Job Description for my specific classification.

_____

Employee Printed Name

_____ _____

Employee Signature Date

REPORTING OF CHILD, ELDER, & DEPENDENT ADULT ABUSE

California law requires the reporting of incidents of Child, Elder, and Dependent Adult abuse that comes to your attention in your professional capacity. Please read the statement below and sign in the space provided to acknowledge that you will comply with the reporting requirements. If you have questions, or need assistance with this requirement, please notify your supervisor. Additional information regarding the codes summarized below is also available from your supervisor.

Section 15630 of the Welfare and Administration Code: Any Elder or Dependent Adult Care Custodian, health practitioner, or employee of a County Adult Protective Service Agency or a local law enforcement Agency, who in his or her professional capacity or within the scope of his or her employment, either have observed a physical injury where the nature of the injury, its location on the body, or the repetition of the injury, clearly indicates that physical abuse has occurred, or is told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, shall report the known or suspected instance of physical abuse either to the long term care ombudsman coordinator or to a local law enforcement agency. When the physical abuse is alleged to have occurred anywhere else, immediately or as soon as possible, shall telephone, and shall prepare and send written report thereof within two working days.

Section 11166.5 of the Penal Code: This code requires any child care custodian, health practitioner, or employee of a child protective agency who has knowledge of or observes a child in his or her professional capacity or within the scope of his or her employment whom he or she knows or reasonably suspects has been the victim of child abuse to report the known or suspected instance of child abuse to a child protective agency immediately or as soon as possible by telephone, prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

DRUG – FREE WORKPLACE

In compliance with the regulations published January 31, 1989, of the Drug-Free workplace Act of 1988, 34CFR. PART 85, SUBPART F, **Angelus Home Health** prohibits the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance by its employees. It will be the employees' responsibility to notify the Agency within 5 days after conviction of a criminal drug violation, which occurred in the workplace. The following disciplinary action will be taken within 30 days by the Agency against any employee who violates these prohibitions:

1. Require satisfactory participation by the employee in a drug abuse assistance or rehabilitation program approved for such purpose by a Federal, State, or Local Health, Law Enforcement, or other appropriate Agency.

OR

2. Appropriate personnel action up to and including termination.

I have read, understood and adhere to report all report child, elder, and dependent adult abuse to the local law enforcement agency. I also read and understood the Drug-Free workplace Policy of **Angelus Home Health** and agree to abide by the terms of the policy.

_____
Employee Printed Name

_____ _____
Employee Signature Date

GRIEVANCE PROCEDURE

It is the policy of the Agency not to discriminate on the basis of handicap. The Agency has adopted an internal grievance procedure providing for prompt and equitable resolutions for any complaint alleging any action prohibited by Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) or the US Department of Health and Human Services regulations. Section 504 states, in part, that "no otherwise qualified handicapped individual ... will, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance ... " the law and regulations may be examined in the office of the Agency Administrator, who has been designated to coordinate the efforts of the Agency to comply with Section 504.

1. Any person who believes she or he has been subjected to discrimination on the basis of handicap, in contradiction of the policy stated above, may file a grievance under this procedure. It is against the law for the Agency to retaliate against anyone who files a grievance or cooperates in the investigation of a grievance.
2. Grievances must be submitted to the Administrator within thirty (30) days of the date the person filing the grievance becomes aware of the alleged discriminatory action.
3. A complaint must be in writing, containing the name and address of the person filing it ("the grievant"). The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought by the grievant.
4. The Administrator (or his/her representative) will conduct an investigation of the complaint to determine its validity. This investigation may be informal, but it must be thorough, affording all interest persons an opportunity to submit evidence relevant to the complaint. The Administrator will maintain the files and records of the Agency relating to such grievances.
5. The Administrator will issue a written decision on the grievance no later than thirty (30) days after its filing. **Angelus Home Health** is an Equal Opportunity Employer
6. The grievant may appeal the decision of the Administrator by filing an appeal in writing to the Agency fifteen (15) days of receiving the Administrator's decision.
7. The Agency will issue a written decision in response to the appeal no later than thirty (30) days after its filing.
8. The availability and use of this grievance procedure does not preclude a person from filing a complaint of discrimination on the basis of handicap with the regional office for Civil Rights as per attached.
9. The Agency will make appropriate arrangements to assure that disable persons can participate in or make use of this grievance process on the same basis as the non-disabled. Such arrangements may include but not be limited to, the provision of interpreters for the deaf, providing taped cassettes of material for the blind, or assuring a barrier-free location for the proceedings. The Administrator will be responsible for providing such arrangements.

This is to certify that I have received and understand the above "Grievance Procedure" from the Agency.

_____

Employee Printed Name

_____ _____

Employee Signature Date

MEDICAL RECORDS ELECTRONIC SIGNATURE

BASED ON MEDICARE MEDICAL RECORDS SIGNATURE REQUIREMENTS:

Signature's Purpose: Medicare requires the individual who ordered/provided services be clearly identified in the medical records. The signature for each entry must be legible and should include the practitioner's first and last name. For clarification purposes, we recommend you include your applicable credentials, e.g., P.A., D.O., or M.D.

The purpose of a rendering/treating/ordering practitioner's signature in patients' medical records, operative reports, orders, test findings, etc., is to demonstrate the Medicare services have been accurately and fully documented, reviewed and authenticated. Furthermore, it confirms the provider has certified the medical necessity and reasonableness for the service(s) submitted to the Medicare program for payment consideration.

Medicare Requirements for Valid Signatures

Acceptable methods of signing records/test orders and findings include:

* Handwritten signature
* Electronic signatures

Digitized signature – an electronic image of an individual's handwritten signature reproduced in its identical form using a pen tablet.
Electronic signatures usually contain date and timestamps and include printed statements, e.g., "electronically signed by," or "verified/reviewed by," followed by the practitioner's name and preferably a professional designation.

Note: The responsibility and authorship related to the signature should be clearly defined in the record.
Example of an acceptable electronic signature:
"Electronically Signed By: John Doe, M.D. 08/01/2008 @ 06:26AM
• Digital signature – an electronic method of a written signature that is typically generated by special encrypted software that allows for sole usage.

Unacceptable Signatures

• Signature "stamps" alone in medical records are NO longer recognized as valid authentication for Medicare signature purposes and may result in payment denials by Medicare.
• Reports or any records that are dictated and/or transcribed, but do not include valid signatures "finalizing and approving" the documents are not acceptable for reimbursement purposes. Corresponding claims for these services will be denied.
NOTE: Be aware that electronic and digital signatures are not the same as "auto-authentication" or "auto-signature" systems, some of which do not mandate or permit the provider to review an entry before signing. Indications that a document has been "signed but not read" are not acceptable as part of the medical record.

For reference and exceptions, please refer to:

• The Medicare Program Integrity Manual, Pub. 100-08, Chapter 3, Section 3.4.1.1 B:
http://www.cms.hhs.gov/manuals/downloads/pim83c03.pdf
• MLN Matters Article #: MM5971: http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5971.pdf

ELECTRONIC SIGNATURE REQUEST

This letter serves to request for your signature for the purpose of Electronic signature signing. Should you agree to participate in this process, the company will ensure to implement, follow, and acknowledge the following:

That your Electronic signature will only be used with your consent and in accordance with Federal, State, Department of Health, and Health Insurance Portability and Accountability Act (HIPPA) regulations.

AGREE

I, _____, do hereby certify that my electronic identification and signature for the purpose of my Skilled Nursing / Physical Therapy / Evaluations and Follow-up visits is the legally binding equivalent of a traditional handwritten signature.

DECLINE

I, _____, do not want to participate in Electronic signature signing.

Only write your name on one of the two options.

_____
Printed Name

_____ _____
Employee Signature Date

AUTOMOBILE INSURANCE WAIVER

I stipulate that **Angelus Home Health** is not responsible for any damages to my personal automobile at any time during operating and non-operating hours. I take sole responsibility for keeping my automobile insurance current at all times.

I also stipulate that if I use the service car of **Angelus Home Health** their liability is limited to the full coverage liability of the company car insurance.

_____
Printed Name

_____ _____
Employee Signature Date

Job Title/Position: *Certified Home Health Aide*

Reports To: *Clinical Supervisor*

JOB DESCRIPTION SUMMARY

The home health aide is a paraprofessional member of the home care team who works under the supervision of a registered nurse or therapist and performs various personal care services as necessary to meet the patient's needs. The home health aide is responsible for observing patients, reporting these observations and documenting observations and care performed.

The home health aide will be assigned in a manner that promotes quality, continuity and safety of a patient's care.

ESSENTIAL JOB FUNCTIONS/RESPONSIBILITIES

Responsibilities of the home health aide include, but are not limited to, the following:

1. Providing personal care including:
    A. Baths
    B. Back rubs
    C. Oral hygiene
    D. Shampoos
    E. Changing bed linen
    F. Assisting patients with dressing and undressing
    G. Skin care to prevent breakdown
    H. Assisting the patient with toileting activities
    I. Keeping patient's living area clean and orderly, as appropriate
2. Planning and preparing nutritious meals.
3. Assisting in feeding the patient, if necessary.
4. Taking and recording oral, rectal and axillary temperatures, pulse, respiration and blood pressure when ordered (with appropriate completed/demonstrated skills competency).

5. Assisting in ambulation and exercise according to the plan of care.

6. Performing range of motion and other simple procedures as an extensional therapy service as ordered (with appropriate completed/demonstrated skills competency).

7. Assisting patient in the self-administration of medication.

8. Doing patient's laundry, as appropriate.

9. Meeting safety needs of patients and using equipment safely and properly (foot stools, side rails, etc.).

10. Reporting on patient's condition and significant changes to the assigned nurse.

11. Adhering to the Organization's documentation and care procedures and standards of personal and professional conduct.

The above statements are only meant to be a representative summary of the major duties and responsibilities performed by incumbents of this job. The incumbents may be requested to perform job related tasks other than those stated in this description.

POSITION QUALIFICATIONS

1. Meets the training requirements in accordance with state and federal laws.

2. At least 18 years of age.

3. Ability to read and follow written instructions and document care given.

4. Self-directing with the ability to work with little direct supervision.

5. Empathy for the needs of the ill, injured, frail and the impaired.

6. Possess and maintains current CPR certification.

7. Demonstrates tact, patience and good personal hygiene.

8. Licensed driver with automobile that is insured in accordance with Organization requirements and is in good working order.

Note: Effective August 14, 1990, a person who has successfully completed a state established or other training program that meets the requirements of CFR 484.36(a) and a competency evaluation program, or state licensure program that meets the requirements of CFR 484.36(b), or a competency evaluation program or state licensure program that meets the requirements of S 484.36(b).

Job Title/Position: *Certified Home Health Aide*

JOB LIMITATIONS

The home health aide will not function in any manner viewed as the practice of nursing according to the state's Nurse Practice Act. Specifically, the home health aide will not administer medications, take physician's orders or perform procedures requiring the training, knowledge and skill of a nurse, such as sterile techniques.

_____
Employee Printed Name

_____ _____
Employee Signature Date

INITIAL COMPETENCY ASSESSMENT SKILLS CHECKLIST— HOME HEALTH AIDE

Name: _____

Date of Employment: _____Date Completed: _____

Self Assessment				Competency for the Home Health Aide	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
☐	☐	☐	☐	**A. Demonstrates ability to process paperwork and associated functions necessary to facilitate:**		-	
☐	☐	☐	☐	1. Temperature:		-	
☐	☐	☐	☐	a. Oral	*	-	
☐	☐	☐	☐	b. Rectal	*	-	
☐	☐	☐	☐	c. Axillary	*	-	
☐	☐	☐	☐	d. Digital thermometers		-	
☐	☐	☐	☐	e. Other		-	
☐	☐	☐	☐	2. Pulse (radial)	*	-	
☐	☐	☐	☐	3. Respiration	*	-	
☐	☐	☐	☐	4. Blood pressure	*	-	
☐	☐	☐	☐	5. Bed bath	*	-	
☐	☐	☐	☐	6. Shower/tub bath	*	-	
☐	☐	☐	☐	7. Nail care	*	-	
☐	☐	☐	☐	8. Skin care	*	-	
☐	☐	☐	☐	9. Oral care	*	-	
☐	☐	☐	☐	10. Shampoo	*	-	
☐	☐	☐	☐	11. Toileting/Elimination		-	
☐	☐	☐	☐	a. Urinal		-	
☐	☐	☐	☐	b. Bedpan	*	-	
☐	☐	☐	☐	c. Other		-	
☐	☐	☐	☐	12. Transfer techniques:		-	

Self Assessment				Competency for the Home Health Aide	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
☐	☐	☐	☐	a. Bed to chair	*	-	
☐	☐	☐	☐	b. Chair to standing	*	-	
☐	☐	☐	☐	c. Assist with ambulation	*	-	
☐	☐	☐	☐	d. Other		-	
☐	☐	☐	☐	13. Assists with exercise program range of motion		-	
☐	☐	☐	☐	14. Assistive devices:		-	
☐	☐	☐	☐	a. Walker	*	-	
☐	☐	☐	☐	b. Cane	*	-	
☐	☐	☐	☐	c. Other		-	
☐	☐	☐	☐	15. Positioning	*	-	
☐	☐	☐	☐	16. Optional Skills:		-	
☐	☐	☐	☐	a. Dry dressings		-	
☐	☐	☐	☐	b. Ace bandage wrap		-	
☐	☐	☐	☐	c. Medication reminders		-	
☐	☐	☐	☐	d. Urinary catheter care		-	
☐	☐	☐	☐	e. Gastrostomy site care		-	
☐	☐	☐	☐	f. Observe/record intake and output		-	
☐	☐	☐	☐	g. Hoyer lift		-	
☐	☐	☐	☐	h. Enema		-	
☐	☐	☐	☐	i. Other		-	
☐	☐	☐	☐	17. Documentation Skills: (legible, timely, accurate and complete)		-	
☐	☐	☐	☐	a. Progress notes, flow charts	*	-	
☐	☐	☐	☐	b. Incident reporting	*	-	
☐	☐	☐	☐	c. Relates to POC	*	-	
☐	☐	☐	☐	d. Other		-	
☐	☐	☐	☐	18. Observation and reporting to:		-	

Self Assessment				Competency for the Home Health Aide	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
☐	☐	☐	☐	a. RN/Supervising nurse		-	
☐	☐	☐	☐	b. Other professional		-	
☐	☐	☐	☐	c. Other		-	
☐	☐	☐	☐	19. Adheres to POC		-	
☐	☐	☐	☐	a. Reviews POC prior to care	*	-	
☐	☐	☐	☐	b. Performs services as ordered	*	-	
☐	☐	☐	☐	c. Documents according to POC	*	-	
☐	☐	☐	☐	d. Communicates/coordinates if appropriate	*	-	
☐	☐	☐	☐	e. Other		-	
☐	☐	☐	☐	20. Infection Control		-	
☐	☐	☐	☐	a. Hand washing	*	-	
☐	☐	☐	☐	b. Proper bag technique	*	-	
☐	☐	☐	☐	c. Protective equipment	*	-	
☐	☐	☐	☐	d. Exposure plan	*	-	
☐	☐	☐	☐	e. Equipment care	*	-	
☐	☐	☐	☐	f. Other		-	
☐	☐	☐	☐	21. Emergency procedures		-	
☐	☐	☐	☐	22. Reports and documents key information to Physician, DC Planner, Clinician, Pharmacist, Supervisor	*	-	
☐	☐	☐	☐	23. Knows Resources, HME Lab, other services	*	-	
☐	☐	☐	☐	24. Submits written summary reports as indicated	*	-	
☐	☐	☐	☐	25. Attends case conference as required	*	-	
☐	☐	☐	☐	26. Patient safety/falls risk		-	
☐	☐	☐	☐	27. Meal preparation:		-	
☐	☐	☐	☐	a. Feeding		-	
☐	☐	☐	☐	b. Diabetic diet		-	

Self Assessment				Competency for the Home Health Aide	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
☐	☐	☐	☐	c. Low sodium		-	
☐	☐	☐	☐	d. Low cholesterol/fat		-	
☐	☐	☐	☐	28. Light housekeeping		-	
☐	☐	☐	☐	29. Linen change/wash clothing		-	
☐	☐	☐	☐	30. Other		-	

Comments:

_____

_____

_____ _____
Employee Signature Date

_____ _____
Supervisor Signature Date

_____ _____
Preceptor(s) Date

_____ _____
Preceptor(s) Date

Key for Evaluation Method (to be determined by organization):

Please check used method for Evaluation (majority or for most evaluation method)

[ ] Verbal Test = V

[ ] Written Test = W

[ ] Observation = O

[ ] Demonstration = D

[ ] Special Training = ST

ANGELUS HOME HEALTH
9650 Business Center Drive, Suite 118, Rancho Cucamonga, CA 91730
Tel: (909) 999-0587 * Fax: (909) **697-2179** * Email: angelushomehealth@hotmail.com

HOME HEALTH AIDE OBSERVATION COMPETENCY

HOME HEALTH AIDE'S NAME: _____ ***Please sign and date individual observed skill***

Personal Care Skill	Observed at Home	Observed at Lab/Office	Observer's Signature	Date of Observation
Temperature				
Pulse and Respiration				
Bed Bath				
Sponge, Tub or Shower Bath				
Shampoo - Sink or Tab				
Nail Care				
Skin Care				
Oral Hygiene				
Transfer Techniques				
Ambulation				
Range of Motion Exercises				
Positioning				

Verbalized Understanding of:				
Backrub				
Basic Infection Control Procedure				
Urinal/Foley Care and Emptying Bag				
Bedpan				
Basic principles of diet				
Changing Bed Linens				
Clean bathroom after use				
Home Safety Issues				
Make Occupied Bed				
Handling of Laundry				
Principles of General Cleanliness of Equipment				

To identify the signature(s) above, please fill out required items below: Notes: Patient's Name

OBSERVER'S NAME & TITLE _____ _____
OBSERVER'S SIGNATURE _____ _____

OBSERVER'S NAME & TITLE _____ _____
OBSERVER'S SIGNATURE _____ _____

OBSERVER'S NAME & TITLE _____ _____
OBSERVER'S SIGNATURE _____ _____

Angelus Home Health
9650 Business Center Drive, Suite 118, Rancho Cucamonga CA 91730
Tel: (909)999-0587 * Fax: (909)697-2179

PRE-EMPLOYMENT INTERVIEW

Employee Name: _____

Discipline: [ ]RN [ ]LVN [ ]CHHA [ ]Other _____

Comments:

Suggested Topics: strengths and weaknesses, education, previous employment/work experiences, special certification/I.V. certified, availability/coverage areas, and expectations.

_____

_____

_____

_____

_____

_____

_____

_____
Employee Printed Name

_____ _____
Employee Signature Date

_____
Supervisor's Printed Name

_____ _____
Supervisor's Signature Date

EMPLOYEE HISTORY, PHYSICAL AND HEALTH EXAMINATION
TO BE FILLED OUT BY PHYSICIAN/PHYSICIAN STAFF

Name: _____ Date of Birth: _____ Gender: ☐M ☐F

History (Explain all yes answers below)

Y	N		Y	N		Y	N	
___	___	Neurological	___	___	Vision	___	___	Ears/Hearing
___	___	Seizures	___	___	Heart	___	___	High BP
___	___	Vascular	___	___	Respiratory	___	___	Asthma
___	___	Anemia	___	___	Skin Disorders	___	___	Hay Fever
___	___	Back Problems	___	___	Bleeding	___	___	Arthritis
___	___	TB	___	___	Gout	___	___	GI disorders
___	___	Kidney/GU disorders	___	___	Jaundice/ Liver			
___	___	Thyroid	___	___	Headaches			
___	___	Diabetes	___	___	Other_____			

Explain: _____
Routine Medication Taken: _____

CLINICAL FINDINGS:
Blood Pressure _____ Pulse _____ Temperature _____ Respiration _____
Back Bending __ Straight Leg Bending __ Rising from Supine __ Extremities __

TESTS	Date Performed	Results		Date Performed	Results
PPD	_____	_____	CHEST X-RAY	_____	_____

	No Problems	Other (explain)		No Problems	Other (explain)
HEENT	_____	_____	Gastro Intestinal	_____	_____
Cardiac	_____	_____	Integumentary	_____	_____
Respiratory	_____	_____	Endocrine	_____	_____
Neurological	_____	_____	Psycho-Social	_____	_____

Recommendations:_____

I have examined the above individual and found this person to be free from communicable diseases and able to perform assigned clinical duties and does not have any health conditions that could create a hazard for himself/ herself/ fellow employees/ patient(s), or visitors.

_____ _____ _____
Physician Printed Name Signature Date

Address: _____

Phone Number: _____ Doctor's office stamp:

Form W-4 (2014)

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 2014 expires February 17, 2015. 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 $1,000 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 iincome, 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 2014. 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 $65,000 ($95,000 if married), enter "2" for each eligible child; then **less** "1" if you have three to six eligible children or **less** "2" if you have seven or more eligible children. • If your total income will be between $65,000 and $84,000 ($95,000 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** 0

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

2014

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** 0
6	Additional amount, if any, you want withheld from each paycheck	**6** $
7	I claim exemption from withholding for 2014, 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 2014 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, 1950) of your income, and miscellaneous deductions. For 2014, you may have to reduce your itemized deductions if your income is over $305,050 and you are married filing jointly or are a qualifying widow(er); $279,650 if you are head of household; $254,200 if you are single and not head of household or a qualifying widow(er); or $152,525 if you are married filing separately. See Pub. 505 for details	1	$
2	Enter: { $12,400 if married filing jointly or qualifying widow(er); $9,100 if head of household; $6,200 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 2014 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 2014 Form W-4* worksheet in Pub. 505.)	5	$
6	Enter an estimate of your 2014 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 $3,950 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 2014. 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 2014. 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 - $6,000	0
6,001 - 13,000	1	6,001 - 16,000	1
13,001 - 24,000	2	16,001 - 25,000	2
24,001 - 26,000	3	25,001 - 34,000	3
26,001 - 33,000	4	34,001 - 43,000	4
33,001 - 43,000	5	43,001 - 70,000	5
43,001 - 49,000	6	70,001 - 85,000	6
49,001 - 60,000	7	85,001 - 110,000	7
60,001 - 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 - $74,000	$590	$0 - $37,000	$590
74,001 - 130,000	990	37,001 - 80,000	990
130,001 - 200,000	1,110	80,001 - 175,000	1,110
200,001 - 355,000	1,300	175,001 - 385,000	1,300
355,001 - 400,000	1,380	385,001 and over	1,560
400,001 and over	1,560		

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

You 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.

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 CA	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.